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THE MEANING OF THE LIVED EXPERIENCE OF NURSING FACULTY ON A DEDICATED EDUCATION UNIT

By

Deborah Ann DeMeester

Bachelor of Science in Nursing
Indiana University
1979

Master of Science in Nursing
Indiana University
1990

A dissertation submitted in partial fulfillment
of the requirements for the

Doctor of Philosophy in Nursing

School of Nursing
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ABSTRACT

The Meaning of the Lived Experience of Nursing Faculty on a Dedicated Education Unit

by

Deborah Ann DeMeester

Dr. Tish Smyer, Examination Committee Chair
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In 2011, 58,327 qualified applicants were denied admission to U.S. baccalaureate programs due to an inadequate number of qualified faculty, insufficient clinical placement sites, and resource constraints. Nursing faculty leaders are being challenged to increase enrollment to address a projected worsening nursing shortage and to transform prelicensure nursing education to ensure that program graduates have the nursing skills and competencies to meet the health care needs of the population.

Collaborative educational partnerships offer promising strategies to diminish the nursing faculty shortage, educate more students, and provide stable, rich learning environments. The Dedicated Education Unit (DEU) model is one of these newly developed educational partnerships between a university and a hospital. As part of this model, baccalaureate nursing students are immersed in real-life experiences under the direct supervision of staff nurses who have been trained to be clinical instructors. The university faculty mentor the staff nurse instructors. The faculty role in a DEU differs from their role in the traditional faculty-supervised clinical model; therefore, it is anticipated that faculty may experience a shift in thinking and a period of adaptation to this new clinical model and learning environment. Studies of transition experiences in nursing education have revealed that a period of adjustment can be expected for faculty

who are either new to teaching or new to a different learning platform. The meanings of the experiences of faculty who teach in the DEU model have not previously been studied.

The purpose of this study was to describe, interpret, and offer insight into the meanings of the lived experiences of nursing faculty in DEUs across several prelicensure baccalaureate programs. The phenomenological approach of Max van Manen guided the inquiry, and Colaizzi's seven-step method was used to systematically analyze and interpret the meanings of the hermeneutic faculty interviews. The research question that guided the study was: What is the meaning and significance of the lived experience of being a faculty member on a Dedicated Education Unit used for prelicensure baccalaureate nursing education?

Eight nursing faculty members from seven schools of nursing participated in the study. The findings gleaned from the interview data analysis led to the development of a model depicting the fundamental structures of the overall essence of "The DEU as a New Synergy of Learning: Becoming a Guardian" which includes the three major themes and a total of nine subthemes. The information gathered in this study will be useful for faculty members who are preparing to engage in teaching on a DEU and for nursing education leaders who will be supporting faculty development.

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First and foremost, I must acknowledge the support of my wonderful family. My husband, Gary, has been my rock and my soul mate. He has given me love and encouragement throughout the 32 years of our marriage. My daughters, Stephanie and Kimberly, inspired me daily with their intelligence, wit, and passion for life. The three of us shared a "lived experience" in 2009 as students in our respective doctoral, graduate, and undergraduate programs. We did it, girls.

I did not know what the future held when I embarked on this journey three years ago. I knew that I would be challenged intellectually, but the personal challenges were unanticipated. To all who rallied around me, thank you for helping me find my inner fierceness to be successful in doctoral studies while enduring chemotherapy, surgery, and radiation during my first year and the death of my father the second year. I will never forget the day my IU students all came to class dressed in pink. Thank you to my parents, Leo and Rita, for giving me life. Thank you to my family, friends, professors, colleagues, doctoral student peers, and students for enriching my life. Thank you to Dr. Denman, Dr. Miller, and Dr. Goulet for saving my life.

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Finally, to all women who have joined the ranks of cancer survivors: never underestimate the power of pink.

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CHAPTER I

INTRODUCTION

Background and Significance

Faculty leaders are being challenged to transform prelicensure nursing education to expand enrollment capacity and ensure that graduates have the appropriate skills and competencies for 21st century nursing. Although Buerhaus, Auerbach, and Staiger (2009) reported a recent surge in nurse employment that is likely temporary, the American Association of Colleges of Nursing (AACN) reports that according to the U.S. Bureau of Labor Statistics, approximately 495,000 new nurses will be needed as replacements within a workforce that will need to grow to 1.2 million to fulfill the healthcare requirements of U.S. citizens by 2020. Additionally, the AACN projects that the demand for Advanced Practice Registered Nurses (APRN) will increase with governmental health care reforms (American Association of Colleges of Nursing, 2012c). Although a recent enrollment surge has occurred, the AACN 2011 Survey revealed that 58,327 qualified applicants were denied admission to U.S. baccalaureate programs due to inadequate numbers of faculty (62.5%), insufficient clinical sites (65.2%), limited classroom space (46.1%), insufficient numbers of preceptors (29.4%), and budget cuts (24.8%) (AACN, 2012a). Similarly, the National League for Nursing (NLN) 2011 Annual Survey of Schools of Nursing further confirmed that the three main obstacles to baccalaureate program expansion were lack of faculty, lack of clinical placements, and lack of classroom space (National League for Nursing, 2012). The average age of nursing faculty is rising, and Allan and Aldebron (2008) project that the number of newly prepared nurse educators will not meet the anticipated upcoming retirements. An AACN faculty vacancy survey revealed a total of 1,088 open faculty positions in baccalaureate

and graduate programs of nursing (AACN, 2012b). Inadequate numbers of nursing faculty members and lack of clinical placements and resources will worsen the projected increases in the nursing shortage if schools of nursing cannot accommodate the anticipated demand for more registered nurses and APRNs in the future. Aiken, Cheung, and Olds (2009) found that nurses prepared at the baccalaureate level are more likely to pursue graduate nursing degrees than associate-degree educated nurses; therefore, a focus on strategies to expand capacity in baccalaureate programs will have the potential to fulfill the need for more faculty and APRNs.

The search for solutions to capacity issues must be considered in concert with the quest for nursing program quality enhancement. The 2010 Institute of Medicine (IOM) and the Robert Wood Johnson Foundation joint report, *The Future of Nursing: Leading Change, Advancing Health,* recommends that nurses should achieve higher levels of education through an improved education system. The Carnegie Foundation for the Advancement of Teaching report, *Educating Nurses: A Call for Radical Transformation*, asserts that new graduate nurses are unprepared for the complexity of current nursing practice (Benner, Sutphen, Leonard, and Day, 2010). This report calls for shifts in thinking and approaches to nursing education that include a focus on salience and situated cognition, an integration of didactic and practicum teaching, a shift to clinical reasoning and multiple ways of thinking, and an emphasis on formation. Day, Benner, Sutphen, and Leonard (2009) emphasize the importance of teaching students to use practical reasoning in real time. Citing results of a national survey, Ironside and McNelis (2010) reported that the traditional clinical education model does not allow faculty adequate time to foster clinical reasoning skills due to the time required for skill

supervision. Haas et al. (2002) identified faculty concerns that the threshold for safety had been reached in the traditional faculty-supervised model as the impetus for the development of a collaborative partnership.

Joynt and Kimball (2008) describe the recent surge in the use of a variety of collaborative partnerships that redesign clinical education to utilize the expertise of practicing nurses. One such partnership is the Dedicated Education Unit (DEU) clinical education model, which reserves one or more inpatient hospital units for the exclusive use of one school of nursing. Junior and/or senior-level nursing students learn in a dyadic partnership with one staff nurse clinical instructor, who is in turn mentored as a teacher by a faculty member from the affiliating school (Moscato, Miller, Logsdon, Weinberg, & Chorpenning, 2007).

Preliminary evaluations of the DEU model suggest that enrollment capacity can be increased and there is improved staff and student satisfaction with the clinical learning environment (Joynt & Kimball, 2008; Moscato et al., 2007; Murray, Crain, Meyer, McDonough, & Schweiss, 2010; Mullenbach & Burggraf, 2012; Rhodes, Meyers, & Underhill, 2012). However, little evidence exists to support the educational effectiveness of the model and only meager descriptions of the experiences of the students, staff, or faculty engaged in the DEU learning environment. The AACN joined with the American Organization of Nurse Executives (AONE) to form a Task Force on Academic-Practice Partnerships. They conducted a survey of 295 deans, 111 nurse executives, and 32 public health nursing leaders and found that more than 60% of the respondents reported that they not collected data on the outcomes of their partnerships (AACN-AONE Task Force on Academic-Practice Partnerships, 2012). The 2008 NLN Think Tank on Transforming

Clinical Nursing Education emphasized the importance of challenging the assumptions upon which traditional clinical models are built and conducting research on newly developed clinical models. Dissemination of information about the DEU clinical model was one of the Think Tank's recommendations (NLN, 2009).

The DEU concept was originally developed at the Flinders University of South Australia (FUSA) in Adelaide in the late 20th century to create a learning environment with a culture of respect and dialogue that maximized the contributions of all unit staff nurse clinicians, the assigned academic faculty, and upper-level students who served as peer teachers (Edgecombe, Wotton, Gonda, & Mason, 1999). The DEU model arrived in the U.S. when the University of Portland (UP) School of Nursing introduced its own adaptation in 2003 (Moscato et al., 2007). The UP model deemphasizes the peer tutoring component of the FUSA model in favor of a strong and consistent relationship between a staff nurse clinical instructor and a junior- or senior-level nursing student. Nursing faculty members in the UP model are more closely involved in the DEU than those in the FUSA model as the "university liaisons in residence" who support the staff nurses. Key features of the UP DEU model include (a) the exclusive use of the nursing unit by one school of nursing, (b) a university-sponsored workshop to prepare staff nurses for the instructor role, (c) ongoing mentoring, and (d) collaborative evaluation of student outcome achievement. Because it is better aligned with state boards of nursing regulations and national trends in nursing education, U.S. adopters of the DEU model are using frameworks similar to that of UP, although there is some variation in the working titles given to the staff nurses and the faculty and a school of nursing may use more than

one unit for a DEU-modeled clinical section simultaneously (Ryan, Shabo, & Tatum, 2011; Shake, 2010; Warner & Moscato, 2009).

Definitions of Clinical Education Models

For the purpose of this study, the following definitions of three clinical education models were used.

Dedicated Education Unit (DEU): a clinical model that uses one or more designated inpatient units developed as optimal teaching/learning environments through the collaborative efforts of nurses, management, students, and faculty (Warner & Moscato, 2009). Although both a preceptorship and a DEU use staff nurses as clinical teachers, a DEU provides an ongoing culture of learning for students enrolled in clinical courses at multiple levels. It is important to note that the nursing unit on which students learn in this model is also referred to as a DEU.

Preceptorship: a clinical model that focuses on a one-to-one relationship between a staff nurse and a nursing student during an intense, time-limited clinical experience (Udlis, 2008). In prelicensure programs, preceptorships are most often implemented in senior-level clinical courses with nursing students who are completing the final weeks of the last semester of a nursing program. This model is not unit-based or facility-based and the faculty members may interact with preceptors who are in many different practice locations in multiple healthcare agencies.

Traditional Faculty-Supervised Clinical: a clinical model in which, typically, six to ten prelicensure nursing students are directly supervised during the provision of patient care on one or more nursing units by a faculty member from an affiliating university.

Definitions of Participants in the DEU Model

For the purpose of this study, the following definitions of the participants in the DEU clinical model were used.

Nursing Faculty: registered nurses (RNs) with a full-time academic appointment at a college or university who serve as faculty of record for a clinical nursing course on one or more DEUs. The faculty member serves as the bridge between the affiliating school of nursing and the clinical agency and mentors staff nurses to serve as clinical instructors.

Staff Nurse Clinical Instructor (SNCI): a staff nurse with a valid RN license who, after attendance at an orientation workshop, instructs the same one or two prelicensure nursing students while providing care to a caseload of patients on a DEU. It is important to note that the acronym SNCI was used uniformly in this dissertation regardless of the actual term used by the participants in order to enhance confidentiality by omitting any unique titles that could be a nursing program identifier.

Nursing Student: an individual who is unlicensed and enrolled in an undergraduate clinical nursing course in a baccalaureate program at the affiliating school of nursing. This individual provides patient care under the direct supervision of a staff nurse clinical instructor (SNCI) on a DEU.

Problem Statement

The current state of the science about the DEU model is primarily limited to descriptions and challenges related to establishing DEU partnerships, capacity impact, patient satisfaction, and inquiries that focus on advantages and disadvantages or satisfaction of students, staff nurse clinical instructors, faculty members, and administrators (Castner, Ceravolo, Tomasov, & Mariano, 2012; Glazer, Erickson, Mylott,

Mulready-Shick, & Banister, 2011; Moscato et al., 2007; Mulready-Shick, Kafel, Banister, & Mylott, 2009; Murray et al., 2010; Parker & Smith, 2012; Rhodes et al., 2012; Ryan et al., 2011; Warner & Burton, 2009). More than 100 schools of nursing sent representatives to a symposium devoted to the DEU model in 2007 (IOM, 2010). Although this model is increasing in popularity, strong supporting evidence and rich descriptions of the experiences of participants have not been reported.

Although the DEU model relies on staff nurses to provide the direct clinical instruction, nursing faculty retain the ultimate responsibility for the learning experience. Oermann (1996) contends that, regardless of the setting or model, nursing faculty members play a decisive role in ensuring meaningful clinical experiences that facilitate student achievement of course outcomes and preparation for nursing practice. Warner and Burton (2009) describe faculty as the linchpin in the success of innovative partnerships such as the DEU, yet a study that specifically examines the experiences of the faculty has not been published.

Niederhauser, MacIntyre, Garner, Teel, and Murray (2010) purport that the faculty role changes when clinical education is redesigned to facilitate relationships between student nurses and staff nurses. The change may be associated with a period of transformation within the faculty experience. The nursing education literature from the last 25 years is replete with reports that nursing faculty undergo a period of transition upon initial entry into academia from the practice role (Anderson, 2009; Esper, 1995; Infante, 1986; Janzen, 2010; McDonald, 2010; Schriner, 2007). A period of evolution or change has also been described when either novice or veteran nursing faculty move from the classroom setting to the online learning environment or from a community college to

a research-intensive university (Diekelmann, 2000; Ryan, Hodson-Carlton, & Ali, 2004; Johnson, 2008; Zambrowski & Freeman, 2004). The studies about these transitions have revealed the need for development and support as faculty experience new faculty lifeworlds. The meanings of the experiences of faculty as they have prepared for and moved into teaching in the DEU learning milieu have been unexplored. An in-depth inquiry into faculty perspectives about meanings of the experience of teaching in this promising model of clinical education was needed to address the knowledge gap.

Purpose of the Study

The purpose of this phenomenological study was to describe, interpret, and offer insight into the meanings of the lived experiences of nursing faculty in DEUs across several prelicensure baccalaureate programs. Clinical nursing education is a very resource-intensive undertaking, and it is of paramount importance to prepare baccalaureate program graduates to be safe and effective managers of care. The DEU model of clinical education has the potential to increase program capacity, ensure stable clinical placement sites, use faculty resources efficiently, and provide students with authentic interdisciplinary experiences in a complex clinical environment under the guidance of a staff nurse clinical expert. The findings of this study will deepen the understanding of the faculty experience on a DEU, and the insights gained may ultimately strengthen relationships among the stakeholders, optimize resources, and enhance the model's sustainability. This information will be useful for faculty members who are preparing to embark on teaching in a DEU and for nursing education leaders who will be supporting faculty development for clinical teaching on a DEU. The study is

intended to move what is known about faculty involvement on a DEU from a job description to an understanding of a new faculty "lifeworld."

Research Question

The research question that guided the study was: What is the meaning and significance of the lived experience of being a faculty member on a Dedicated Education Unit used for prelicensure baccalaureate nursing education?

Chapter Summary

This chapter offered background information about the DEU clinical model, which was developed to address nursing program capacity and clinical placement issues and to optimize resources for effective and authentic clinical nursing education. The operational definitions of key concepts, the purpose of the study, and the guiding research question for this phenomenological study of the meanings of faculty experiences on a DEU were presented.

CHAPTER II

REVIEW OF RELATED LITERATURE

The review of literature related to the study was conducted using the search terms *faculty role, nursing education, dedicated education unit, lived experience, preceptorship, clinical education*, *practice education partnerships*, and *clinical teaching* in the electronic databases CINAHL, Ovid, Academic Search Premier, ProQuest, and ERIC. The first three categories of reviewed studies were conducted within the contexts of the following clinical education models: the DEU, preceptorships, and traditional faculty-supervised clinical experiences. The fourth category includes studies conducted about transitions into a faculty position from practice or changes encountered by faculty members when moving from teaching in one learning environment or model to another. The studies are summarized in Appendix A.

Dedicated Education Unit Clinical Model

The majority of the studies reviewed used the DEU as a context focus to look at the perceptions of students and SNCIs. Two were Australian studies of the original DEU clinical model, and eight of the studies were conducted within the context of a DEU in the United States. One U.S. study was excluded from the review because it was limited to a survey of students who were specifically evaluating a peer mentoring program on a DEU rather than any aspects of the DEU clinical model itself. A study conducted within the context of a second-degree program that prepared students for the Clinical Nurse Leader (CNL) role was excluded because the students were involved in graduate level coursework. No studies had an exclusive focus on the faculty experience on a DEU. Five expository manuscripts and two studies conducted within the context of a DEU were also included in the review.

In one of the earliest evaluations of the Australian FUSA model DEU, Gonda, Wotton, Edgecombe, and Mason (1999) used semi-structured questionnaires to collect data from students and SNCIs. Themes that emerged were (a) the DEU as a preferred placement model, (b) opportunities for student and staff nurse learning, (c) peer teaching and learning, (d) clinician and academic facilitation, (e) workload issues, and (f) positive relationships. Students reported that they would have liked more frequent feedback meetings with the academic faculty. In a later study of an Australian model DEU, Ranse and Grealish (2007) used a community-of-practice framework to analyze focus group data from 25 nursing students. Acceptance, learning and reciprocity, and accountability were the identified themes, with the student responses all positive in nature. The positive student and SNCI responses in the Australian studies lent support for the development of DEUs in the United States.

Two studies conducted in the U.S. included the faculty perspective on a DEU in conjunction with those of SNCIs and nursing students. Moscato, Miller, Logsdon, Weinberg, and Chorpenning (2007) used student questionnaires, focus groups, a faculty time survey, and faculty meetings to evaluate a DEU in the United States three years after implementation. Students reported feeling supported and part of a team; SNCIs reported feeling energized and challenged, yet uncertain about their student evaluation skills. Faculty reported that their greatest challenge was maintaining communication with and supporting the SNCIs. The time survey demonstrated that faculty spent a considerable amount of time being present on the nursing unit, but only minimal time with teaching, coaching, and evaluation activities with the very busy SNCIs. Faculty reported interacting with students in clinical reasoning activities while on the unit. Although this

study adds information about nursing students' and SNCIs' perceptions of the DEU experience, neither the reliability and validity of the instruments used nor the sample sizes of the student, faculty, and SNCI participant groups were reported. It is unclear whether the focus group participants knew the faculty investigators. The study provided a list of activities in which faculty members spent their time on a DEU and communication challenges with SNCIs, but the essence of the faculty experience was not explored.

Rhodes, Meyers, and Underhill's (2012) longitudinal, descriptive, mixed-method study of DEU outcomes, perceptions, and satisfaction included a sample of 85 senior nursing students, 45 staff nurses, and four faculty members. The study procedures included the distribution of surveys and conduction of focus groups. The students completed a 21-item investigator-developed survey about perceptions, benefits, and satisfaction using a four-point Likert-type response scale both at the end of the DEU pilot and again the following semester. Content validity was established using a panel of four experts, and reliability measures revealed a Cronbach's alpha for the scale of 0.88. The reported subscale mean student scores were 3.7 for staff-student relationships, 3.8 for critical thinking and learning, and 3.6 for evidence-based practice. A total of 31 students completed the 23-item Clinical Learning Environment Scale – Revised (CLES-R), which used a five-point Likert-type response scale, during the second semester of the study. The reported CLES-R subscale reliability measures ranged from a Cronbach's alpha of 0.43 to 0.79, with an overall reliability coefficient of 0.85. The reported subscale mean student scores were 4.25 for staff-student relationships, 3.87 for hierarchy and ritual, 4.1 for DEU nurse commitment, 4.0 for patient relationships, and 4.6 for student satisfaction.

Rhodes et al.'s (2012) study also measured staff nurses' responses to a 23-item investigator generated survey about professional and academic goals that had a reported reliability of 0.79. The reported subscale means for staff nurse scores were 3.5 for satisfaction, 3.4 for professional development, 3.5 for team effort, and 3.3 for support for nurse. Fifteen of the 45 staff nurses participated in focus groups. A focus group was conducted with the four faculty participants at the end of the second semester of the DEU pilot. The questions posed were about differences, challenges, and the development of the staff nurses as teachers. The responses included one report that the faculty role is different in a DEU but no elaboration was provided. The faculty participants described how they spent time mentoring staff nurses in professional development and mentoring students in how to interact with the DEU nurses. Faculty satisfaction with the DEU was generally positive. This study found that students, staff nurses, and faculty in that sample had favorable perceptions of the DEU clinical model, but it does not offer in-depth information about the faculty experience. It is limited to faculty from one university without reported demographic characteristics and data were gathered collectively as a focus group. The procedure for analysis of the focus group data is not reported nor whether the session was audiotaped for confirmability. Although this study offered several pages of mixed-method results about student and staff nurse responses, the faculty focus group responses were summarized in five paragraphs. A rich portrayal of the faculty experience was not described.

Four studies have focused exclusively on students' and/or SNCIs' perceptions within the DEU model. An external evaluator was used to conduct separate focus groups with 16 junior-level students and nine staff nurse clinical instructors in Mulready-Shick, Kafel,

Banister, and Mylott's (2009) pilot study of student achievement of quality and safety competencies on a DEU. The students in the study created and presented quality improvement and teaching-learning projects to the DEU staff. Students reported feeling a greater sense of responsibility for the coordination of care and interdisciplinary communication. The SNCIs reported being impressed with the project presentations and described opportunities for incorporating patient safety teaching. This study was strengthened by the use of an external evaluator and focus group questions that were mutually agreed upon by all members of a DEU task force. Although the student projects were well received, completion of this type of project would not require placement on a DEU.

Ryan, Shabo, and Tatum (2011) explored students' and SNCIs' satisfaction and student achievement of course outcomes in a pilot study on a newly created pediatric DEU. The data collection strategies included focus groups, field notes taken during clinical conferences, electronic student self-evaluations, and a six-item clinical course evaluation tool. The sample included 24 students from a DEU, 22 students from a faculty-led clinical site, and an unreported number of DEU staff members. The DEU students reported performing relatively more hands-on nursing care and had higher satisfaction scores on the course evaluation tool. Identified student themes were: (a) no more watchful waiting, (b) what a nurse is, (c) practice makes perfect, and (d) part of the team. The DEU staff gave positive feedback, but the themes were not reported. The quality of this study was lessened by the lack of reported tool psychometrics, small sample size, and unreported significance level of the between-group differences. Furthermore, the inclusion of other staff members who were not instructors calls the

validity of the staff findings into question. It is unclear whether the investigator knew the participants.

Mullenbach & Burggraf (2012) studied student perceptions before and after a clinical experience on one of five long-term care DEUs which were also known as Dedicated Learning Units (DLUs). They found significantly ($p < .05$) higher scores for student perceptions of being prepared after the DLU experience. Student journal analysis revealed mostly positive comments about the clinical model.

Murray and James (2011) used a strategic alliance framework to evaluate a DEU partnership. Using unspecified clinical evaluation data and staff nurse comments, they surmised that the staff nurses believed that the students gained improved prioritization and delegation skills, better team integration, more opportunities to perform psychomotor skills, and increased confidence and critical thinking ability. This single-site study did not report the sample size, reliability or validity of the evaluation tools used, or how the data were collected; therefore, the results may not be generalizable.

Five expository manuscripts regarding the policy and politics of DEU development or DEU evaluation methodologies were reviewed. Burke, Moscato, and Warner (2009) and Glazer et al. (2011) both described the processes of relationship building and political navigation that they contend are integral to successful DEU partnerships. Burke and Craig (2011) underscored the regulatory challenges that the developers of DEUs may face and suggested collaboration with local boards of nursing. Two publications proposed possible models through which the effectiveness of the DEU model can be measured; however, the perceived experiences of the faculty or other stakeholders were not included (Murray et al., 2010; Murray, MacIntyre, & Teel, 2011).

Two studies completed within the context of the DEU clinical model respectively investigated either a nursing unit's readiness to become a DEU (Parker & Smith, 2012) or patient satisfaction on a unit that had become a DEU (Castner, Ceravolo, Tomasov, & Mariano, 2012). Neither of these studies included any inquiry into the experiences of faculty, students, or staff nurses.

Most of the studies that used the DEU clinical model as the context to investigate the perceptions of the participants used satisfaction surveys and/or focus groups for students and staff nurses. All of the inquiries that included faculty members were based upon focus group data. According to Patton (2002) the advantages of focus groups are that (a) they are efficient, (b) false information and extreme views are minimized, and (c) they have inherent mechanisms of checks and balances. However, the potential for power struggles, domination by a few participants, and the loss of confidentiality may decrease the trustworthiness of focus group data. The review of the studies that have been completed within the DEU context suggests that the model's benefits need more in-depth study. The lack of information about the faculty experience on a DEU supports the need for this study.

Preceptorship Clinical Model

Because both preceptorships and DEUs use staff nurses as the primary clinical teachers of students, studies of preceptorships may provide relevant information for DEU faculty and stakeholders. In both models there are intentional faculty interactions with staff nurses and nursing students. One integrative review and three studies of faculty engagement in prelicensure preceptorships were reviewed. The studies were conducted using samples of preceptors and/or students with or without the inclusion of faculty

members as participants. One study collected data from a sample that was limited to faculty participants. One expository article about the faculty experience in a preceptorship was also included in the review.

Udlis' (2008) integrative review of 16 empirical studies of undergraduate nursing student preceptorships identified that the most prevalent variables studied were (a) student outcomes, (b) performance, (c) socialization, (d) role concepts, (e) learning styles, and (f) competence. Udlis' review revealed that 56% of the studies generally supported the efficacy of preceptorships and 44% found no significant differences between precepted and traditional faculty-supervised models of clinical instruction.

Hsieh and Knowles (1990) explored faculty facilitation of relationships with a sample of 12 preceptors, 12 students, and two faculty members in a two-year nursing program that used a preceptorship model. Data collection included naturalistic observations, faculty debriefing, and a three-item questionnaire given to students and preceptors. Students and preceptors were asked about the development of their relationship with each other and which faculty behaviors were most helpful. The investigator validated observations during faculty member debriefing sessions. The seven themes that emerged were (a) trust, (b) clearly defined expectations, (c) support systems, (d) honest communication, (e) mutual respect and acceptance, (f) encouragement, and (g) mutual sharing of self and experience. Trust was crucial to all of the other themes. The faculty members considered role modeling and providing guidance during student peer support meetings to be facilitative behaviors. The presence of the investigator, who accompanied the faculty during visits, may have influenced the interactions. This study describes facilitative faculty behaviors from the perspective of students and staff nurses, but

insights from the faculty perspective were not deeply explored. The generalizability of the results to a baccalaureate program may be limited.

Nehls, Rather, and Guyette (1997) employed a Heideggerian interpretative phenomenological approach in an exploration of the lived experiences of 10 nursing students, 11 staff nurse preceptors, and 10 faculty members in a senior-level clinical course the end of the program. The interviewers sought descriptions of paradigm cases from the participants. "Learning nursing thinking" was the constitutive pattern identified based upon the prevalence of descriptions by students, preceptors, and faculty members. The investigators labeled the faculty experience as "teaching as nursing" due to the inseparable nature of teaching from nursing. They used a team approach to build consensus on the interpretations and verified the overarching theme with outside experts to enhance trustworthiness. This study adds to nursing education knowledge by describing the synergistic experiences of senior-level students, preceptors, and faculty members in a collaborative triadic teaching model. It adds a rich description of the collective experience of participants, but the faculty experience may have been diluted since data from all participant roles were jointly interpreted.

Luhanga, Yonge, and Myrick (2008) used grounded theory to explain the processes preceptors use in managing unsafe nursing students, conducting semi-structured interviews with 22 staff nurses serving as preceptors for senior-level nursing students in acute care settings in Canada. Faculty members were not consistently present during the student experiences and made infrequent visits. In describing situations in which students were experiencing difficulties, the preceptors reported reliance on the faculty to facilitate decisions about student performance and emphasized the importance of faculty

availability. The researchers developed a model for the process of precepting a student thought to be unsafe. The faculty responsibilities were described as developing a joint plan of action with the preceptor, creating an environment conducive to learning, giving ongoing feedback, planning remedial interventions, and ultimately making the decision about whether the student should receive a failing grade. Continuous monitoring, communication, and active involvement were considered crucial elements of the faculty role in preceptorships. The faculty perspective was not considered in the study.

Yonge, Ferguson, Myrick, and Haase (2003) used telephone interviews with a sample of eight faculty members to explore preparedness for teaching in preceptor-based clinical courses. They reported the level of perceived preparedness as inconsistent and referred to faculty as the "forgotten link." Those who felt well prepared had read research reports, attended presentations, interacted with other faculty, and/or were familiar with the setting. Those who felt unprepared had inadequate information and/or were unclear about expectations. Yonge et al. summarized the faculty responsibilities in a preceptorship as supporting students and preceptors, ensuring students' knowledge application, communicating curriculum trends, and completing administrative and scheduling tasks. This study draws attention to the need for faculty preparation prior to engagement in teaching collaboratively with preceptors.

Beeman (2001) expressed her thoughts and feelings about the initial faculty experience of using staff nurse preceptors for a clinical group of seven junior-level nursing students on a post-surgical unit. Faculty responsibilities were depicted as recruiting preceptors, conducting a preceptor workshop, conducting five post-conference sessions with students, being available for consultation, and managing the overall

experience. The author shared personal reflections on the experience that included emotions such as nervousness, concern, worry, and uncertainty about where to spend time during the scheduled clinical experience. Relinquishing power was considered as a possible factor in these reported emotions. Finding time to talk with students was the only reported challenge. Benefits included serving as a resource and guide for preceptors and being able to focus on facilitating understanding of concepts with students rather than "running from student to student passing medications and performing various skills" (Beeman, 2001, p.133). This self-report adds insight to the meanings of the faculty experience when moving from a faculty-led model to one using staff nurses; however, generalizations cannot be made from the experience of one person.

The studies conducted within the context of preceptorships reveal that faculty teaching in preceptorships value the opportunity to role-model professional nursing. Faculty who are new to preceptorships may feel uncertain about their role; however, preparedness can be enhanced by interacting with experienced peers and reading relevant research papers. Finally, preceptors desire increased faculty involvement with students whose performance is substandard.

Traditional Faculty-Supervised Clinical Model

The traditional faculty-supervised clinical model has been the "gold standard" for clinical education for a long time. The researcher recalls being educated in this model during her baccalaureate nursing education in the late 1970s. Many faculty assigned to DEUs may have experience teaching or having been taught themselves in this traditional model. This portion of the literature review included two integrative reviews, three descriptive studies, and three phenomenological qualitative studies.

Oermann (1996) performed an integrative review of 94 clinical teaching studies from 1965 to 1995 that investigated teacher behaviors, clinical teaching methods, student perceptions, and other factors that related to student clinical experiences. Several of the studies of teacher characteristics or behaviors were examined from the perspective of nursing students. The review revealed that effective clinical teachers are willing to share knowledge with clear explanations, plan meaningful assignments, demonstrate clinical competence and judgment, and evaluate students in a fair and honest manner with positive and consistent feedback. After review of studies of faculty-student interpersonal relationships, Oermann noted that clinical teaching is an interactional process in which faculty must develop effective relationships with learners. The positive impact of enthusiasm for teaching was consistently identified in the research review. Oermann concluded that further study is needed to more clearly describe the role, instructional activities, preparation, and stresses of clinical teachers. A total of 46 of the studies in Oermann's review were investigations of clinical teaching methods. Making patient assignments, evaluating students' written assignments, stimulating critical thinking through clinical post-conferences, scheduling observation experiences, enhancing instruction through the use of multimedia, and collaborating with staff nurses in preceptorships were the faculty activities most commonly studied during the 30-year time frame of the review. Many of the studies in the review used small convenience samples. This review added to the body of knowledge about characteristics of successful clinical faculty and the activities clinical faculty may perform, but subjective faculty experiences were not revealed in these studies.

Halstead's (1996) integrative review of 31 research-based studies explored the significance of student-faculty interactions in nursing education. This review was framed around the areas of student socialization, power balance, and various aspects of student faculty interactions. Halstead concluded that faculty interactions and role modeling heavily influence students' socialization into nursing and development of a professional identity. Furthermore, faculty who demand power and control may negatively influence students in the clinical learning environment. Although there were several inquiries into student perceptions of faculty interactions, Halstead found little research that explored faculty perceptions about their student interactions. The few studies in this area were comparisons of what students and faculty considered important in interactions. Students tended to value interpersonal relationships more highly than faculty. Faculty placed a higher value on portraying competence. This review highlighted the importance of faculty-student relationships in nursing education and provided support for the need to explore how faculty members experience their relationships with students and other stakeholders on a DEU.

Five quantitative studies of clinical nursing faculty were reviewed. Ard, Rogers, and Vinten (2008) surveyed National League for Nursing (NLN) members and state boards of nursing representatives in a descriptive study of the essential components and participants in clinical nursing education. A total of 2,218 NLN members and 28 board of nursing representatives participated in the study which involved completing a demographic questionnaire and a 51-item instrument that included five subscales and used a four-point Likert response scale. The survey was based upon a literature review and the research team's personal experiences as educators. In addition to the quantitative data collected,

the investigators reviewed the "many" qualitative comments that were included in a space provided for further remarks. Ninety-three percent of the respondents agreed or strongly agreed that the active involvement of a teacher is essential for an experience to be considered clinical. Ninety-three percent also agreed that faculty members should think conceptually about clinical learning rather than viewing it as rotations to meet required clinical hours, and 97% agreed with the need for an immersion experience. Five scale items pertained to the role of the faculty members as clinical teachers, resulting in almost unanimous agreement (99 – 100%) that teachers should (a) work with the agency staff to promote positive learning environments; (b) help students clarify and reflect on their clinical experiences; and (c) facilitate, guide, critique, and evaluate student performance. Ninety-six percent of the respondents agreed or strongly agreed that teachers should work with students to develop learning outcomes and arrange experiences. The lowest level of agreement was on the item that the teacher does not need to be physically present; only 58% of NLN members and 47% of nursing board members agreed with this statement. Notably, this item was the only negatively worded item on this subscale. The research team included comments from two respondents about faculty presence. One respondent contended that faculty presence should be the gold standard and another asserted that clinical faculty must be passionate and clinically experienced. Noteworthy study findings were the perceived importance of active faculty member involvement and lack of consensus about the importance of faculty member presence. Because faculty member presence and involvement may be different in a DEU model, these findings lend further support for the need to explore these aspects of the faculty experience in a DEU. The large sample size was a strength of the study; however, the reliability and validity of the

results are unknown because the psychometrics of the instruments used were not reported. This study did not focus on one particular model of clinical instruction; therefore, generalization to any one clinical instruction model must be made cautiously.

Ironside & McNelis' (2010) study of clinical education in prelicensure nursing programs included an instrument that asked faculty to identify and rank the three most time-consuming activities performed in the clinical setting. A total of 68.6% of the 2,386 faculty respondents ranked supervising students' skill performance as one of the top three. Of the respondents who ranked this activity as number one, 51% indicated that direct skill supervision accounted for 50 - 100% of their time in clinical. Assisting students to synthesize clinical information (48.8%) and questioning students to assess their knowledge of their patient's status (36.6%) were the second and third most frequently cited activities. Only 9% included interacting with clinical agency staff and other health care providers in the top three. The top three challenges identified were providing appropriate guidance and supervision to students (50.2%), teaching students to make clinical judgments (49.1%), and providing meaningful feedback to students (28.6%). Although supervision and feedback were among the top three activities in which faculty engaged, providing "appropriate" guidance, giving "meaningful" feedback, and supervising students' skill performance were among the top five challenges faculty faced. Anticipation of patient or student needs, time organization, and reliance on staff nurses or more experienced students were the most frequently reported strategies used to deal with these challenges. They rated the strategies as somewhat effective or effective; however, the investigators noted that is unclear whether the respondents answered from the perspective of effective management of the clinical day or from the perspective of

effective student learning. The investigators also noted that some participants reported exhaustion and frustration in their faculty role in the clinical setting.

Additionally, Ironside and McNelis (2010) asked the respondents about the use and nature of activities prior to and immediately after clinical experiences. Nearly 77% of respondents reported using a pre-conference group meeting prior to clinical, whereas 90% reported having group post-conferences at the end of the clinical day. A limitation of these findings is that the respondents were not asked about the model they employed in clinical teaching; therefore, it is unknown whether any respondents were involved in preceptorships or other collaborative models. Because the majority (60.1%) of the respondents had primary teaching responsibilities in associate or diploma programs, generalizing the results to baccalaureate programs must be done with caution. This study served to highlight the challenges faculty face when directly supervising student clinical experiences in current complex clinical environments.

Langen (2003) studied faculty practice requirements and role perceptions of staff nurses and full-time faculty members who taught students in acute care settings using the traditional faculty-supervised clinical model. A convenience sample was recruited from four schools of nursing and from four hospitals, each of which was associated with one of the four schools. Six faculty members and 10 staff nurses participated from the two schools/hospitals that required faculty practice, and nine faculty and 12 staff nurses participated from the two schools/hospitals in which faculty practice was not an expectation. Demographic data were collected using a questionnaire and each of the hospital's staff nurse job descriptions and each school's faculty job descriptions were reviewed. Separate tape-recorded focus groups were conducted with staff nurse

participants and faculty participants. The role episode model was used to formulate the questions, which were aimed at gathering perceptions about role expectations, role overload, role conflict, and role ambiguity. Experts reviewed the questions, the data, and the data analysis. Staff nurses reported less role overload and role conflict when engaged with faculty who maintained active clinical practice. Role ambiguity was commonly reported among the staff nurses regardless of faculty practice. Clinical faculty members reported experiencing role overload and role conflict that were not related to their own faculty practice status. Common complaints were a lack of time to interact optimally with students, difficulty with computer documentation, and the inability to meet the expectations of the staff and school administration. Faculty participants reported that staff nurses were overly task-oriented and did not keep them informed about patient status changes; staff nurses reported that faculty members did not communicate expectations clearly. Role ambiguity was not identified as a problem among the faculty respondents.

Additionally, Langan's study examined consensus and dissent among "role senders" and "focal persons" in two separate analyses. Staff nurses and administrators from both service and education were the role senders and faculty were the focal persons of the first analysis of role expectations. There were 34 expectations relative to the faculty role identified; however, there were only three areas of consensus between the role senders and focal persons: (a) teach, guide, and supervise nursing students; (b) orient, prepare, and coordinate student experiences; and (c) deliver safe patient care. Teaching, guiding, and supervising students were in the faculty job description of all four schools of nursing in the study. The main item of divergence between the role senders and focal persons

was whether it was an expectation of faculty or the staff nurses to teach first-time technologies to students.

Administrators and faculty were the role senders and staff nurses were the focal persons of the final portion of Langen's analysis from which a list of 30 staff nurse role expectations was created. The four areas of consensus about the staff nurse role expectations were: (a) invite students to observe or participate, (b) retain ultimate responsibility for patient care, (c) work as a team with faculty and students, and (d) teach students as a professional obligation. Of those four shared expectations, only retention of ultimate responsibility for patients was on the staff nurse job descriptions. The lack of consensus about items such as maintaining licensure and certification, giving safe care, documenting accurately, and following policies and procedures raises the question of whether the four different groups were divergent in their understanding of whether they were to identify global role expectations of staff nurses or only those responsibilities that related to interacting with nursing students. This calls the reliability of the consensus analysis into question. This study revealed the perceived ambiguity and communication difficulties that staff nurses and faculty face in traditional clinical models.

Four qualitative studies were reviewed. Ferguson (1996) used Gadamer's phenomenological approach to explore the lived experience of clinical educators in Australia. The four interviewees had a one-semester part-time contract to teach students in the traditional faculty-supervised clinical model. The five identified themes were (a) being human, (b) having standards, (c) developing one's own teaching style, (d) learning as you go, and (e) not belonging. The themes were then combined to form an overall model of the lived experiences that was portrayed as a "spinning top" with discrete

patterns and colors. Ferguson determined that a wealth of information had been collected after four interviews, but the achievement of saturation was not indicated. Several threats to the trustworthiness and authenticity of data included a personal and possibly hierarchical relationship with some participants, personal phone recruitment when contacting participants for other business related to the investigator's clinical coordinator role, and the lack of job security among the participants.

Five part-time faculty members were interviewed in Dickson, Walker, and Bourgeois' (2006) hermeneutic phenomenological inquiry of the lived experience of learning facilitation in a clinical practicum. Although the faculty identified staff nurse "buddies" each day with whom to pair the nursing students, the clinical model that served as the context for this Australian study was not a formal preceptorship nor a DEU and the faculty role involved some direct supervision of students' skill performance. Using Giorgi's methods, the analysis revealed five themes: (a) knowing your own limitations, (b) stepping in or stepping back, (c) developing alliances, (d) acknowledging reciprocity, and (e) identifying appropriate nurse buddies. The participants' sense of their own strengths and limitations guided their determination of when to relinquish teachable moments to nurse buddies and when to use guidance, knowledge impartment, and role modeling in providing care and patient education. One participant described a public relations aspect to the role when describing relationship-building within the facility to ensure access to valuable learning opportunities and negotiating with staff nurses to allow students to spend the day with them. The themes identified in this study add to the body of knowledge of the faculty experience when working collaboratively with staff nurses, but the lack of clarity in the described hybrid clinical model limits its usefulness.

Gazza (2009) conducted hermeneutic interviews to gain insight into the lived experiences of full-time nursing faculty in a baccalaureate program. The eight female participants taught both didactic and clinical courses. The investigator used a demographic questionnaire, an interview guide with prompts, and field notes as information-gathering tools. Themes that emerged from a five-step thematic analysis were (a) making a difference in the student, the profession, and the world; (b) being a gate keeper to the profession; (c) balancing multiple roles; (d) using support is vital, can't do it alone; and (e) developing workplace relationships – the good, the bad, and the ugly. The stories told were both positive and negative in tone, and this study provided insight into the complex nature of the lived experience of nursing faculty members. It should be noted that the study was not limited to clinical teaching and included an examination of the overall experience. The authors created a list of recommended strategies to address specific problems extracted from the transcripts.

Gazza and Shellenbarger (2010) used an approach identical to Gazza's (2009) study with a sample of nine part-time female faculty members who primarily taught clinical courses using a traditional faculty-supervised model. Themes discovered were (a) achieving the dream, (b) a group divided, (c) for the love of the students, and (d) jump in and figure it out. The results were compared to Gazza's earlier findings and a list of recommendations was made. Both groups found student interactions rewarding and both needed supports for their teaching. The groups differed in that more part-time faculty reported feeling disconnected from the program and full-time faculty reported more negative interactions with peers. This study adds additional evidence that nursing faculty

value making a difference in the lives of students, and it highlights similarities and differences in the experiences of full-time and part-time faculty.

The majority of the research that relates to the faculty role in the traditional faculty supervised model primarily focuses on what to "*do*" rather than how the role is experienced. Although faculty members consider fostering clinical judgment to be paramount, they report spending the majority of their time walking from student to student supervising skills in the traditional model of clinical teaching.

Faculty Transitions

Both novice and experienced educators may face a period of transition when moving into a new or different teaching assignment. Expository works, integrative reviews, or research studies selected for inclusion in this review focused on three aspects of nursing faculty transitions: (a) the newly appointed nurse educator, (b) the educator who has moved from the classroom to an online teaching platform, and (c) the educator teaching in a new curricular model or program. It is not prudent to assume that expertise in nursing practice or one learning context will transfer to immediate adaptation into a new teaching and learning environment.

Three expository manuscripts about the experiences of the novice nursing educator were reviewed. Using role theory as a framework, Infante (1986) contends that the transition from practitioner to a teacher of nursing is neither natural nor simple and that the two roles may actually be conflicting in nature. In order to assimilate into the new educational reference group, the role transition requires the new nurse educator to make a change in knowledge, skills, behavior, and values. In order to promote long-term role clarification, role models and mentors can serve as positive guides. Infante emphasizes

the complex nature of the transition process, including the reciprocal relationships that must be developed among the nurse educator, the student, and the staff nurses. Proper preparation and initiation into the role can minimize role conflicts that may arise for the new nurse educator.

Janzen (2010) proposes a model of transitional actualization for the novice clinical nurse educator. Using Carroll's *Alice's Adventures in Wonderland* as a framework, Janzen suggests that a novice educator initially presents at the looking glass and must gain a sense of self, others, and the role itself through reflection and interaction. During transition, the educator steps through the looking glass and begins a period of transformation from expert practitioner to expert nurse educator that occurs with the passage of time and active engagement in the role. Finally, the educator moves through to the other side of the looking glass where true change and actualization are realized.

Danna, Schaubhut, and Jones (2010) offer personal accounts of the transition from being nurse leaders to becoming nursing faculty members with an emphasis on the required adjustments. The authors outlined a sample new faculty orientation program and proposed strategies for collaboration between the leaders of nursing practice and nursing education to better prepare new faculty.

McDonald (2010) conducted an integrative review of the literature about the transition from staff nursing to the nursing faculty role. The 21 included articles were grouped into three categories: (a) knowledge deficit, (b) culture and support, and (c) salary and workload. The majority of the reviewed articles were expository or descriptive. Preparation, orientation, and mentoring programs were major themes across the articles in the area of knowledge deficit. In the area of culture and support, mentoring

and retention strategies were a common theme. Compensation and role responsibilities were the main themes of the salary and workload category. McDonald includes a narrative account of her own experience when she was new to the faculty role and its relationship to the articles reviewed. The author does not differentiate among expository or research-based articles, and the overlap among the three categories is significant.

Four qualitative studies of the novice faculty member experience were reviewed. Siler and Kleiner (2001) used Heideggerian phenomenology to study the meaning of the experience of nursing faculty members who were in their first year of employment in their current position. Using purposive sampling from 11 schools of nursing, saturation was achieved after interviewing six novice faculty members and six experienced faculty members who were in their first year at a new school. Expectations, learning the game, being mentored, and "fitting in" were the common identified themes. The researchers focused the report on the theme of expectations and noted that experienced faculty had more realistic expectations and knowledge about negotiating the academic culture. The novice faculty members reported feeling poorly prepared for the academic culture and found that strong clinical expertise did not provide them with the necessary skills for the academic role. The novice educators noted that concrete rules to follow while performing tasks in the new role were not provided and they often had to figure things out independently. The researchers concluded that nuances of the complex nursing faculty role may be difficult to articulate. The researchers recommended ongoing dialogue between novice and experienced faculty members to inform both ends of the experience spectrum. This study highlights the nebulous nature of the complex faculty role and further supports the need for rich in-depth descriptions of the faculty experience.

Peterson and Spencer's Organizational Culture Model and Schlossberg's Adult Transition theory were the basis of Schriner's (2007) ethnographic examination of the similarities and differences among the cultures of clinical nursing, the academic discipline of nursing, and the professoriate as described by nurses making the transition from the clinical nursing role to one in academia. The investigator collected the data through document reviews, 11 observation sessions, and 13 participant interviews with seven full-time faculty members without doctoral degrees who had been in a teaching role for three years or less. The thematic analysis of the data revealed six overarching themes: (a) stressors and facilitators of transition, (b) deficient role preparation, (c) changing student culture, (d) realities of clinical teaching and practice, (e) hierarchy and reward, and (f) cultural expectations versus cultural reality. In response to the cultural dissonance, stress, and lack of confidence that the participants reported, Schriner recommended that new clinical faculty need mentors, opportunities to learn the skills of pedagogy, and a system of rewards that recognizes their clinical expertise. Although the ethnographic methodology included observation and document review, the reported results of this study appear to be based solely upon the interviews.

In a qualitative study of the work role transition experience of 18 advanced practice nurses who were in their first or second year of academic teaching in a school of nursing, Anderson (2009) used tape-recorded semi-structured interviews. Member checking (i.e., validating data with participants) and peer debriefing were used until saturation was achieved. Six patterns were identified within the overarching metaphor of the "sea of academia" including (a) sitting on the shore, (b) splashing in the shallows, (c) drowning, (d) treading water, (e) beginning strokes, and (f) throughout the waters. The transitions

were described as being fluid, with periods of swirling or currents that moved participants backwards or forward. Anderson identified subthemes of drowning, which were leaving the comfort zone, fitting in and establishing relationships, learning and unlearning, facing reality, and questioning. Keeping up, adjusting, and needing or soliciting feedback were characteristics of the "treading water" phase of the transition. For the "beginning strokes," the respondents eventually began to initiate change, reach out, develop vision, and find balance. Characteristics within the theme of "throughout the waters" permeated the entire transition period and included striving for excellence, seeking answers, and reacting to students. This study provides insight into the potentially turbulent evolution that a new faculty member may experience.

Schoening (2009) used grounded theory in a doctoral dissertation research study of 20 nurses' experience with moving from the bedside to the classroom. The transition was described as a journey without a roadmap. Themes included (a) an unfamiliar environment, (b) fear of failure, (c) professional identity issues, (d) boundary issues, and (e) time constraints. The Nurse Educator Transition Theory was created which includes the anticipatory expectation, disorientation, information seeking, and identity formation phases.

There were five studies reviewed that explored faculty experiences when moving from teaching in the classroom to teaching using distance education technology. Diekelmann, Schuster, and Nosek's (1998) interpretive phenomenological inquiry into the common experiences of 31 faculty and academic staff across 27 departments who used distance-education technology revealed not only their perceptions of web-based teaching, but also their reflections about transitioning from the classroom into the online

environment. Five common experiences were identified: (a) losing familiar landmarks and touchstones, (b) challenging conventional pedagogies, (c) reawakening to new roles, (d) learning from experience, and (e) creating new pedagogies. Teachers reported that distance education precluded them from teaching in familiar ways and the transition initially resulted in a sense of being “un-at-home” (Diekelmann, Schuster, & Nosek, 1998, p. 7). The teachers shared struggles related to the loss of embodiment in their teaching, and they had to adapt their previous reliance on visual cues and physical presence. Faculty-student relationships were recast. Teachers used trial and error and ultimately rethought pedagogical assumptions. They described the value of sharing wisdom in meetings with other faculty members who taught in distance education. The use of a convenience sample from a single Midwestern university limits the generalizability of the study. The researchers did not differentiate responses from faculty members or staff members in the analysis, and the operational definition of staff is unclear. This study, however, does lend insight into the unease that faculty members may experience when changing to teaching in a new learning environment from one in which they are comfortable.

Ryan, Hodson-Carlton, and Ali (2004) used teleconferencing to conduct focus groups composed of 19 faculty members teaching in distance-education programs in one of eight schools of nursing. A story matrix of the faculty experience was created using dimensional analysis. The faculty members’ stories provided insight into the experience of moving from an expert classroom educator to a novice online educator. Faculty members reported having to adjust to a new context with new conditions and new technologies through trial and error and peer or technology support consultation. They

also described the role change as transitioning from an authority figure to a facilitator of learning. Recommendations included an ongoing need for orientation, development, and mentoring. The researchers suggested that collaboration with experienced online educators facilitates the establishment of new landmarks, new pedagogies, and transition into the new role. The researchers used these results to develop a 56-item questionnaire that was used in a follow-up study of 68 faculty members from 28 schools of nursing (Ryan, Hodson-Carlton, & Ali, 2005). Although many of the results were specific to online teaching methods, the items that measured agreement about faculty adjustment to online teaching revealed that the majority of respondents agreed their faculty role had changed (60-85%) and that relationships with students had changed (52-65%). The researchers suggested that the follow-up study added further support for the need for faculty development and mentoring to support faculty who are crossing the bridge from the classroom to online teaching.

Johnson (2008) describes the paradigm shift that occurs for faculty who transition to online teaching. Using purposive sampling, 12 graduate faculty members who were new to online teaching at one private university were interviewed. Five themes emerged: (a) structuring and delivering course content, (b) faculty development, (c) student roles and responsibilities, (d) communication and relationships, and (e) the faculty role. The participants reported the need to rethink or shift their teaching and learning philosophies. They recounted finding balance between the time restructuring that was required and the increased freedom and flexibility of online teaching. The participants valued collaboration with faculty who were experienced in online teaching. Several shared their perceptions about the role that faculty learning style preferences may play in the

adaptation to web-based environments. For example, a self-reported introvert expressed relative comfort with this milieu, whereas a self-reported extrovert asserted that an exclusively online teaching assignment might result in feelings of loneliness. Some participants described feelings of anxiety about the role changes that are inherent when transitioning to online teaching. Some participants who taught an online course that used preceptors for physical assessment competency evaluation reported feeling a loss of control; however, another faculty member reported a willingness to relinquish that direct supervisory responsibility. Faculty development was recommended for teachers preparing to make the transition to teaching web-based courses. The participants' online teaching experience ranged from one to 10 years with a mean of 3.7 years, which may have decreased the accuracy of the participants' recall of the time in which they experienced the transition. The convenience sample was recruited from one university.

Paulus et al.'s (2010) qualitative study used a case study method with a sample of 25 nursing faculty members who attended all or part of a technology enhanced faculty development series about online teaching. Data was collected from attendance records, five post-workshop surveys, needs assessments, archived virtual text chats, transcripts from forums and blogs, and focus groups. Six themes emerged: (a) plugging in, (b) peer sharing-modeling-community building, (c) multidimensional learning, (d) role-shifting and meta-learning, (e) paradigm shifting, and (f) sustaining momentum. The faculty in this study described engaging in community building with other faculty participants through the process of paradigm shifting. Some participants expressed uncertainty about their ability to transform their teaching to the online environment. Some participants expressed that relinquishing control was difficult, yet ultimately liberating and rewarding.

Included in the review were three studies and two expository manuscripts that explored other types of faculty transitions such as moving to a different program level or teaching within a new curriculum model. Campbell and Dudley (2005) described the implementation of a clinical partner model that included a teaching team comprised of a university faculty member with oversight of two baccalaureate-prepared adjunct faculty members, who in turn directly supervised clinical groups of students on two different units. Although student satisfaction ratings were reported as 3.9 on a four-point response scale, the university faculty members reported that they experienced initial confusion, competing demands, and dissatisfaction with the quality of the interactions with students. The adjunct clinical instructors' mean overall rating of their own overall performance (3.8) was higher than their mean rating of their ability to teach critical thinking and give feedback (3.4). This study does not identify the psychometrics of the survey instruments, the methods used to gather the data about the faculty perspectives, or the number of faculty, clinical adjuncts, or students who responded. This study suggests that faculty teaching in an innovative new clinical model may have some initial negative experiences despite the benefits of enrollment increase.

Hegge et al.'s (2010) expository depiction of a clinical academic partnership (CAP) model provides brief reports of the experiences of all stakeholders. This multilevel model includes a collaboration of staff nurses as bedside teachers of students, university faculty mentors, and university academic consultants. The academic consultants are responsible for general oversight and scheduling of the CAP program. The faculty mentors reported having time to engage in more meaningful dialogue and "learning moments" with students. They also reported that the CAP model provides a buffer to

balance the multiple demands of the faculty role by affording them more time for scholarly productivity. This report brings to light the benefits that may be perceived by faculty who accept the challenge of teaching using a collaborative innovation.

Haleem, Manetti, Evanina, and Gallagher's (2011) descriptive study of nursing students' evaluation of a newly implemented senior internship experience included anecdotal reports of faculty resistance. Positive student evaluations of the experience ranged from a mean of 4.39 to 4.61 on a five-point response scale. The researchers reported that newer faculty members were receptive to the idea of the internship; however, the most experienced faculty members lacked enthusiasm and desired more evidence to support the initiative. Haleem et al. noted that faculty members' engagement with teaching in the model ultimately led to increased faculty support.

Paulson's (2011) used an interpretive phenomenological framework in a study of a sample of seven full-time faculty members who had recently transitioned into teaching in a new curriculum with innovations that included clustering clinical experiences into the senior year with simulation, educating students in immersion experiences, and implementing a new grading system. Data were collected by using semi-structured audio-taped interviews. Themes that emerged included: (a) perception of innovative teaching with subthemes of actual differences and how to address challenges, (b) utility of structure with subthemes of compression and effect on mission/philosophy, (c) opportunity with subthemes of integrative teaching and course relatedness, (d) valuing with subthemes of autonomy, license, and lifestyle, and (e) embracement of change with subthemes of history and morphing of the mindset. This study highlights the potentially

transformative experience of faculty in the early stages of engagement in a new curricular model.

Zambrowski and Freeman's (2004) expository manuscript about faculty members who move from teaching in an associate degree program to a baccalaureate degree program in a university setting suggests that the transition to expectations of the new setting may lead to faculty stress. These faculty members may need to rethink their faculty role, ascertain how to navigate the tenure process, and learn a new workplace culture. The authors suggest a formal mentoring program to support faculty who are new to the institution.

The studies of faculty transitions reveal that a period of adjustment and possible unease may occur until teachers learn to adapt their teaching strategies and become experienced in the new learning environment. Faculty development and peer support can enhance this period of adjustment. No published studies have investigated this experience from the perspective of faculty members who have shifted into the DEU milieu of learning.

Chapter Summary

Although some evidence exists that the DEU clinical model promotes student satisfaction and greater perceived achievement of learning outcomes, the faculty experience of teaching in this clinical model has not been deeply or exclusively explored. Studies of preceptorships reveal that faculty members may be unprepared and uncertain about aspects of the faculty role when collaborating with staff nurse preceptors. Studies of faculty-supervised clinical models have focused on faculty tasks and faculty role descriptions rather than on understandings of the faculty experience. Studies of the role

transition experience reveal that a period of adjustment can be expected for faculty who are either new to teaching or new to a different learning environment. An in-depth inquiry that is solely focused on describing and interpreting the journey of becoming a DEU faculty member has not been published.

CHAPTER III

METHOD OF INQUIRY: GENERAL

The word phenomenology is derived from the Greek word *phenomenon,* which means something that reveals itself by coming into the light (Heidegger as cited by Fleming, Gaidys, & Robb, 2002). This study explored the meanings of the lived experiences of nursing faculty members in a DEU using the phenomenological approach of Max van Manen. Nursing is a practice discipline and the insights gained through the use of van Manen's (1990) pedagogical stance and approach can produce "action sensitive knowledge" (p.21) that can be applied in the practice of nursing education. Although van Manen is a contemporary phenomenological scholar, his approach is grounded in the work of scholars from the 19th and 20th centuries.

Historical Foundations of Phenomenology

The term phenomenon was used in the scientific writings of Immanual Kant in 1786 to emphasize his contention that only the appearance of things, rather than the actual things, can be known (Cohen, 1987). According to Cohen (1987), the early or "preparatory phase" of the phenomenological movement started in the 19th century when Brentano (1838 – 1917) and Stumpf (1848 – 1936) called attention to the importance of individual perceptions and "intentionality" or consciousness in the study of phenomena of importance to humans.

The German philosophers Husserl (1859 – 1938) and Heidegger (1889 – 1976) were staunch advocates and scholars who advanced the development of phenomenology as a human science as the movement progressed into what is known as the "German phase." (Cohen, 1987). Edmund Hussurl is considered to be the founder of the philosophical

tradition of phenomenology. According to Laverty (2003), Hussurl's initial work was in the field of mathematics, but his interest in philosophy eventually overshadowed his earlier leanings. Hussurl emphasized the importance of describing the structure of the "lifeworld," which was a departure from the traditional objective measurement traditions of Galileo and Descartes. Hussurl contended that the lifeworld is presupposed in the mathematical scientific traditions (Fjellan, & Gjengedal, 1994). Hussurl sought faithful descriptions of the lifeworld experienced by humans. To enhance this faithfulness, he incorporated the concepts of intentionality and reduction into his view of phenomenology. He defined intentionality as the internal experience of being conscious of or responding to something through individual perceptions. Phenomenological reduction is the process of "bracketing" one's preconceptions and presuppositions in order to experience the "essence" of a phenomenon as it truly is in its pure or unadulterated form (Cohen, 1987).

Heidegger's hermeneutical phenomenological traditions are built upon the foundations of Hussurl, who was his teacher. Heidegger emphasized the importance of interpreting underlying meaning - the hallmark of the hermeneutic perspective. According to Heidegger, humans exist in the world in situations. Shared human practices, traditions, language, and disclosive spaces are "clearings" that promote elucidation and understanding of the meaning of being in the world (McNiesh, 2010). The focus of this approach is on illuminating those details that seem ordinary or trivial in daily life in order to create an understanding of their meaning. Heidegger's hermeneutic approach emphasizes meaning and interpretation that go beyond description (Laverty, 2003; Leonard, 1989).

The phenomenological movement moved to France after World War II (Cohen, 1987). The French philosophers Merleau-Ponty (1908 – 1961) and Sartre (1905 – 1980) continued the work of Hussurl and Heidegger, which then evolved into phenomenological existentialism. During the French phase of the movement the concept of embodiment or "being in the world" through each person's individual perspective was added. Merleau-Ponty proposed four existential lifeworlds that can be used to facilitate inquiry, reflection, and writing. Prior to the French phase, phenomenology was purely a philosophy rather than a method (Cohen, 1987; Dowling, 2007; Speziale & Carpenter, 2007).

Max van Manen's Approach to Researching Lived Experience

Van Manen (1990) considers hermeneutic phenomenology to be a human science that is both descriptive and interpretive. He explains that his use of the word *description* encompasses both descriptive and interpretive processes. Although the textual descriptions of the experiences must allow the phenomenon to speak for itself, interpretation is inherent in the process of linguistically or symbolically capturing the phenomenon's essence. According to van Manan, an advantage of this approach is the possibility of gaining plausible insights that bring us in more direct contact with the world by uncovering and describing a phenomenon's structures and its true nature or essence. If this essence is sufficiently described in language, the description "reawakens or shows us the lived quality and significance of the experience in a fuller and deeper manner" (van Manen, 1990, p.10). Hermeneutics attempts to extract the meanings of experiences as humans live them in their daily existence, which van Manen calls the lifeworld.

Van Manen contends that this approach is scientific in nature because phenomenology is systematic, explicit, self-critical, and intersubjective. The researcher employs specific modes of questioning, reflecting, focusing, and intuiting when collecting and interpreting information. The researcher attempts to explicitly articulate the structures of meaning in textual and/or symbolic form, while continually examining and evaluating the goals and methods of the inquiry. The researcher needs others, for example, the reader of the text, in order to "develop a dialogical relation with the phenomenon, and thus validate the phenomenon as described" (van Manen, 1990, p. 11).

Thoughtfulness lies at the heart of hermeneutic phenomenology. Van Manen shares Heidegger's 1962 characterization of phenomenology as a heedful and mindful wondering about life and the meaning of living life. Ultimately, the aim of phenomenological research is discovery that will enable us as human beings to "become more fully who we are" (van Manen, 1990, p.12).

Van Manen (1990) describes his foundational model as a "textual reflection on the lived experience and practical actions of everyday life with the intent to increase one's thoughtfulness and practical resourcefulness and tact" (p.4). He considers phenomenological research to be the interplay among six activities: (a) turning to a phenomenon that seriously interests us, (b) investigating experience as we live it rather than as we conceptualize it, (c) reflecting on the essential themes, (d) describing the phenomenon through the art of writing, (e) maintaining a strong pedagogical relation to the phenomenon, and (f) balancing the research context by considering parts and the whole (van Manen, 1990, pp. 30-31).

Phenomenological Activities Related to this Study

The researcher embraced van Manen's traditions by imbedding these six activities in the study of the experiences of nursing faculty members on a DEU. The researcher selected this research focus because she was responsible for supporting and sustaining an iteration of this model of clinical education in her current role as a faculty leader. It was critical that the meanings of the experiences were revealed as the faculty participants were truly living them, rather than as what the researcher expected to find; therefore, "phenomenological reduction" was undertaken prior to the inquiry.

According to van Manen, a complete phenomenological reduction is impossible. Van Manen uses Merleau-Ponty's 1962 four-step process of reduction, which begins with an awakening of a sense of wonder about the phenomenon. Next, the researcher strives to overcome feelings, inclinations, and expectations that could prevent experiencing the phenomenon as it truly presents itself. Third, the researcher abandons theories and scientific conceptualizations that could cloud the view of the phenomenon. Finally, *eidetic* reduction requires the researcher to see through specific lived experiences in order to see the universal essences "that lie on the other side of concreteness of lived meaning" (van Manen, 1990, p.185). In light of his contention that researchers will not achieve full reduction, van Manen encourages researchers to make beliefs, assumptions, and biases explicit and come to terms with them and hold them at bay, rather than attempting to forget or ignore what we already know. Because the researcher has been a participant in the establishment of several practice education partnerships that were based upon the DEU clinical model and had one experience teaching a six-week clinical course using this partnership model herself nearly three years prior to data collection, she engaged in

deep reflection to identify and set aside the assumptions and biases that may have come out of her own experiences.

Phenomenological research makes a distinction between appearances and essences. In order to achieve van Manen's third activity, reflection on essential themes, the researcher used open-ended questions that allowed the participants to share what it was that constituted the nature of their lived experience of being a faculty member on a DEU. The researcher strived to capture the essence of what it is that makes this experience different from other faculty teaching experiences.

Van Manen (1990, p.101) offers four lifeworld "existentials" as guides to reflection: (a) lived space (spatiality), (b) lived body (corporeality), (c) lived time (temporality), and (d) lived human relations (relationality or communality). These four existentials are considered the fundamental structures of the lifeworld in phenomenological human science. Spatiality may be considered "felt" or perceived space. Lived space may describe the ways we experience our daily existence or how we feel about a space. Corporeality refers to our physical or bodily presence in the world. Temporality refers not to clock time, but to subjective time as we are in the world. Relationality refers to how humans approach and interact with each other and maintain interpersonal space in shared environments. The four existentials can be differentiated, but not separated from each other. The researcher noted any participant references to space or "at-homeness;" embodiment or presence; time or dimensions of past, present, or future; and relationships or interactions with other stakeholders in the DEU learning environment. Although these existentials may be one guide to reflection, it was important to be open to other themes that revealed themselves.

The fourth and fifth activities, writing and maintaining a strong orientation, are integral to van Manen's approach. In order to be powerful and convincing, phenomenological text must be oriented, strong, rich, and deep (van Manen, 1990). The text should be engaging, involving, and evoke a response from the reader. The goal is not to simplify, but to reveal the depth of character and contours of the phenomenon. Van Manen asserts that artful writing will reveal action-sensitive knowledge that will lead to situational perceptiveness and tactful thoughtfulness that enhances competence and helps educators understand themselves. The researcher included quotes from the faculty participants that contained detailed descriptions and anecdotes or that displayed emotions and feelings.

The final activity, finding balance between the parts and the whole, may be accomplished by periodically stepping back to look at the big picture. Van Manen (1990) suggests that the researcher should consider working with the data from a thematic perspective; however, he does not outline a specific procedure for analysis. His six activities do not constitute a procedure, but rather are intended to capture the spirit of a phenomenological inquiry. Van Manen's approach is especially focused on philosophical foundations, interviewing, and writing. Colaizzi's (1978) method of phenomenological analysis can be used in tandem with van Manen to strengthen the process of formulating meanings and theme clusters.

Research Plan

Participant Selection

Patton (2002) emphasizes that the most useful informants are individuals who have experienced the phenomenon of interest. The use of theoretical or purposive sampling,

which maximizes the range of information that may be uncovered, will improve the transferability of the findings (Guba, 1981).

In order to gather information that cut across program and participant variations, faculty with experience on a variety of DEUs in several regions of the U.S. were invited to participate. Snowball sampling had been planned during the course of the study. With snowball sampling, early participants are asked about other potential study participants (Polit & Beck, 2008). Although some participants made suggestions of schools from which to recruit, all of them had previously been identified by the researcher.

Data Generation Methods

The researcher used hermeneutic interviews for data generation. Van Manen (1990) suggests using hermeneutic interviews as one approach to gather information and to develop a conversational relationship with the participant about the meaning of an experience. In the discussion of what it means to turn to a phenomenon of interest and the nature of that lived experience, van Manen (1990) advises how questions might be posed to begin the hermeneutic interview. He uses his interest in pedagogy for the following examples: "What does it mean to be a teacher?" or "What is it about teaching that makes it possible for it to be what it is in its essence?" (p.42). Beginning a question with "what is it like" to have a certain experience is another suggestion offered. Asking participant faculty members what it is about the teaching experience on a DEU that makes it different from other teaching strategies facilitated the elucidation of the unique essence of the lived faculty experience within the context of this clinical model.

The interview can be used both to explore and gather experiential information as well as to establish a conversational relationship with the participant. Van Manen (1990)

encourages researchers to elicit accounts of personal stories and anecdotes. Probes such as "Can you share a specific instance or situation?", "Can you think of a story about a person or event?", "How did you feel in that situation?", or "In what way?" were used to gain a deeper understanding as the interview progresses. Due to the nature of the hermeneutic interview, having a lengthy and structured interview schedule would not have accomplished the desired goals.

The interviewer made an effort to avoid gathering information that was too meager, overly copious, or unfocused. Van Manen (1990) alerts researchers that insufficient information can result in an overreliance on personal opinions or perceptions. Poorly run interviews can lead to confusion and disorder, leaving the researcher in a state of bewilderment about where to begin to work with the data. Van Manen (1990) states that interviews can "go everywhere and nowhere" (p.67). The researcher used van Manen's recommendations to formulate the initial question and probes and to conduct the interviews.

Data Analysis Methods

Van Manen's approach is principally focused on philosophy, interviewing, and writing. Colaizzi's (1978) method of analysis blends well with van Manen's approach because of the emphasis both place on meanings and validating the interpretations with the participants.

Although Colaizzi asserts that there is no one phenomenological method of analysis, he suggests a seven-step procedure that consists of the following: (a) reading all descriptions, (b) returning to the protocols to extract significant statements, (c) formulating meanings of significant statements, (d) organizing formulated meanings into

clusters of themes, (e) integrating the results, (f) formulating an exhaustive description of the phenomenon, and (g) validating the findings with the participants. These seven steps are overlapping and the sequencing can be free and flexible depending upon the nature of the phenomenon of interest. Colaizzi presents guidelines for each step of this method of analysis.

Reading all descriptions. Colaizzi recommends that the researcher first carefully read the descriptions to make sense or acquire a feeling for them.

Extracting significant statements. When the readings are complete, Colaizzi endorses a return to the descriptions to extract significant statements that directly pertain to the phenomenon of interest, while noting any repetitious comments among the transcripts.

Formulating meanings of significant statements. During the third step, the researcher uses creative insight to arrive at the meanings of the participants' statements. These formulations must "discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon" (Colaizzi, 1978, p. 59).

Organizing formulated meanings into theme clusters. Colaizzi recommends repeating the meaning formulations with each transcript, then aggregating them into clusters of themes. This step of the method is divided into two parts: (a) validation of completeness through comparison with the original transcripts and (b) identification of discrepancies or contradictions among the themes. At this point, the researcher must consider personal tolerance for ambiguity and avoid the pitfalls of ignoring data that are outliers or generating a theory prematurely.

Integrating the results. The researcher integrates the results at this point into an exhaustive description of the topic.

Formulating a description of the fundamental structures of the phenomenon. Colaizzi's sixth step is to formulate an exhaustive description of the fundamental structures of the phenomenon of interest as a statement that is as unequivocal as possible. Colaizzi shares an example in which he describes his phenomenon of interest in three narrative paragraphs that are both succinct and rich in description.

Validating findings with the participants. The final step of Colaizzi's method is return to the participants in a single or multiple interviews to ask them to validate the findings so far. Any new themes that emerge should be integrated into the final product.

Ensuring Trustworthiness

Guba (1981) argued that all research, whether it is based upon the scientific (quantitative) or the naturalistic (qualitative) paradigm, must consider the truth value or "trustworthiness" of the findings within the context of the study. According to Guba and Lincoln (2000), peer debriefing, triangulation, and member checks are strategies that can enhance the credibility of a phenomenological study. The researcher can validate the growing insights and request advice through debriefing with uninvolved, yet qualified, peers or experts. Asking a phenomenological expert to review the transcripts and select the most salient statements from which themes may emerge may be considered another form of triangulation through cross-checking. Guba and Lincoln recommended checking back with the interviewees (members) to solicit input both during and at the end of the study.

When considering transferability, the researcher determines the degree to which the findings of the study may be "applicable" in other contexts or with other respondents (Guba & Lincoln, 2000). The use of thick narrative descriptions can improve the transferability of the study results. The descriptions used should be sufficiently vivid so as to "impart a vicarious experience" of the phenomenon. The use of rich descriptions will also facilitate judgments regarding the applicability of the themes to other similar contexts (Guba & Lincoln, 2000). The use of theoretical or purposive sampling, which maximizes the range of information that may be uncovered, improves the transferability of the findings (Guba, 1981). Researchers using purposive or "purposeful" sampling select participants based upon a judgment about which ones will be the most informative for the purpose of the study (Polit & Beck, 2008).

Dependability equates to reliability or the probability that the results would be replicated if the study were repeated. In the case of a phenomenological study, the researcher strives to reveal meanings that would be similar to those that emerge from interviews with participants in the same or a comparable context. Guba and Lincoln (2000), describe the use of a dependability audit, which is based upon concepts borrowed from the accounting world. This audit entails keeping detailed records about the process of both data collection and data analysis. The audit trail includes all of the raw data collected, including the original audio-recordings if the interviews were taped.

Neutrality should be addressed to establish the degree to which the findings "are a function solely of the conditions of the inquiry and not of the biases, motivations, interests, or perspectives of the inquirer" (Guba & Lincoln, 2000, p. 376). The process

of triangulation, previously described as a strategy to enhance credibility, can also serve to improve confirmability.

Two other strategies are practicing reflexivity and completing a confirmability audit. Guba and Lincoln (2000) suggest that the most appropriate way to practice reflexivity is in the form of a journal that is continually updated in the field. The researcher reflects upon his or her own epistemological stance, personal assumptions, biases, or prejudices about the context of the study, as well as the rationale for why the study was set up in a particular way. This method is consistent with van Manen's (1990) perspective that a researcher can only acknowledge and deal with, not forget, those personal perspectives. In a confirmability audit, each finding is traced back to the original data. The identified clusters of themes are verified as being reasonable, meaningful, and real.

Guba and Lincoln, as cited in Holloway and Wheeler (2010), added "authenticity" to the recommendations for boosting qualitative rigor in 1989. Authenticity can be enhanced by using purposive sampling of participants who are unknown to the researcher, obtaining informed consent, and honoring the voluntary nature of participation. Speziale and Carpenter (2007) recommend eliciting both positive and negative descriptions of the phenomenon to establish authenticity.

Chapter Summary

This chapter provided an overview of the historical foundations of phenomenology, followed by an explanation of Max van Manen's interpretive phenomenological approach to the study of lived experience, which was used to guide the data collection for the study. This chapter continued with methodological considerations relative to the research

plan of this study including data generation, Colaizzi's data analysis procedures, and strategies to ensure trustworthiness and authenticity.

CHAPTER IV

METHOD OF INQUIRY: APPLIED

Participant Recruitment and Selection

Using purposive sampling, participants were recruited from prelicensure baccalaureate nursing programs that had DEUs established during the time period from January of 2003 to January of 2012. Participants were invited from a range of baccalaureate programs in both public and private institutions that had variations in size and location. According to Polit and Beck (2008), purposive sampling is intended to recruit a sample that will most benefit the study. A type of purposive sampling is maximum variation sampling that is designed to include participants who may have more diverse experiences and viewpoints, which may result in a more thorough exploration of the phenomenon. Polit and Beck (2008) note that phenomenologists tend to rely on samples of 10 or fewer; the researcher set a preliminary goal of recruiting at least 10 participants. However, achieving saturation and interviewing faculty who held a wide range of perspectives was considered more important than any predetermined number in this phenomenological research study.

The inclusion criteria used for prospective participants were nursing faculty members who (a) currently had held a full-time appointment at any rank in a baccalaureate nursing program for at least one full academic year at a private or public college or university, (b) were licensed registered nurses at the time of the study, and (c) had completed at least one semester as faculty of record for a university clinical course on a dedicated education unit within the preceding 12-month time period. Nursing faculty members who (a) held adjunct or part-time faculty appointments, (b) were currently in the process of teaching

on a DEU for the first time, or (c) were teaching on a DEU in an associate-degree, diploma, practical, vocational, or advanced degree entry-into-practice nursing programs were not included in the study.

The selection of educational institutions with experienced faculty and established DEUs was designed to promote rich descriptions from participants who had a wealth of experiences. Participants were recruited from both private and public universities located in several geographic locations within the continental United States in order to capture a broader spectrum of faculty experiences. This method of recruitment allowed the researcher to include faculty members who had a wide range of years of teaching experience and who taught on DEUs that varied by patient population and semesters of operation. The criterion of teaching in a DEU within the last 12 months was consistent with van Manen's (1990) contention that hermeneutic interpretations require retrospective reflection after an experience rather than introspection during an experience. Because full, detail-laden descriptions are desirable in this methodological approach, the purposive sampling methods of recruiting participants with recent experience minimized recollection from the distant past. Gazza and Shellenbarger's (2010) study suggests that differences exist between the lived experiences of full-time and part-time faculty; therefore, this inquiry was limited to full-time faculty. Baccalaureate programs were chosen in support of the *Future of Nursing* goal that 80 percent of the nursing workforce be baccalaureate-prepared by the year 2020 (IOM, 2010).

Gaining Access

Protection of Human Subjects

The researcher obtained approval from the Institutional Review Board (IRB) of the University of Nevada, Las Vegas (Appendix B) and requested permission from the appropriate administrator at each school of nursing from which participants were recruited.

Recruitment

Using nursing databases, nursing education conference brochures, and online search engines, the researcher identified baccalaureate programs in the U.S. accredited by the National League of Nursing Accreditation Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE) that had used the DEU clinical model for one or more clinical courses. The researcher noted the affiliating institutions of the authors and co-authors of research studies and expository manuscripts in the review of the literature related to DEUs, as well as the affiliations of presenters in published brochures from national nursing education summits and various other education conferences. Using dedicated education unit and DEU as keywords, a Google search revealed press releases and online hospital newsletters announcing the establishments of several DEUs. New searches were completed during the data collection phase of the study to identify additional programs. The researcher reviewed the websites of the identified nursing programs and the accreditation agencies to verify that they were accredited baccalaureate programs. Of the 32 programs identified that potentially had operating DEUs, three were excluded because the school websites revealed that they were either associate degree programs or master's entry into practice programs. The remaining 29 programs had

DEUs on a wide range of units including adult medical, adult surgical, pediatric, maternal/child, psychiatric, critical high acuity, geriatric, and transitional care patient populations. These baccalaureate nursing programs were then categorized into divisions by geographical locations using the regions and divisions of the U.S. Census Bureau to provide a systematic method. The Census Bureau divides the United States into four regions with a total of nine divisions; the Northeast region with (1) New England and (2) Middle Atlantic divisions; the Midwest region with (3) East North Central and (4) West North Central divisions; the South region with (5) South Atlantic, (6) East South Central, and (7) West South Central divisions; and the West region with (8) Mountain and (9) Pacific divisions (U.S. Census Bureau, n.d.). The researcher had identified one or more nursing programs using the DEU model in each of the nine divisions and each division was designated for recruitment by tier. The first tier was composed of two nursing programs located in states that were closest to the researcher's home residence. To facilitate the logistics of interview scheduling and to allow ongoing transcription and analysis during the study, recruitment took place in one tier before moving on to the next. During the course of the interviews, the researcher used the snowball sampling technique of asking some of the participants if they knew of other schools of nursing using the DEU model. All the programs identified by participants were already on the researcher's list. Saturation was achieved after recruiting from schools in six of the nine geographical divisions.

As the first step of the recruitment procedure, the researcher sent an e-mail message about the study to the program director or administrator responsible for oversight of the baccalaureate program and/or DEUs at each identified college or university within a

geographical division. The administrators of 14 different schools of nursing across six of the geographic divisions were contacted over the course of the study. The body of the message explained the purpose of the study, the operational definition of a DEU, the eligibility criteria, and an offer to answer questions about the study. A recruitment flyer (Appendix C) was included as an electronic attachment and an offer was made to mail hard copies of the flyer through the United States Postal Service. Administrators who agreed to share the invitation with their faculty were asked to distribute the brochure using their preferred method. The flyer provided interested participants with study details and the contact information of the researcher. The researcher sent a follow-up e-mail to administrators from whom she had not heard several weeks after the initial contact with an offer to answer questions and a repeated request to distribute the flyer. The researcher did not make any additional contact with the administrators after the second request or after getting responses from faculty in order to maintain their confidentiality. With logistics, travel, and financial considerations in mind, the researcher made contacts by region and continued until saturation was achieved. According to Morse (2007), sampling ceases when nothing new is learned by the investigator during the interviews. This requires ongoing analysis during data collection to identify that no new themes are emerging. No new themes emerged during the last two interviews.

All of the participants who agreed to participate in the study contacted the researcher via e-mail in response to the flyer. The researcher responded to each participant's e-mail message with a request about her willingness to schedule a telephone call to answer questions about the study procedures and to verify eligibility. All of the telephone calls

were scheduled at a date and time that was convenient for each participant. Because of the expense and logistics involved in the travel scheduling, the researcher e-mailed the consent form to participants to allow them time to carefully and privately preview it several days prior to the telephone conversation. Each phone call was approximately 15 to 20 minutes in duration and, after answering questions, the researcher scheduled the date, time, and location of the face-to-face interview in accordance with each willing participant's preference. An IRB-approved contingency plan was used for the seventh and eighth interviews. The seventh participant called the researcher on the morning of the scheduled interview to request rescheduling to a later date because one of her family members had become ill. With the interviewer having a booked flight home that evening and a distance between the respective cities of nearly 1,000 miles, the interview was rescheduled to be conducted by telephone later in the month. The eighth participant e-mailed the researcher requesting that the initial phone call to answer questions and verify eligibility be rescheduled due an illness in her family. She then requested that the actual interview be scheduled in the evening via telephone, which was best for her family situation. The researcher accommodated this request.

Privacy and Confidentiality

The first six semi-structured face-to-face interviews were conducted using a digital tape recorder at a comfortable private location that was chosen by and convenient for the participant. Each of the settings had a closed door and only the researcher and the participant were present in the room. The researcher had a second digital tape recorder activated as a back-up if mechanical malfunction were to occur. Both recorders were in plain view on a table during the interviews. The researcher conducted the two telephone

interviews from her home at a time that was convenient for the participants. The researcher was alone at the time of both interviews with all windows and doors closed and she had the tape recorders placed near her home landline speakerphone. The participants were assured that no one else was present who could overhear the conversation. Written consent for the telephone interviews was obtained using mailed forms via the U.S. Postal Service.

The researcher carried a satchel containing the consent forms and demographic questionnaires in a secured accordion-style portfolio that had a closure device, and the tape recorders were transported in a small box that also had a closure device. All of the items containing data remained within sight in the researcher's carry-on bag and were locked and placed at her feet during air travel. All electronic information was stored on a password-protected computer, and any printed data were kept in a locked cabinet in a locked office. After the digital audio file was uploaded to the computer, the original file was erased from the tape recorder. After compliance with the three-year storage time requirement of the UNLV IRB, the documents will be destroyed.

Each participant was coded on the demographic questionnaire, field notes, recordings, and transcriptions by the date and time of the interview which were known only by the researcher. Upon completion of the data collection, the participants were given pseudonyms in the written analysis and no references were made that could lead to the participants' identification. The researcher transcribed the audio recordings in a private room with a closed door while wearing headphones.

Informed Consent

Before the interview began, the researcher obtained written informed consent for participation in the interview and follow-up contact, as well as for audio-taping (Appendix D). The researcher ensured that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Family Educational Rights and Privacy Act (FERPA) patient and student privacy guidelines were followed and that the participants' human rights were protected during the collection, analysis, and reporting of the data. No patient names or student names were used in any of the interviews. Occasionally, some of the participants mentioned the name of the school of nursing, the health care agency, an administrator, or one of the SNCIs. The names were redacted in the transcripts. The participants were informed that participation in the study was strictly voluntary, that there were no repercussions for nonparticipation, and that confidentiality would be maintained. The participants had the right to refuse to answer any of the questions on the questionnaire or any posed during the interview, and they could withdraw from the study at any time.

Data Generation and Analysis Procedures

Data Generation

After written informed consent was obtained, the participants were asked to complete a 21-item demographic questionnaire (Appendix E). There were eight items intended to provide the researcher with an overall demographic depiction of each participant: gender, age range in decade increments, highest earned degree, academic rank, total years as a nurse, total years in academia, years of experience at their current institution of learning, and previous appointments. Because the participants would be asked to talk

about their faculty lifeworld in the context of the DEU, the researcher wanted to obtain a snapshot view of the participants' overall teaching workload. Therefore, they were asked about the number and types of courses they taught in an academic year in terms of didactic, web-based, or clinical. Because relationality with students would be addressed in the interviews, the researcher was interested in knowing whether the participants taught the co-requisite didactic course in which the DEU students were enrolled. Those who taught the didactic course might have additional opportunities for interactions with the DEU students. Because the participants were asked to explain how the DEU faculty experience was unique in contrast to traditional clinical models, two questions were included about clinical teaching experience using the traditional faculty-supervised model. The participants were asked if they had used this model and, if yes, to indicate both the total number of years they had used it and when they had last used it. There were three questions about the participants' experience on the DEU in terms of length of time and recentness of experience. They also were asked to indicate the semester and year in which they first became faculty on a DEU, how many semesters of DEU teaching experience they had, and when they last taught on the DEU. Finally, they were asked to indicate whether the DEU was established prior to their involvement or if they had a role in developing the clinical site as a DEU because the experience might be different for faculty who had been on a development team than for those who had replaced a previous faculty member on a DEU.

In order to provide a context for the participants' narratives, two questions were asked about characteristics of the patient population and the students' learning on the DEU. The participants completed the questionnaire in approximately a five-minute time period

and had the opportunity to ask the researcher for clarification of any items. The participants who were interviewed by phone mailed their questionnaires to the researcher via the U.S. Postal Service.

After completion of the questionnaire, the researcher verified that the participants were ready for the interview to begin. The tape recorders were turned on to the record mode after this verification. The researcher verbally verified that the telephone participants were ready and notified them when the tape recorders were activated and when they were turned off. It was important to establish an atmosphere of trust and congeniality before querying the participant about emotions and meanings of experiences. The interviewer then asked the question that guided the study and used probes when needed. According to Patton (2002), probes can deepen the response and increase the richness of the accounts. Appendix E lists the guiding question and probes to further the dialogue.

An audit trail was initiated at the onset of the data collection. The researcher maintained a small journal in which to make succinct and pertinent field notes about the venue and the behavior, clothing, and deportment of the interviewee. The researcher focused on listening, acknowledging, and noting verbal and nonverbal cues, rather than talking or taking voluminous notes. At the end of the interview, the researcher thanked the participant and reiterated the request for permission for a follow-up contact to validate the accuracy of descriptions and interpretations. The researcher asked participants to indicate their preferred method of communication and which e-mail or street address the researcher should use in future communication. Later verification with

each interviewee is recommended by Colaizzi (1978), Guba (1981), and van Manen (1990) to enhance credibility.

Data Analysis

Colaizzi's (1978) method of phenomenological analysis was used in tandem with van Manen's (1990) philosophical approach to strengthen the process of formulating meanings and theme clusters. In preparation for this method of analysis, verbatim transcriptions of the interview audio recordings were completed by the researcher during the data collection process. Phenomenological data collection and data analysis must occur simultaneously to identify when saturation has been achieved. The transcripts were analyzed using the following seven steps:

Reading all descriptions. The researcher carefully and thoughtfully read all of the transcripts to acquire a general feeling for them.

Extracting significant statements. After the general reading, the researcher returned to the descriptions to extract significant statements that directly pertain to the faculty experience on a DEU, while noting any repetitious comments among the transcripts. In accordance with Colaizzi's (1978) method, significant statements were succinctly paraphrased.

Formulating statement meanings. The researcher used insight to attempt to discern the meanings of the participants' statements about experiences on a DEU. Because the methodology for this study blends van Manan's approach and Colaizzi's analysis methods, the four lifeworld existentials guided reflection in the formulation of meanings.

Organizing formulated meanings into theme clusters. The formulated meanings were then aggregated into clusters of themes. First, completeness was validated by

comparison with the original transcripts. The researcher then looked for any discrepancies or contradictions among the themes. Data that appeared to be outliers were carefully considered.

Integrating the results. The researcher integrated the three major themes and nine subthemes into an exhaustive description of the overall essence of the lived experience of nursing faculty on a DEU.

Formulating a description of the fundamental structures of the phenomenon. The researcher identified the fundamental structures of the phenomenon, which were the three major themes and nine subthemes. An overall model was developed that demonstrated how the themes provide a depiction of the process of becoming a DEU faculty member over time.

Validating findings with participants. The researcher contacted the participants via their preferred e-mail to ask them to validate the findings. Six of the eight participants responded. Several made suggestions that certain subthemes be emphasized and one shared her discernment of the subthemes she believed best reflected her experience. No major additions were suggested by the participants, but the researcher reviewed the final product to ensure that their comments were integrated.

This process facilitated the handling of a large amount of textual data, yet it allowed the researcher to dwell on and truly engage with the information in a manner that was consistent with van Manen's hermeneutic approach and Colaizzi's method of analysis.

Ensuring Trustworthiness and Authenticity

Rigor of the study was strengthened by using strategies to enhance the trustworthiness and authenticity of the data collection and analysis. Guba (1981) recommends taking

measures to ensure credibility, dependability, transferability, and confirmability to enhance trustworthiness. The researcher used the following strategies to enhance those qualities of the study as well as authenticity.

Credibility

The researcher used prolonged engagement with the interview transcripts through multiple readings and engaged in member checking through e-mails with the interviewees after transcription and the identification of initial formulated meanings. During the study, the researcher periodically dialogued with the dissertation committee chair about the analysis.

Dependability

All records of locations, times, dates, and observations made by the researcher throughout the study were included in a written audit trail. The audio-recordings were kept as digital files to serve as archival documentation of the accuracy of the transcripts throughout the study. The researcher also sent the transcripts to the participants for their review. All eight participants selected e-mail attachments as the preferred method of transcript review.

Transferability

The purposive sampling method and the inclusion of full, thick, detailed descriptions in the written analysis of the data enhanced the transferability of the results.

Confirmability

The researcher practiced reflexivity before the study by identifying assumptions and holding them at bay as described by van Manen (1990). Throughout the study, the audit trail was used to include a commentary of personal reflections, observations, and

impressions as suggested by Shenton (2004). A confirmability audit was completed with the dissertation committee chair by e-mailing the de-identified initial and subsequent theme analysis files and discussing them via telephone conversations.

Authenticity

Authenticity was enhanced by using purposive sampling of participants who were unknown to the researcher, obtaining informed consent, and honoring the voluntary nature of participation. In accordance with Speziale and Carpenter's (2007) recommendation to elicit both positive and negative descriptions to establish authenticity, the list of interview probes included an invitation for participants to share stories of both successes and challenges in the faculty experience on the DEU. The researcher included examples and anecdotes that illuminate the essence and meanings of faculty experiences.

Assumptions of the study include that the participants were truthful, had accurate recall of events, and were capable of deep reflection.

Chapter Summary

This chapter presented the methods for protection of human subjects, recruitment, privacy, and confidentiality for the study. Additionally, the application of van Manen's phenomenological approach to data generation and Colaizzi's method of data analysis were included. Strategies to enhance the trustworthiness and authenticity of the study were explained.

CHAPTER V

FINDINGS

The purpose of this hermeneutic phenomenological study was to describe, interpret, and offer insight into the meanings of the lived experiences of nursing faculty in DEUs across several prelicensure baccalaureate programs. The research question that guided the study was: What is the meaning and significance of the lived experience of being a faculty member on a Dedicated Education Unit used for prelicensure baccalaureate nursing education? This chapter will describe characteristics of the faculty participants and the data collection and analysis procedures through which the findings were revealed. The overall essence, themes, and subthemes of the faculty experience are captured from the faculty narratives and presented in a diagrammatic representation of the essence, theme, and subtheme structures.

Description of Participants

A total of eight full-time nursing faculty members participated in the study. None of the participants resided or taught in the researcher's state of residence and none were known to the researcher. The participants resided in five different states among four divisions of the continental U.S. The participants taught in seven different pre-licensure baccalaureate nursing programs, four of which had both traditional and second-degree accelerated track programs. All of the participants were females. One was in the 30 to 39 age range, two were in the 40 to 49 age range, four were in the 50 to 59 age range, and one was in the 60 to 69 age range. The length of time participants had been nurses ranged from 10 to 45 years, with an average of 26.9 years in nursing. Six participants held academic appointments at public universities and two had academic appointments at

private institutions. Four had earned doctoral degrees including three who held a doctorate in nursing (Doctor of Nursing Science or Doctor of Philosophy in Nursing) and one who had a doctorate in another discipline. Four participants' highest completed academic preparation was at the master's level. The total number of years of experience in academia ranged from two years to 30 years. The participants' had an average of 9.9 years of experience in an academic role.

The participants' teaching workloads were wide-ranging, and several reported that their workload varied from semester to semester. One participant did not teach in the classroom and the number of didactic courses taught by the other seven ranged from one to "five or more" each year. Five of the participants taught the co-requisite didactic course in which the DEU students were also enrolled. Three participants taught three to four web-based courses per academic year; one taught two web-based courses and one taught one web-based course. Three participants did not teach an online course. The number of clinical courses the participants taught per academic year ranged from one to "five or more" with a mode of four clinical courses.

All eight participants had previously taught a practicum course using the traditional faculty-supervised clinical model, with the experience ranging from one semester to 27 years. One of the participants had last taught using the traditional model eight years prior to the time of the current study. The other seven had last used the traditional model from one to four years prior to data collection. One participant continued to teach a clinical course using the traditional model on the unit during rotations when her DEU students were not scheduled to be there.

The number of completed semesters during which the participants had been faculty of record on a DEU ranged from one to six semesters. Seven had taught on a DEU during the spring semester of 2012 and one participant's most recent experience was during the fall of 2011. It should be noted that all of the participants reported having some level of involvement in the development and planning for their DEU clinical site. None had taken over teaching on a DEU that had been established by a previous faculty member. This finding was not surprising in light of the fact that the most remote time of implementation of any of the participants' DEUs was 2009 or three years. Two of the DEUs had been established during the 2009-2010 academic year and four were established during the 2010-2011 academic year.

When asked about the number and level of students engaged in experiences on the DEU, several participants explained that these factors varied from semester to semester. The participant with the lowest number of students on a DEU had four to five and the participant with the highest number had 12 to 24 students; however, all 24 students were not present on the DEU at the same time. Six of the participants had six to twelve students in their DEU clinical groups. The mode was eight. None of the students on the participants' DEUs were sophomores. Most participants listed multiple levels of students that were on their DEU at various times, with first- and second-semester students from both the junior and senior level; however, none indicated being responsible for different levels of students on the DEU simultaneously. Four of the DEUs had second-semester seniors on the DEU early in the semester prior to the end-of-program capstone immersion clinical course that was scheduled for the end of the semester.

The participants' DEUs had unique patient populations including medical-surgical, medical, pediatric, geriatric, progressive care, or critical care units. Two of the participants described their DEU as encompassing more than one unit in the facility. The participant profiles are summarized in Appendix G, and the Demographic Questionnaire Results Summary tabulations are presented in Appendix H.

Data Collection

The interviews were conducted over a four-month time frame between March and June of 2012. Each participant chose a private setting for the interview, and the location choices included one participant's office at the school of nursing, one conference room at the school of nursing, one office at the hospital where the DEU was located, one empty office at the school, the researcher's hotel, and a participant's home. The phone interviews were conducted from the researcher's private home with no one else present. The phone interviewees identified their homes as their location.

Each of the participants' choice of location was private and appropriate for the interview. The furniture varied across the settings, with some having a table and several chairs, some having a desk and two chairs, and one having a couch, table, and chair. The venues ranged in size from a small office that was approximately eight feet in both length and width to a large kitchen estimated by the researcher to be approximately 20 feet by 15 feet. The researcher allowed each participant to choose the preferred seat and seating position. The researcher sat either facing or diagonal to the participant with the recorders on the table or desk between them. No significant distractions occurred during the interviews and the researcher turned off the ringer on her cellular telephone. One participant had to briefly stop to speak with a family member and some traffic noise in

one urban setting was occasionally overheard, but, neither disrupted the flow of the interviews.

Written consent was obtained prior to starting the data collection. The consent form had been e-mailed to each participant several days or weeks before the interview. Each participant was given the opportunity to again read through the consent form while the researcher sat silently, and any last minute questions were answered before the form was signed. A paper copy of the consent form was provided for each participant to retain.

Each participant completed a 21-item demographic questionnaire that took approximately five minutes to finish. The researcher explained that participants' disclosure of answers was voluntary and that they could decline to answer any or all of the questions. Most asked clarifying questions about one or more questionnaire items. All of the participants chose to complete the questionnaire in its entirety. After completion, both the consent form and the questionnaire were placed into the accordion file and the closure was secured and placed back in the researcher's satchel.

The researcher asked each participant if she was ready to begin the interview. After receiving an affirmative response, the two tape recorders were set to record and the researcher stated, "We are now recording." To establish rapport, provide context, and serve as an ice-breaker, the researcher initiated the interview by asking each participant to tell her about the DEU on which they taught. The participants all spent approximately five to ten minutes describing the history and collaborative development of their DEUs and explaining various guidelines and processes. To answer the question that guided the study, the researcher then proceeded to use open-ended questions and probes to explore the meanings and feelings associated with the experience of becoming and being a DEU

faculty member. (Appendix C). Immediately after the interview, the researcher recorded observations and reflections in the form of written field notes that were added to the audit trail.

Data Analysis

The researcher's data analysis procedure was guided by Colaizzi's (1978) seven-step method for phenomenological inquiries. Colaizzi emphasized that the sequencing of the steps may overlap and appropriate modifications may be made depending upon the phenomenon being studied. Van Manan's (1990) four lifeworlds guided the researcher's theme reflection during this analysis.

Creating initial impressions. The researcher began the analysis by reading the protocols to acquire a feeling for them. For this study, the researcher listened to each tape recording and wrote down her thoughts and reactions into the field note journal. The researcher then created a verbatim transcription while listening to each recording a second time. The accuracy of each transcript was verified by listening to each recording a third time while comparing it to the written document.

Extracting significant statements. The researcher reread each transcript while manually highlighting key statements, passages, or paragraphs. Statements that expressed feelings, passages that characterized relationships, and anecdotes from participants' stories that captured the essence of the faculty experience or lived meaning were examples of transcript sections that were marked for inclusion in the analysis.

Formulating meanings. The researcher reread the highlighted areas of text that had been extracted from the first protocol and made manual notations in the margins about possible underlying broad meanings of the statements or passages. For example, when

one participant said “I know they’re in good hands” the researcher interpreted the meaning of the statement as “awarding trust.” The researcher diligently avoided imposing theories or causality, instead remaining focused on formulating meanings that had connections to the data in accordance with Colaizzi’s recommendations. This process was repeated for each protocol over the course of study. During this process, the researcher made note of passages that related to van Manan’s four lifeworlds of corporeality, temporality, relationality, and spatiality. The broad meaning interpretations were manually compiled as a list for each protocol.

Creating theme clusters. The researcher then reviewed each list of meaning interpretations to identify emerging overarching common themes. Each transcript protocol was reread in its entirety and saved as a document with a unique font color. During this review, the researcher validated the presence of themes within the protocol and made note of other themes that may not have been captured during the previous read. After this review, a separate Microsoft Word document was created for each of the emerging themes and the statements, passages, or paragraphs were copied and pasted into the respective theme document to which each related. The unique font colors were maintained in the theme documents to facilitate ease of identification of the participant and the page and line number were included to allow the researcher to easily return to the full original transcript to review text that preceded or followed the excerpt. The researcher then read through each passage within the clusters and determined whether to keep it in the current cluster, move it to another cluster, include it in a new cluster, or delete it. At that point, the researcher noted patterns and relationships within the themes and regrouped them to create subthemes. Being mindful of Colaizzi’s recommendation

that researchers avoid ignoring themes that don't seem to fit with the others to minimize the risk of eliminating an important part of the phenomenon, the text that had not been highlighted was reread.

Integrating themes clusters into an exhaustive description. The researcher then wrote the name that had been given to each theme and each subtheme on 2.5 by 3 inch note cards and placed them on a large table. The cards were rearranged several times until they captured the overall essence of the faculty experience as revealed from the faculty narratives about their experiences on the DEU. This essence was then entitled "The DEU as a New Synergy of Learning: Becoming the Guardian."

Identifying the fundamental structures of the phenomenon. The researcher noted that the final arrangement of the theme and subtheme cards elucidated the fundamental structures of the faculty experience. These three themes and nine subthemes were arranged in a left-to-right directional diagrammatic representation of how the faculty participants experienced becoming a DEU faculty member. (Figure 1)

Overall Essence, Themes, and Subthemes

Overall Essence: The DEU as a New Synergy of Learning: Becoming the Guardian

The faculty participants often described experiences of learning to adapt to teaching using this new collaborative clinical model as a process that evolved over time. Figure 1 depicts this evolution as the three circles on the left gradually merge in the middle into two and ultimately to one on the right. The word guardian is defined as "one who protects or oversees," and synergy is defined as "an effect of the interaction of the actions of two agents such that the result of the combined action is greater than expected as a simple additive combination of the two agents acting separately" (Webster-Dictionary

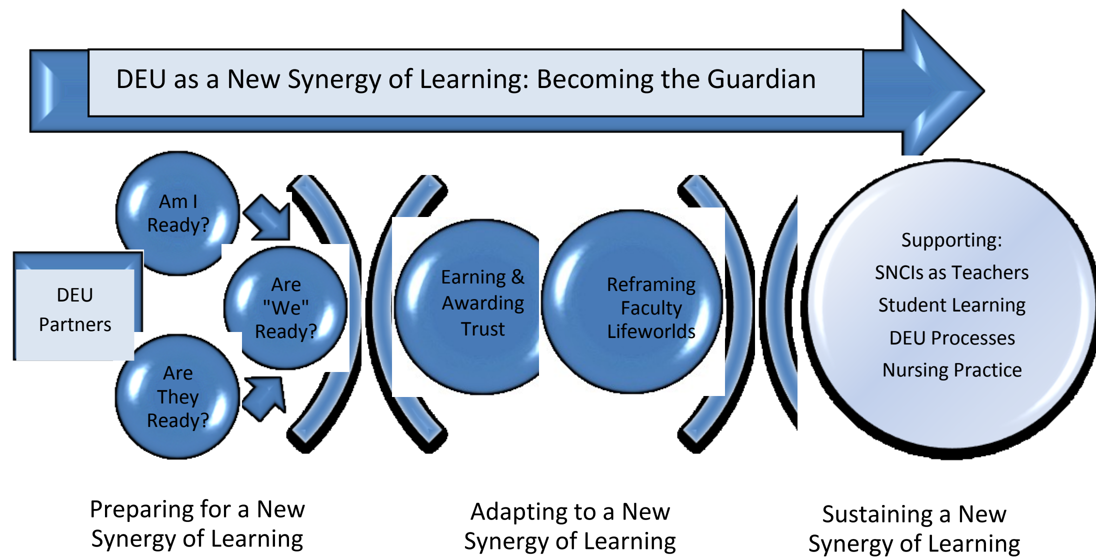

Figure 1. Essence of the DEU as a New Synergy of Learning: Becoming the Guardian

Online Dictionary, 2009). A DEU capitalizes on both the teaching expertise of the education partner and the clinical practice proficiency of the hospital partner in the creation of a new learning environment that is synergistic in nature. The term "becoming" was chosen to portray the passage to a new faculty role experience and "guardian of synergy" aptly portrays the essence of the faculty narratives about how they perceive their responsibilities in supporting the model and its stakeholders.

> I'll give you an analogy. It's like when you're cooking something on the stove and you're just constantly checking and it's simmering just like it should be. Just simmering and not boiling over. (Carla)

> Sort of keep my finger on the pulse of the organization and the University needs. (Dora)

The final interview probe posed to each of the eight participants was to share what three words came to mind that they believed best captured the essence of the DEU faculty experience. Of the 24 total word responses, only the words "coach" and "professional"

were chosen by two participants. Twelve of the 22 word responses included terms that described attributes of DEU faculty members either as adjectives (forward-thinking, innovative, collaborative, proactive, professional, and supportive) or nouns (adaptability, flexibility, independence, patience, integrity, and enthusiasm). Three of the word responses described roles of the DEU faculty member (coach, mentor, and leader) and three words were nouns that underlie the nature of the DEU faculty experience (empowerment, relationships, and communication). One participant chose the adjectives "rewarding", "challenging", and "fun" to describe the essence of her lived experience as a DEU faculty member. One participant expressed some difficulty articulating a third word to describe the essence of her experience:

> I don't know what the word is for this, but it's seeing something come to fruition. And I don't know what that word is. But it's like birthing a baby. I've helped birth this DEU and seeing the fruits of the labor, no pun intended, of …you know, everybody's efforts. (Helen)

Theme: Preparing for a New Synergy of Learning

All eight of the faculty participants had had some level of involvement in the development of their DEU as a student learning site and all emphasized that shared vision, mutual benefits, and shared governance among the partners must underlie the creation of a successful DEU. Most of the participants indicated that meetings between the leadership of the school of nursing and the health care organization, often at the level of the Dean and the Chief Nursing Officer, had occurred prior to their involvement. The contractual agreements and unit selection were typically in place prior to the involvement of the faculty participants. They stressed the importance of the alliances of upper management. Fiona said, "You need the leadership buy-in to make this work"; however,

this was viewed more as an antecedent to their own lived experience, which began with personal preparation and collaboration at the unit level. Therefore, the left-hand box in Figure 1 represents the antecedent partnership, and the left-hand circles represent the three subthemes of the faculty preparatory experience: Am I ready?, Are you ready?, and Are "we" ready?

Subtheme: Am I Ready?

In response to the question, "How did you come to know how to be a DEU faculty member?", seven participants shared how they prepared themselves for participation in the DEU. Four had read the current literature or attended conferences:

> Because I knew a little bit about the DEUs just from reading about it and so we just kind of started the talking going. (Helen)
>
> I read some literature about how it sort of works. (Abby)
>
> I was given a list of the published literature that is available on a DEU. And so I read some of that… [Referring to the SNCI training orientation session] I went through that myself to see what it is that they are being told. (Betsy)
>
> At that conference there were other DEU presentations. I made a point to go to every one, including there was one from the people from Portland. And I know that the chair of our program here also went to the same conference this past fall. And I know that person said the same thing. They went to all the DEUs that they could go to. And the thing that the two of us have learned is that no two DEUs work alike. And that's been kind of eye-opening. (Carla)

Four of the participants reported taking advantage of opportunities to shadow or interact with faculty colleagues who were already engaged in the DEU model; however, the majority of them emphasized that they designed modifications to fit with the learning environments of the unit that had been selected for their own DEU:

> The faculty member who had that DEU helped orientate me and train me and I was able to shadow her one day on her DEU and she was my mentor. It's a very, very different structure, a very different hospital. (Betsy)

> And so I was able to learn from the “master” so to speak that did a DEU (in a different hospital) and get a feel for evaluation tools and, you know, how to help the students and what to do and what not to do and that kind of thing. (Helen)

> And so she just basically shared with me the tools that she used and remembering how to handle conflicts that I might not have, well, I would not have had to deal with before. If it was meshing well and how to handle that and how to make sure that the students are being engaged and not being wallflowers. And so a lot of it was just actual tools that she provided for me and I just kind of made them my own. And just probably being a sounding board for questions. Because you know, you can read till you're blue in the face all the literature that comes out. But until you've lived it you cannot appreciate those nuances that are going on. And she was able to give me a heads up on those before they actually occurred. It was very helpful. (Helen)

> When we transitioned our unit into a DEU there were only two other units up and running at my school. So I spoke with those faculty members, but I have to say I didn't get a ton of guidance. (Abby)

> I had a little bit of a role model because we did have a [nursing specialty area] DEU going on. I spent some time talking with that faculty member, but I developed mine a little bit differently because she has the students at the first semester junior year and I have students the first semester senior year. And [hospital name] had specific requirements. (Fiona)

Fiona later went to say:

> But I really, when I developed this one, I just said, "This is mine and I'm going to do it a certain way." And again, once I got familiar with that unit, I've really taken it on as mine. I have developed all kinds of things. So a lot of it's just through my own knowledge and experience and working very closely with the [nurse leader] who mentored me into the unit and into that culture. The unit has a fabulous culture as well. I just drew on all my own experience and knowledge and assessment of what the students were like and what the unit was like - and figuring it out as we went along. (Fiona)

Subtheme: Are They Ready?

Six of the participants addressed the importance of SNCI orientation and preparation for the role prior to implementation of the model or as new SNCIs join the teaching team. Some of the faculty described being an organizer or presenter in the workshops while others were not active participants in this phase of preparation:

We basically started from scratch and there was a group of us. Because I was the clinical faculty involved, I - along with a couple of other faculty - put together the training program for the SNCIs. (Greta)

At the University we have, at the beginning of every semester, a continuing education day for clinical faculty. I've been involved in a lot of those as one of the faculty developing those programs. So we have the new SNCIs come to that so they can participate and learn a little bit more about what it's like to be teaching within our University. What are our procedures? We've done everything from role-playing working with students to how to use the evaluation tools to talking... Like last time we did a whole bunch of things, but one of the things we did is that we had pair-ups of [course faculty] so that we could share: What are you doing? What are the expectations? What should we expect students to know by the time they get to us? So we've had the SNCIs participating in those workshops so that they're getting some of the big-picture continuing education as well as working with myself. (Fiona)

Well, I teach SNCI classes. I sit them down and say, "Okay, so here's what you need to expect. Okay. So a student at this stage of the game knows this. They should be able to tell you this, this, this, and this. They've had patho. They've had pharm. They should be able to describe to you this process or give you this information. Here are the medication sheets I give them with action - mechanism of action, class, side effects, what they need to assess beforehand. They should have this with them. (Elaine)

In the beginning we did training for the people who were going to be SNCIs. And they were in two small groups - one maybe about 10 and the other maybe about five. And then there was another training session of maybe, I think, about three. It was a very small session. It's during that session that - because it is such a small group and I get a chance to really talk with them - that I hope and think they see “the me” that I want them to see and the person that I want them to perceive me to be in terms of wanting to be available for them. (Carla)

And the University sets up an orientation for them, brings them over, discusses course outcomes with them, and prepares them to be not really adjunct faculty, but sort of a faculty- type prestigious thing. (Dora)

What happened is, there was a special DEU SNCI education developed for that first facility and the group involved were invited in for training, here at this University, and it was focused on how was this different than a new graduate, how is this different than a [precepted Capstone experience] at the end of the students’ education. (Betsy)

Subtheme: Are “We” Ready?

In the previous subthemes, the words “I” and “they” were used. The participants described how they experienced working collaboratively at the health care organization with managers, staff educators, or other nurse leaders at the unit level to become a cohesive team of “we” with shared expectations and mutual respect. Scheduling logistics were mentioned as a critical element in developing an infrastructure for success:

> Everybody came with positive expectations. This was a good thing. We were going to make this work. (Carla)

> And thankfully I wasn't in on the initial part, you know - setting up meetings with the CEO of the hospital and all those people. But very soon thereafter, we started meeting and talking about exactly what does this mean? What is a DEU? How is this going to affect us? How is this going to help your students? What's in it for us and what's in it for your students? How will this change how they do what they normally do on a shift-to-shift basis on the floor? (Helen)

> I'm very sensitive to the regulations that the hospitals need to follow. In my past life I was very involved with policies and procedures. So I'm very sensitive to what they need to do and total respect for everything that they do. And I think that’s part of it. (Betsy)

> So we sat down, the three of us, and talked about how we wanted to set it up. That it was really important for us that there be the idea that you would take the best of baccalaureate education and the best of diploma education. So we wanted these students to feel part of the staff. We wanted them to feel like they could free up the parts of their brain that were being engaged in like, “Where's the bathroom? And what about this SNCI? And what do I know?” And so the rules that we set out from the very beginning were that we would try to keep the triad, the one SNCI with the two students, as consistent as possible. We wanted them to come back. (Elaine)

> The first semester the nurse leader and I did a lot of collaboration about details like - what should the schedule will be? When should I come and debrief? When should lunch be? (Fiona)

> The biggest frustration for me was scheduling. Trying to get the student's schedule and the SNCI's schedule to match up. I found that I spent a lot of time trying to develop a schedule that met everybody's needs. (Greta)

> And we try to get our clinical days on [two specific days of the week]. But that's another whole thing; the reality of it is there's no nurses. Every nurse in the world would love to work [those two days] and be off on the weekends. (Betsy)

> Okay, so these are the criteria when I'm making the schedule - that I try to make sure that everybody gets, they are paired with somebody else and then try to work two days in a row, and they're working 12-hour shifts, 7 a.m. to 7 p.m. … (Carla)

Theme Summary

The contractual agreement between a school of nursing and a health care organization is typically antecedent to the involvement of the faculty of record for a new DEU. The faculty participants engaged in personal preparation for their role by reading and eliciting advice from experienced DEU faculty, which they in turn modified to fit the needs of their partnership. The researcher had not intended to limit recruitment to faculty who had been involved in the development of their respective DEUs; however, all of the volunteer participants in the study had some degree of involvement in the creation and had been faculty on the unit since its inception. They primarily collaborated at the unit level to clarify expectations of the participants and to create an infrastructure for success. Scheduling was an important component of this planning. Several participants had some responsibility for planning or presenting the SNCI orientation workshop.

Theme: Adapting to a New Synergy of Learning

All eight participants had some experience teaching in a traditional faculty-supervised clinical model, ranging in length of time from one semester to 27 years, and none of them had experienced teaching in the DEU clinical model prior to their current academic appointment. All of them shared their perceptions of how they experienced the process of learning to adapt as a faculty member in this new clinical model. One participant shared that she had anticipated change:

> And initially we had hoped to implement this model [earlier]. And when that didn't occur, that gave me extra thinking time on this. And I knew that the changes were going to be great. I studied the model and I think I had a pretty good idea of some things that were going to be different. But you don't ever know that, of course, until you experience it. (Carla)

Two subthemes emerged: gaining and awarding trust and framing the faculty lifeworlds.

Subtheme: Gaining and Awarding Trust

Seven participants described how they came to earn the trust of the SNCIs and/or their own feelings about trusting the SNCIs and the students. Although they emphasized the importance of trust, they experienced trust in different ways.

Four participants shared their perceptions about being trusted or respected for their knowledge by the SNCIs or other unit personnel on the DEU:

> You have to be open to the unit. It's one thing to know that the unit is supportive of you coming in, but it's also how you enter the unit because you're a guest there. I think this particular unit that we're on was so open and so receptive that they made it really easy for me. But I made a point to spend some time getting to know what was going on and they were very helpful in that. I actually went in and spent a few hours on the unit so that I would get a sense of it. And making relationships. They totally respect me and appreciate my knowledge and my role and they're very friendly to me. And I think it's because I was so open and respectful of them. We worked together and they could see that I knew what I was talking about and I knew what I was doing. And I appreciated them for what they had to offer. And I think that's really important going into any teaching situation; but particularly in a DEU because you have to rely on them so much. (Fiona)

> Most of the nurses went to school right around there and they grew up there and they work there, and so they don't let others or outsiders in - and I'm definitely considered an outsider. They don't let them in as easily, so I really had to earn their trust as a traditional unit before I was even able to be in a DEU. I think if I wasn't present on that unit, they would dismiss me right away. I think the biggest thing, and I know that I did mention it and it's not always possible, is to be able to run a traditional unit on the floor and gain the floor and the SNCIs' and the nurses aides' trust - for a faculty member I think is really important. So when you just kind of jump in and say, "Hey, you're gonna do all this work and I'm going to circulate around" - it's a different model for a lot of people. So by me being there

> for a full year - two semesters - they got to see me, they got to see how hard I work, and how much I care about the students. And I was able to tell them, "This is what we're going to do," and I think that that's very important…We decided that an active role is how the nurse or the SNCI is going to really know that you're in charge. That you're the person to talk to. That you have a knowledge base. So that trust level was really huge. (Abby)

> I'm one of them. You know, I'm a practicing nurse. I don't come in and... I have been told I'm very approachable. Terrifying to students, mind you, and fairly intense as a clinician. But if you want me to do something, I'll do it. If you want me to explain something, I'll explain it. I don't make people feel stupid. I don't make them feel like they should know things. And they know stuff I don't, you know… [After describing an incident in which she asked for help] The student sees I didn't know how to do it. It wasn't safe. I asked for help, you know, which is great. The clinical teacher sees…Well she's not unwilling to learn stuff, so that breaks down another barrier. So that's how I approach it. (Elaine)

One participant attributed the current level of high trust to the transfer of previously built trust in the traditional clinical model that was maintained as her unit became a DEU:

> And because I was blessed with already an awesome relationship with the staff and the management on that floor, we worked very easily together. If something wasn't working we, you know, figured out a way to do it. There were never any expectations of the other that were unrealistic. And the manager of this floor is very, very committed to her nurses teaching other nurses. I mean that is one of her big values and so she has instilled that in those nurses, so they have this attitude of loving to have students - which is not typical. (Helen)

One participant explained how, when using a high acuity area of the hospital, she enhanced the SNCIs buy-in of the model by working to ensure that the students would be perceived as helpful rather than as a burden:

> They don't just stand there with their hands in their pockets. They do assessments, they do care. Take a set of vital signs, do an EKG, and so they're useful. And for me the big thing is staff will accommodate students as long as they are not too much additional work. (Elaine)

Five of the participants talked about trust as a reciprocal phenomenon. Several of the participants shared how they came to develop trust in the SNCIs' ability to teach the students. The participants often spoke of feelings about the high proficiency of the staff

nurses and their own perceived shortcomings in meeting the learning needs of students in the traditional model when discussing entrusting their students to the SNCIs on the DEU:

> I've begun to realize, and I'm thinking back to when the place that I had been at started doing computerized charting; things were changing so rapidly in the clinical area. And I was only in the clinical area 1 to 2 days a week for maybe 8 to 10 weeks in one semester and the same thing in another semester with long periods of time in between those two rotations. And especially from the spring until I went back in the fall, things were just changing so quickly in the clinical area that I begin to feel dated myself. I began to not feel as good about my own performance as a clinical instructor using a traditional teaching model as I had felt for many, many, many years. I just began to feel like I wasn't the best person to teach the students. I really felt like that the nurses who were on the floor doing the care day after day after day - were the best ones to teach the students. So I personally took that trust that I had in those nurses and I "awarded it" so to speak, to the nurses at this other place even though I had never worked with them. I am a person who very much sees the world, and everything around it and all that, as half full. It's never half empty. (Carla)

> I have total trust in what those nurses are doing on the DEU; their clinical skills are fresher than mine for the most part. And, you know, I don't think that it's my job to show students how to do the clinical skills there; that's what their SNCI is for… I have total trust, maybe to a fault, in the facility that I work with about who they choose for SNCIs. (Betsy)

> You know I have to trust that they're going to...I can't double-check 16 assessments in the course of a day with the thoroughness that the SNCI is going to do that. So I have to trust that they're going to follow up with the students….And you also have to really, I think, really want them to get an excellent clinical education, knowing that they're going to get taught things that are different perhaps from the way that you would teach them or do them yourself. (Elaine)

> Because they're [SNCIs] doing what I've asked them to do; but, I don't worry about them and I know [the students are] in good hands…And I can't possibly do all those things when I have my students by myself. (Helen)

> And at that time we only assigned the students one to two patients apiece. And I would have to try and work with each one of those students myself, which wasn't working given that we have all electronic documentation and medication administration. And then so everything, when it changed, several years ago, it became very difficult to be that faculty member. And be all things to the students. So, in looking at that, I looked at trying to develop a different model. Because it just was not working…But as far as the SNCIs, I know them all quite well. I've come to know them well. I know what their strengths and weaknesses are. And know when to kind of step in and step out. (Dora)

One participant expressed the feeling that she had established trust with the SNCIs, but she described conditions under which she awarded that trust:

> I can trust the SNCIs to kind of take care of the kids who are doing well. I can focus my attention on the kids who are not doing well. (Elaine)

One participant described feeling uncertain about what might happen if she left the unit and completely entrusted the students to the SNCIs:

> So I ... I feel like if I left the unit for four hours and was somewhere else or if I was available by cell phone or something like that, not only would the SNCIs not know my personality and know me as well, but I wouldn't be on the pulse of what was happening with my students. So things can change in an instant in a hospital, and decisions can get made that are poor or need to be reacted to and me being there and being a presence there allows the students and the SNCIs to come to me at any moment. (Abby)

Helen talked about her belief that the right students had been selected for the DEU as she described her high level of trust in the SNCIs in her statement:

> We took that opportunity to say, for me to say that, "I need for you to be that person. You have total authority to do what you know and say what you know is right for the student because you know we hope that we have chosen well the people that are going to do the DEU." (Helen)

Subtheme: Reframing the DEU Faculty Lifeworlds

The participants' stories revealed transformations in the meanings of their faculty lifeworlds as they ventured into teaching within the DEU clinical model. Using van Manen's (1990) four lifeworlds to guide this part of the analysis, the participants' perceptions and stories were clustered in terms of how they reframed the meanings of lived body (corporeality), lived time (temporality), lived relationships (relationality), and lived space (spatiality) in their DEU faculty role. Van Manen emphasized the interrelatedness of the four concepts and the participants' stories did reveal the overlapping essence of the lifeworlds. Perceptions about changes in embodiment and

relationality were described most frequently and with the most depth by the participants. Embodiment was often discussed in tandem with traditional clock or calendar time. Lived time was explored as a time orientation that van Manen differentiates from clock time.

Lived Body. In response to the question, "What is the meaning of faculty presence" in the DEU model, four of the participants described initial feelings of loss or uncertainty as they realized that their sense of embodiment in the DEU was different from that in the traditional model:

> So the first thing that I remember feeling, when this started - because I did go to the unit the very first day we implemented this - was what's my place? What's my role? Who am I? What am I supposed to be doing? And it was awkward, because typically in the past of course I'm going to the room with the students, helping them get their medications out. Well, they were with their nurses doing that now…And the biggest thing that I've given up is the actual ability to stand back and see the learning that's taking place in my students. Which since I had been a clinical instructor for so many years, I derived a great deal of pleasure from. (Carla)

> When I get the opportunity to be there with my students, number one, I get to be with the kids. And pediatric nurses are just kind of weird this way. We are who we are because of the patients. And so, when they're in the DEU, I really miss that contact. (Helen)

> Probably the first day was okay, but there was definitely a transition in my role in sort of how I felt because I used to be indispensable to the students. So you know they would need me. They couldn't give a med with anybody else really unless I had okayed it. (Abby)

> That I think is probably one of the biggest drawbacks of this role - my main patient information that I'm receiving from students is secondhand through either the clinical teachers or the students. And in one way I think that it's less rewarding because I'm still in practice as well, so I do like the patient contact. (Greta)

One of the themes that had the greatest variation was how the participants perceived the meaning and importance of their physical embodiment or presence with students,

SNCIs, and occasionally patients on the DEU. The participants' accounts of embodiments seemed to fall along a continuum, with continual physical presence during student experiences at one end of the spectrum (two participants) and rare physical presence on an as-needed basis at the other (two participants). The other four participants purposefully planned a periodic physical presence at varying, yet regular intervals. The participants described making decisions about presence within the context of their personal insights into the culture of their specific DEU and their perception of the needs of the SNCIs and students.

The faculty participants often spoke of physical embodiment in conjunction with time in terms of the frequency of their visits, the timing of the visits, when or if they chose to leave, and how they spent their time when present. When asked to explain differences between the roles in the traditional faculty-supervised model and the DEU model, Fiona explained, "Well, you know, when you're a traditional faculty member you have to be there the whole shift and I've done that many years. And I really like not having to be there the whole shift." Dora described visiting the unit the day prior to the scheduled traditional clinical experience:

> I used to, the day before, come in and make an assignment for the students. And try to pick the patients and figure out logistically who the nurses might be. And I tried to select the nurses that I knew that might work well with the students. And then try to find patients, you know - that would kind of fit. (Dora)

Although a stronger presence early in the semester that gradually waned to less frequent visits seemed to be the most common pattern, Betsy explained her perception of the fluid nature of faculty presence on a DEU this way:

> The rules are loose. I need to be able to have a presence so that I'm there enough, but not to where I'm annoying. And I'm not always sure what that is. If I have a problem with a student or SNCI that I am watching closely - a student usually - I

> get there more frequently. So last year I went, it was almost like a routine, I would go pretty much a lot or all the time. This varies…every semester varies. (Betsy)

> Again, in the very beginning, when I was trying to define what my role was going to be, I spot checked more often. I just kind of went to the unit; I was hardly there for much time. I talked to the nurses, I talked to the students, said "How are things going?" "What are you doing today?" Then, as I started checking, when I would go I was almost an interruption to what they were doing - because they were so incredibly busy on this unit. So I don't go often. I may go twice a semester. (Carla)

> But, after that first shift and I would just go up there - I felt it was just dumb.It's like "Why am I here?" To like say, "Hi, how are things going?" That's about all it was. And she also said you can just kind of pop up in the middle of the day and it's like I'm spying on them or what? (Helen)

> …So I felt sort of like I was standing around the first half hour or so then I realized - okay, this is my role and this is what I need to play. And I've become more acclimated to it as time has gone on, so I've taught in the DEU for a year and a half, for 3 semesters, and every semester gets better and better. But I'm learning how to play a more active role without running around. (Abby)

> So for each student, for their first clinical shift, I was present at the beginning and then I would come back the next day while another student was there and work with the SNCI. You know, what experiences did they have? What types of things were the students involved in? And try to formulate a plan for the next time that the student arrived. I was probably on-site, I would say...Two to three, sometimes even four times a week depending on how frequently the students were there. (Greta)

Some participants alluded to being concerned about the added responsibility being placed on the SNCIs when they reflected on the meaning of the faculty presence in a DEU. They tried to make certain that the SNCIs understood that they were always available and not just depositing the students on the units:

> My concern was that I didn't want the nurses to feel deserted. I was really very worried that nurses might feel that we had dumped on them. Just left the students and run off. (Carla)

> I was present in the hospital, reachable, and most of the time on the floor. No, I didn't drop them off. (Elaine)

> I think that when the nurse sees me there all the time they know that they can come to me if they had an issue with the student, if they had a concern about the student. (Abby)

Betsy shared her perspective that it is a personal decision in her statement, "Once the students get established with that relationship, the faculty member has choices. I have chosen not to go in and be proactively involved in clinical skills with my students with the SNCI."

Five participants discussed specific situations, both unplanned and planned, in which their physical embodiment might include performing nursing actions with students such as physical assessments, administering medications, or other nursing interventions. Examples of unplanned performance of care were typically described as a response to the SNCI being busy:

> Generally the daily meds or the morning meds are given with a SNCI or the nurse, unless the SNCI is swamped and I'm available and I can kind of do it. So they see that. They usually see the morning assessment, but again - if they're swamped, I will go in with them. (Abby)

> You know, maybe we need to go and provide the care for this patient while you do something else if you are that busy. (Dora)

> …in a DEU setting, I'm much more of a collaborator with and a resource for the staff. It's sort of how I'm positioned, so I'll put in Foleys, I'll start IVs. I'll help them out clinically as well. You know, can you drop this NG tube? Can you help me assess this patient? Can you...You know I will boost. I feel more a part of the staff as well, and so my presence is more permanent. (Elaine)

Four participants described situations involving more intentional engagement in nursing actions with students either because a learning opportunity had arisen or as a deliberate component of student evaluation:

> Some weeks, if there's a patient who is particularly unusual or interesting and either the family's okay with it or, if the patient's alone, I check with the nurse. And we'll go in and I'll demonstrate something like a physical exam or will talk about a particular clinical scenario. Some weeks, we just do it in the conference

> room because I don't feel it's appropriate to go. For all six or seven of us to go look at the patient…Sometimes we just go in and talk to the parents. One time I went in and demonstrated with a student using alternative practices to help with pain management. It really depends on what's going on. (Fiona)

> I kind of assess them as we go through the first few weeks. You know, I'll do an assessment with everybody. I'll give meds with everybody to assess their knowledge. (Elaine)

> I go around and assess the patients after they've assessed the patients because the nurses might not always have time to check and double-check their charting and all of that so I sort of take my role as the one that needs to find the...or fine tune each of the students' skill levels, knowledge base, make sure that they're correctly tying it into practice. (Abby)

> The other thing that I do, too, that is an evaluation is that I'll go in and talk to families and patients and sometimes, usually with the student, but I've done that even without the student before. So I ask, "Hi, how's my student doing today?" And they will tell you. (Betsy)

One participant described an aspect of her embodiment in terms of using her senses of sight and hearing since she is sometimes present when the SNCI and students are working together:

> I would observe the SNCI working with the student. A lot of the time I would catch them around the time that they were doing a med pass, because we have very specific, as all schools do, policies in regards to how the students should be administering medications. (Greta)

When this participant also mentioned, "And then if they were going to do a procedure, I might observe them doing a procedure and then I would also spend some time talking with the student," the researcher asked her to clarify whether she was actually supervising the student's performance or if she was observing the SNCI-student dyad in this performance. She characterized her involvement as:

> A more passive role, absolutely. Because my feeling was that the SNCI is the preceptor and is the one that is there with the student. That is basically in charge of that educational experience. And I didn't want to interfere or undermine that relationship. (Greta)

Two of the participants disclosed their feelings about coming to terms with the new sense of embodiment as DEU faculty and giving themselves permission to leave the physical confines of the unit although they remained on call:

> And I talked to the SNCIs on the unit, you know, after this first semester when we did this. And I was very honest about the way I was feeling. And one of them said to me, and I've taken this away and kind of made peace with it. She said, "You know, if you had stayed and been there a lot, it might have been more awkward for us to trying to define our role with the students." And I thought, well, that's really good information to have. And the more I thought about it, she's right. Because it was new to them, it was new to me. And if I had stayed, it would have been a hard decision about who's going to do what with whom. So, by me not being there, the nurses and the students really had to bond. And I think it worked out better. (Carla)

> So I never embraced that philosophy of making that physical connection with them each time. So this last semester I always am there for their first shift to introduce them to their SNCI and make sure they are comfortable with where everything is, and that they know they can call me, and make sure they have my phone number and all that kind of stuff - and then I have to walk away. And that's real hard, too; because, it's like they're starting their day and getting going - and I'm like "Okay, well bye," and it's like (laughs) it's not easy for me. So I, that's all I do, is I check on them that first day. I may call them if something is going on and to see how something is going; but, I don't hover over them. (Helen)

Lived Time. Van Manen (1990) considers lived time to be more of a time orientation to past, present, or future rather than actual clock time. The faculty participants spoke of frustration encountered in the past when teaching in the traditional model and collectively spoke of how the present experience spawned their hopes for the future of the DEU students who would enter the profession more prepared. It was this sense of optimism for the futures of the students, the profession, and the blossoming staff nurse educators that illuminated the essence of the participants' lived time:

> What they gain from this model to me is more than what I feel that I could give in a traditional setting when I had eight students. I feel that the opportunities that they get in the setting, that they're allotted in this setting is just phenomenal…I think the most rewarding aspect is just the level of excitement that comes from the students and the volume of experiences and the variation of experiences they're

allowed to have with this one-on-one type of setting… It is rewarding in that the students really take charge of those patient interactions. They really see themselves as the one in charge of caring for that patient. I think it makes the students have more meaningful interactions with the patient. (Greta)

The good thing is that students who are good are going to fly. They're going to be amazing because we can let them. There's enough freedom that they can go to the limits of what they are allowed to do. The students who are sort of mediocre are going to do well because they have this focused attention. There's continuity. There's understanding between the clinical teacher and the student. They don't have to figure out what they can do and can't do every week…So for me; it's an opportunity to provide students with the tools and the resources to actually be good practitioners. To be good clinicians. And then if they choose to go on to be researchers or managers or whatever, then at least they've got that base and they've got that confidence that they can go forward. So I find it really rewarding. I mean I've found teaching anyway to be, clinically anyway, really rewarding. But this is an opportunity to really build something. (Elaine)

I like that. I like challenges. I like developing in newer ways. A big part of my job right now is educator and if I get to educate more than just my senior students I think that's great. That's where I'm making a contribution. So I'm not just training the new generation of nurses, I'm also helping to mentor nurses now into that educator role and I think that's great. (Fiona)

And so, I know that when those kids are in the DEUs they are getting such an incredible experience. You know, they're working one-on-one with somebody who wants to be teaching them. And they're involved in, you know, three, four, or five of their patients. And they know what's going on and they're invited to go see other things and it's just that's just such a vested interest in those students. And I can't possibly do all those things when I have my students by myself. (Helen)

Just opening that door and that opportunity to these students and them being so excited and you know shooting me an e-mail or a text and just going,"I just absolutely love this." And you just know that you've helped open something for this person. And that's really…that's what more my life as a nurse is now is opening doors for students as opposed to helping heal and care for the children. And I guess why I'm prideful or proud is because I had a part in that. And that they got to experience something that they otherwise would not have. The DEU gives me the opportunity to give others that chance - which is worth having to sit on the sidelines. (Helen)

One of my personal goals with the DEU is that it allows students to get a better handle on two of the skills that I think that students don't get to experience as much in nursing school because of the fragmentation of the care in the traditional setting. One is time management and the other is prioritization and delegation. I think that being embedded with the nurse from the very beginning really gives the

> student a sense of how they're going to have to figure out how to organize their day, how to prioritize their day. How do you decide which patient that you see first? So I was very excited for this opportunity. (Greta)

> For the most part the students verbally tell me very quickly. They have done this both years - very quickly. "Oh my God, you know, I've been able to do more skills in my first clinical here than I did in my entire previous clinical"…But, still they see immediately the difference with working side-by-side with one instructor, who is the SNCI, versus being one of eight. (Betsy)

Elaine described her feelings upon noticing that many of her former DEU students were now staff nurses in the health care organization where her clinical students have experiences in this way, "Really proud. Really satisfied. Really, like…centered. Like... Okay, I'm in the right place, doing the right thing and producing good students. Good nurses."

Lived Relationships. The participants shared how they experienced changes in the meaning of their relationships with students and with the staff nurses who were now formally serving as SNCIs. Several participants included nursing leaders within the health care organizations or faculty colleagues as they shared their perceptions about relationships with others as a DEU faculty member. Five of the participants imparted a sense that the nature of relationality with students had changed:

> So the relationship is different, but I also have more time to speak with the student. So I'm able to gauge their challenges and their areas of need and I try to turn that into a positive thing. So I would say that the relationship is different, but I feel like I have awareness of their knowledge that's greater than when it was on a traditional unit. (Abby)

> I think they're different in that in the traditional model, you're the person that they kind of go to for everything and you're there the entire time. That's why I thought it was so important to have those weekly meetings with them so that I could still maintain a similar type relationship with the students. (Greta)

> My perception is that, from the student side, they see me as totally different than a faculty member that they would have for psych or for their maternity or for their public health because they have a traditional faculty. So you know... I don't

> know, they might think I'm sitting around eating chocolate or whatever, you know, and not thinking about them. I make it clear that any time they're in the hospital I'm on call. (Betsy)
>
> I think we develop a very special working relationship. We are less feared and the expectations are kind of out there from both ends. They know what to expect and they know what is expected of them and the… I found it a very positive relationship, one that they come back and give us hugs all the time for. (Dora)
>
> It's a lot more casual. I get to know them. (Elaine)

Two participants talked about giving of themselves to students in different ways in the DEU model:

> Because I don't have the same relationship with my students, and I've kind of missed out on that. I think that I have found myself when I'm grading their papers…I think I find that I want to comment almost maybe more than I might have in previous years. Because I want them to have that little piece of me. It's me wanting to give to them and me wanting to share with them and have them learn from me. And I don't know if that's egotistical or not, but it's the truth. So, I have found that I've spent maybe more time than usual grading papers, trying to give them a little piece of me. (Carla)
>
> I feel like I give them guidance, because they still do look to me as "Is this okay to do? Am I allowed to participate in this experience?" It gives them somebody that they can come to that is a little bit impartial, that's not working on the unit. (Greta)

One participant, who has chosen to limit the amount of time she spends physically present on the DEU, laments the loss of a close relationship with students in this way:

> That's one of the things that makes me sad. Oh my gosh, you have hit the nail on the head here. I have real close relationships with my students and I know them by name. And that's not true of my DEU students because I just don't see them often enough to remember who they are. And that just bothers me like you can't imagine. And I know that if we haven't spent enough time together for me to remember their names - then I have not had the relationship with them that I so enjoy and desire. And I know that my students that I do have that with are benefited from it as well. So that, yes - that is a downside to it. (Helen)

Betsy spends time on the DEU, but she is not physically present for the entire shift. In describing how she fits into the faculty-student-SNCI triad she explains:

> And those two, the SNCI-student relationships, can get very tight. To the point of the faculty...they almost forget. Like "Hello, you know there's somebody else around here." The dynamics are like very interesting to sit back and watch how they evolve. (Betsy)

The participants contrasted their relationships with SNCIs compared with their relationships with staff nurses in the traditional model. They shared how communication had moved beyond physical interactions on the unit during traditional clinicals experiences to now include telephone and electronic exchanges. Conversations in the DEU model may be initiated by SNCIs:

> When I had a traditional unit, it was me and them or sort of them and I. We sort of worked parallel with the nurses. There wasn't a ton of interaction. We talked to them, but we didn't... You know it wasn't necessarily like we were making decisions in the patient's care. (Abby)

> I think I have a very good relationship with the clinical teachers. I communicate with them over and above the weekly e-mail that they send me. They call me when they have questions. They're not apprehensive to call me at all. I get calls from them. I get e-mails from them. And then when I see them on a daily basis, it's a very easy-going, very much a give-and-take equal relationship. (Greta)

> That if they had a student that they were concerned about - they would get in touch with me. That's been very few and far between, but you know a couple of things that they've e-mailed me back about - more it's been a matter of the staff e-mailing me when they really want to praise a student. Although neither one of those, the good or the bad, has come through very much. (Carla)

Although one participant viewed her relationships with students positively, she explained how situational factors affected her relationship with the SNCIs:

> That is probably a little less positive. It's a good relationship, but they are still working for the hospital. And right now I will tell you that the hospital is in a state of chaos because of the reduced reimbursement and all of the things that are going on with healthcare reform, which has impacted the relationship with the clinical teachers. (Dora)

Four participants included their faculty colleagues when discussing changes in lived relationships as a DEU faculty member. Some participants perceived a sense of curiosity

or even skepticism from their faculty colleagues at their schools of nursing. Two of the participants alluded to feelings of needing to collect evidence or explain the model to garner more support from faculty colleagues:

> And we kept a lot of data on both groups and we found that - we weren't really trying to indicate that the DEU was a better model at that point; but we knew we had a lot of raised eyebrows even among own faculty and out there in the community because we were doing something different. (Carla)

> …you get a lot of flack from your own faculty who don't see the value. Who don't understand why…So there's this sort of real tension in our faculty about what the purpose of what we are doing is and so seeing as mine is to produce excellent clinicians, I don't care if they're happy with what they're doing or not, frankly, because the stakes are too high. (Elaine)

> I think that some of the faculty are on board with it. Some feel that it wouldn't work in every setting. Some feel that it wouldn't... It's not the best learning experience for every type of student. I do agree to some extent, but I haven't met any major resistance from any faculty and more of it is just curiosity as to "What do you mean by a DEU?," because they don't have experience in a DEU themselves. (Greta)

> We've had some pushback. There are a few faculty members…They don't really understand it. They don't know that the outcomes and standards are upheld like they would be in a traditional clinical unit. But there are questions about it. There's also questions sort of, you know, "What is it that you do? What do you do, do you just sit there?" sort of thing. And we have to prove ourselves. I think I sort of expected it, but you know at first it hurt my feelings a little, but then I got over it. I dealt it and you have to sort of know that you're doing the right thing for you. (Abby)

Lived Space. The participants often spoke of lived space in tandem with embodiment as they described where they engaged in teaching-learning activities in their previous and new faculty lifeworlds. When describing learning spaces in the traditional model, they typically talked about being in patient rooms; in the spaces where medications were obtained, given, and documented; or in a conference room or a classroom that was used for pre-conferences or post-conferences. Elaine explained that she would get "stuck" in

patient rooms in the traditional model, leaving her students unsure of their next course of action.

The most common overall space of learning for the DEU clinical was still the physical confines of the DEU itself, but the participants described an expanded sense of their personal faculty lived space that encompassed not only the traditional physical spaces for learning; but virtual and nontraditional space as well. Two of the participants described only the tangible structures of the DEU itself as their primary lived space in their faculty role; however, they did describe spatial changes on the DEU:

> And I can sort of position myself more centrally. Like I can just kind of hang out at the nurses' station and people will come to me rather than chasing them around the floor. So it feels a little more deliberate. (Elaine)

> I sort of hang out at the nurses' station when I'm not sort of going into the rooms. But I circulate the floor probably 500 times a day. I'm always kind of walking around and finding students and then pulling them in for things. (Abby)

The other six participants did not describe limits to their perception of lived space as a DEU faculty member. Although all of them reported being on call via cellular telephone when the students were engaged in clinical experiences on the DEU, their lived space could be on the DEU unit or another space or room within the health care agency, or it could be off-site in a faculty office or even the faculty member's home. Only two participants reported having a designated space at the health care facility where they could meet with students or do other work.

All eight participants discussed some type of space, either virtual or physical, for student reflection, communication, or sharing, which several found to be a critical component of clinical education regardless of the model. Of the four participants who described using an online platform for debriefing, two (Carla and Helen) used only

virtual or cyberspace for this purpose within their university office, home, or wherever they had computer access:

> The other thing that I thought was important to maintain with experiences, again having done clinical teaching for many years, I thought that it was important that we try to have some semblance of coming together in some type of a post-conference. Because you miss out on that. That's been, I think, a very important reflective time in my experience teaching students. At the end of the clinical day in a traditional clinical teaching model when you pull everybody together and you sit down and you talk about things. You don't have that anymore with this experience. So I require my students to participate in one discussion board post-conference. And the topic for the post-conference really varies from semester to semester. (Carla)

> They write on a discussion board. They tell me about their experiences and all these things that I asked them about. And when I read them, I sit there and live vicariously through their posts going, "Oh yes, I can just imagine that." And it's…I may actually even have a little bit of jealousy in that this is going on and they're having these great experiences in spite of me. I'm sitting at home you know. I mean, I totally live vicariously through my students. I'm not the one who's in there. (Helen)

Two participants, who blended face-to-face debriefing with online reflection described their virtual components in this way:

> We have a discussion board. We ask three reflection questions and we bring in the quality and safety and evidence-based practice piece and all of that into those questions. And they have to describe their incidents of the day, their best experience, their worst experience, and what they'll do differently, and I respond to them. (Dora)

> We did a virtual post-conference. I wanted to know about safety in one of them and we had a bunch of discussions about safety - just little global conversations about it. And then the second one was about hope or losing hope. (Betsy)

Some participants shared their belief that it was important for the students to have a physical coming together either in a classroom at the university or a small meeting space at the healthcare facility. None of the participants scheduled post-conferences at the end of the day. Betsy's rationale for this decision was, "Because the shifts are generally 7 a.m. to 7 p.m., I'm not going to kill those people at eight o'clock at night, and they have to

be somewhere [the next] morning." Three participants scheduled gathering sessions during the clinical day at the facility. One participant explained her rationale for scheduling a meeting in the middle of day:

> So what we decided to do was to set up a kind of conference that allowed for reflection in action…So they kind of were able to debrief what was going on with their patients and what sort of issues were going on. But the important thing was that it happened at noon or it happened at like 12:30…You know, I think what happens is in that whole debriefing thing. The students, if you do it at the end of the day, well then they can talk about the problems but they have no resources to fix them. So what we decided to do was move that conference to the middle of the day so that not only could they identify what was going on, but they could strategize how to fix it in the last half of the clinical day. (Elaine)

The participants who scheduled midday conferences described a mixture of debriefing activities and more structured learning activities:

> We break at lunch and we reflect and enjoy lunch. Or we have a speaker come. So if we're studying, so if in their academic course load they're studying respiratory, I have someone come from respiratory therapy at the hospital and to demonstrate ventilators. Or if it's cardiac, we do EKG interpretation or arrhythmia interpretation. Or dialysis - we bring them to dialysis and we also have a speaker come in. So, those are the typical lunch time things that we do with them. (Dora)

> We talk about the patients and we talk about, you know, what were the challenges? Or what were the "ah-ha" moments? Or the critical thinking that goes on with these patients. I teach them how to present. At the beginning of the semester, obviously, they're really learning and we talk about how do you present your patient? And then I see tremendous growth over the six or seven weeks. So by the end of the semester we are talking more about, okay, what was the challenge and how did you handle it? And so I mentor them - oh, you can think about this or how did you do this? Or this is how I would handle a difficult situation. We just talk for an hour. And some of those debriefings or some of those hours too, they meet with, like, the social worker and the case manager and so that they get to learn more about the unit. (Fiona)

> And so what I did was, I taught a class from like 1 to 2 or 2 to 3. Kind of that lull period in the afternoon. Give them a chance to kind of sit down and do something different. But we went over stuff. We did respiratory drugs. We did cardiac drugs. We did end-of-life care. We did all these little seminars. Like 10 seminars throughout the course and they were multidisciplinary. We had respiratory come in and we had the head of our palliative care. So we brought in

> all of these different people. And because so much more is required to function on this unit, we figured the additional class was worth it. (Elaine)

Three faculty members shared their experiences holding a clinical conference in a room at the university on a non-clinical day when students were on campus for didactic coursework:

> So on a weekly basis for an hour…I would sit with a group and we would talk about their experiences. We would talk a little bit more about what their goals were for the remainder of the rotation and what my goals were for them and just to hear out if there were any difficulties or if anybody had any concerns. If anything needed to be addressed. Also, having the group share their experiences. (Greta)

> But I would say that the post-conference gives me a chance away from the hospital to really speak with the students. We talk a lot about their assignments, and they do care plans and concept mapping and we can actually tease that out in front of everyone else with an open discussion. It's not a red pen on the paper, sort of "you did this wrong." It's "why do you think that? Argue that for me because I don't understand that and maybe another student doesn't understand that." (Abby)

> It was a period of time that was a good time to have a post-conference here. And so I did that a couple of times. But, you know, it didn't…well, the first one it seems like it was mostly just shoring up some logistics that could have been done outside of spending that time. Another time it seemed like there's just distractions. The students were just distracted; they weren't "with" me. And so I looked at that a little bit different this year, and I made it much more structured. I was just kind of testing their ability to do a lit review and come up with an evidence-based article pretty much right out of the gate. (Betsy)

Theme Summary

The participants discovered ways to earn trust and to give trust to the SNCIs. The majority described trust as developing over time. The participants earned respect through the display of an open and respectful attitude and the demonstration of knowledge and commitment. Though most faculty participants believed that the SNCIs had sharper clinical skills than theirs and several completely entrusted the clinical

supervision of the students to the SNCIs, some maintained a more active role in student supervision or described their feelings of trust as more conditional in nature.

The participants' new experiences as they entered the DEU faculty lifeworlds that had the most meaning and evoked the most intense and occasionally negative emotions were lived body and lived relationality. There was a great deal of variability in the physical presence on the DEU among the participants. They sometimes described struggling with their decision about how often to be physically present on the DEU. Relationships with SNCIs were experienced as being more collegial and student relationships were experienced as being more casual than in the traditional model. There were perceived differences in lived time and fewer boundaries in lived space; however, the participants' expressions of feelings about time and space changes were less intense and more positive in nature than their feelings about changes in embodiment and relationships.

Theme: Sustaining a New Synergy of Learning

Although the process of becoming a DEU faculty member was reported as ongoing and continually evolving in nature, as the participants gained experience they gradually learned the importance of their role in sustaining and improving the synergy of learning that was occurring in the DEU clinical model. The participants described the supportive essence of being a DEU faculty member in this way:

> And then as the faculty person - that would be me - I just make sure that all of that happens and that the clinical teachers are working with the students and that the students are getting out of this experience what we have set as their program objectives…So that is part of my role, to evaluate how those clinical teachers are doing, how the students are doing. (Dora)

> It's very much a relationship job and I have been told that from my advisors here at the University that this job is really a huge amount of just relationships. Going and making sure that things are going well. (Betsy)

> And I would come in at that time just to make sure that those pieces were in compliance with our policies so that these students were getting the same education as the others in the traditional setting. (Greta)

> And I'm an overseer in making sure that things are working and that things are falling into place. (Helen)

> And I really felt that for me the importance was to have a presence. To be a support, but to be kind of in the background a little bit. (Greta)

The four subthemes that emerged were supporting the SNCIs as teachers, supporting student learning and evaluation, supporting various DEU processes, and supporting evidence-based nursing practice.

Subtheme: Supporting Staff Nurse Clinical Instructors as Teachers

Although the SNCIs had attended orientation workshops, the participants embraced the responsibility of providing ongoing mentoring and support for the SNCIs. One participant described the essence of this as:

> But I think the more interesting challenge is working with the SNCIs. Mentoring the new ones as they come on and making sure they don't think they know everything, but yet reinforcing what they do know. (Fiona)

Five participants discerned the importance of facilitating the SNCIs' understanding of appropriate expectations for the students who were on the DEU each semester as different groups came through and how those expectations may vary among students who were at different points in the nursing program:

> That's been an interesting challenge for us to work with the staff on kind of "sliding back and sliding forward" with expectations…[With a less experienced group of students] the staff were a little bit in shock. It was a little bit different for them and I really had to work with them on expectations. So I think we've kind of covered that ground but I think it's the thing that every year I'm going to need to remind them where these students are in the curriculum. (Carla)

> I sit them down…and say, "Okay, so here's what you need to expect. Okay. So a student at this stage of the game knows this. They should be able to tell you this, this, this, and this…So what we spent a lot of time doing is sort of framing out

what are the needs of students are at each particular stage. Like what are they really able to do? How do we move them from here to there? (Elaine)

This unit used to have students every day of the week practically and they did a lot of senior [Capstone preceptorships]. And they said, "Oh, it's not going to be a problem. We know what to do. It's going to be just like a preceptorship". And I said, "No, it's not." And they said, "Well, yeah it is." And I said, "Okay, well we'll see." Because I knew it wasn't. And sure enough, the first semester with the groups, the SNCIs found they were struggling. They were having trouble because they expected these last semester seniors who could function at a certain level and they didn't realize that it was going to be different. And so I had to do a lot of… I definitely had to be addressing this with them and with the nurse leader so that the SNCIs had the appropriate expectations for these students. And then we had to talk about how you mentor and develop critical thinking and clinical judgment. And then you need to start pushing them out to be a little bit more independent and all of that. (Fiona)

So they (SNCIs) were pretty well versed in how things could be done. It was more, sometimes it was more of ,"You could let the student do that." That it was okay to let the student do something. I think that they tended to err, at the beginning, on the side of caution as they were getting to know the students and the students' abilities. (Greta)

I have been called to find out if they can do something or how I felt about something. And so that was good. (Helen)

Three participants illustrated how they supported SCNIs' ability to foster students' critical thinking or clinical reasoning:

And I actually developed a set of questions that I would talk about with them every week. So it's like, "How are the students doing? Let's talk about their clinical judgment and critical thinking. How are you eliciting that from the students?" In the beginning, especially with the new SNCIs. Or tell me how they're developing with these skills or give me an example of what you've seen as improvement in terms of their judgment and critical thinking to demonstrate how they're doing. Or are there any problems? And sometimes there are problems and we talk about it. Either that person, the SNCI will manage it or I will manage it. (Fiona)

To promote their [SNCIs] question-asking of the students, I also make sure that the SNCIs know what the students are learning. So this is what they're covering in content this week or this is what they've had up to this point. These are their skills. This is what they've been tested on. This is what they need to know sort of thing… So I try really hard to give them that appreciation that I think they need, so when they do come and they're really "on" we try to say, "Hey, you did a

> really good job today with the students. This was really good how you challenged them." They like that positive reinforcement, so I give it to them. The students, in general, really like to be questioned, to have them ask, "What is this med for?" "What is this for?" "Why are you doing this?" "What are you assessing for?" And I try... It's hard for the SNCIs to remember to do this because they're so busy and they're trying to take care of their patient load. But I try to say "Hey, you asked a lot of really hard questions today. So-and-so really liked it." And I say it in front of the student so that they all know that that's what we're looking for. (Abby)

> I had one SNCI once who was like, "Well, you know I was kind of bad at meds, too, in school." And I'm like, "No, no! I don't care if you were bad. They can't be bad. There's no slack here." So sometimes you need to kind of remind the SNCIs that this is not about you feeling good about your own adequacies in nursing school. I see that you're totally competent now, but you know, this can't happen. (Elaine)

Two participants perceived that the SNCIs lacked confidence and skill in giving students both positive and constructive feedback. They shared experiences of how they supported the SNCIs in gaining more expertise:

> The SNCIs who are the employees at this hospital didn't really feel comfortable correcting or addressing problems of my students. And so there was actually one instance of that - and not until after the student was out of the DEU and doing some other things - that I found out some things that should have been nipped in the bud. And so we talked about it. (Helen)

> I've put together some materials about how to help students develop critical thinking, communication with students, and how to give feedback. We do some role-playing. I meet with the SNCIs at the beginning of every semester and then at the end of the semester I also touch base with them and say, "What kind of support would you like?" And so then I can come back to them with things like... One semester a SNCI asked me, "Well you know, I don't always know how to give them feedback." So we did some on-the-spot role-playing in the beginning of the semester meeting…My role is really to mentor the staff as well as work with the students. And I gave them some ideas about how to do difficult feedback and what are the parameters for skillful communications. Not saying, "You did this wrong," but saying, "How could we do this differently or how do you think that went?" Things that we know are very effective ways of giving positive, giving constructive feedback. So I've done a lot of that with them. (Fiona)

Three participants explained the essence of some of their supportive efforts as more general support of the SNCIs as persons and as nurses:

> And I can also tell in how they are working for that day. And sometimes I'll just pull them aside and say, "Hey what's going on? Do you need to talk? Is there something I can help you with?" (Dora)

> They are critical. They are so important because they're doing the real work. I really appreciate them and I make sure to give them whatever support they need. And even if they don't realize it, sometimes if I'm talking with them during the week, during my time there and I sense something that they might need some help with, I'll say, "What about this? Or how are you doing this?" (Fiona)

> You know, within the situation I think I give them support. I know that I give them support - that support to still take care of their patients the same way if not better. Their patients often have an extra set of eyes or two extra set of eyes to be with and to keep them company when it's a little bit busier for the nurse. I would say that I try to sort of keep their morale up. (Abby)

Subtheme: Supporting Student Learning and Evaluation

Although there were variations in how much time the faculty participants spent on the DEU interacting with students, three of them discussed their perception that the DEU enhanced their ability to spend quality time with nursing students:

> And then in the afternoon, the students have a list of expectations that they are supposed to glean from the care of their patients. And what I do is go around and go over them with each [student] individually. And see what they know. And try to match up that academic piece with the practice piece. And help them see the big picture. Also to work with their clinical reasoning and their critical thinking. And to try and determine their confidence levels, maybe going into the DEU and coming out. And how they're feeling about organizing the care for between three and six patients. (Dora)

> They [SNCIs] still don't have a lot of time to really sit down and analyze, and tear apart and think about process, and think about development - and I can do that. And so I feel like I'm giving the students another level of teaching that they don't get in the traditional role. Or I feel at least that I wasn't always able to give in the traditional role. (Fiona)

> And so it's eight o'clock in the morning - what do you want them to look like at seven o'clock at night when you hand them off? Okay, how are you going to get there? So these kinds of questions really inform for me what they're thinking about, how well they're prioritizing, whether they understand the implications of what they find. And if not, then you know we talk about it. So then, "Did you consider this?" (Elaine)

Three of the participants commented on how student engagement may be different in the DEU model. They reflected on how they, as DEU faculty, evaluate or encourage student engagement in the learning experiences:

> It works out well because they're given this sense of being more than just a student. But I'm holding them to a higher expectation because I am not looking over their shoulder. I expect for them to be engaged, to seek out things, to never turn down an opportunity ever, to do whatever it takes. To suck this experience dry of what it has to offer. And if they're bored - that's nobody's fault but their own. So that's some other things that I learned from last year when I would have students who would tell me they were bored. And I was like, "You've got to be kidding." So it's got a real learning curve to it as far as figuring out what to say. Because you know, like this semester I said, "Don't even tell me that you even thought of being bored because that's your fault. You go find something. You go look at charts, go read x-rays, go do all this." And they did. And so that was good. (Helen)

> I've been in nursing long enough that I can do kind of an assessment of you just by looking at you. And I see how you look when you're in torn-up jeans and very casual and all nice and relaxed here; you know, when we're meeting, okay. And then when you're in there, when its game day, "game on" and you're in your scrubs and you're all polished up. And you've got that adrenaline look in your eye, because it's really a very intense floor you're on, you look different. You look like two different people. But there's a certain look that I know is outside of the normal look, of the student on-game. There's a look that I can tell if you are not engaged, if you're an outsider looking in. There's a look that I can tell if you are scared out of your mind and, you know, some of that I expect in some of the first weeks. But, you know I look at you, and I see - how do you look? (Betsy)

> It means that they are up for the challenge - that they're always reading. That they're not trying to hide. You know I don't think that students in a DEU generally can, but there's less of that when I'm present on the unit. So I am as visible as possible. (Abby)

Four of the participants discussed the benefits and ramifications of having the DEU staff members take part in the evaluation of students:

> I love talking to the unit secretary, the CNAs, the other nurses, you know, and they will tell you. With the CNAs, that's how you know if you've got a team player. Or if you have a nurse that's just going to do her thing and act like she's a little above other people. (Betsy)

I think there's definitely an awareness. I wouldn't just say that it's one set of eyes either. I mean the charge nurse, the unit secretary - we are all very aware of or I make them very aware of - professionalism and how they need to act on the unit. Everyone's sort of watching and the students know that. And I would say that they sort of raise the bar in terms of professionalism because of it. (Abby)

They can't fly under the radar. They cannot hide in the bathroom…In this situation you don't miss them, because it's like Klieg lights on them. By about halfway through the semester, I start really paying attention to, okay, who's not where they need to be? And the great thing about a DEU is that you get a lot of SNCI feedback because they're the ones really in there. (Elaine)

We actually had a couple of students that both the clinical teachers and myself had significant concerns about. I think that the fact that their [SNCI] input is so critical to the evaluation of the student. A student had to go on clinical warning and the expectation was that we met as a group - myself, the SNCI, and the student - to formulate a plan together. (Greta)

One participant expressed some trepidation about the evaluative abilities of the SNCIs:

So I would say that to a certain extent, my communication with the nurses or the SNCIs, their assessment of the students is very valuable. And I say that or I take that with a grain of salt, because what they expect and their expectations may be different from mine and our collegiate perspective. But I assess them. (Abby)

Three participants explained they had approached some difficult teaching and learning situations that had arisen with students on their DEU:

Honestly, as much as putting the students on clinical warning was not an ideal situation, it really encompassed the need for the faculty to be involved in the DEU and have a presence in the DEU. (Greta)

The student was having a really difficult time getting organized and prioritizing. And so the SNCI told me about that, you know. It wasn't like reporting on the student, it was a three-way conversation and so, we would check in on that and try to come up with some ideas of how to help that and I would talk about some things that we could do here back at school, and so forth and so on and we actually had a sit-down meeting about it. And this is what needs to happen in order for you to get more organized. You need to do this, this, and this. And so, you know, that was a very strong SNCI who was able jump in and help turn that around. (Betsy)

> …the SNCIs will tell me. They're like, "Your student can't find their way out of a paper bag." And I'm like, "Oh really, how interesting. Let me go and look at that a little more closely." I also am rather well known for kind of coming up behind students and just say, "Hey what's going on? You know, what's going on with your patient? Tell me what's going on. What's your plan?" (Elaine)

Two participants described how they provided additional support in situations in which the student was from a non-Western culture. In both situations, they described feeling that they had facilitated a positive outcome:

> I had one student of a non-Western culture and she was very timid. And she was working with the SNCI who is fabulous and this was not her first - it was her second or third time - working with the student, but I think she was having a little bit of a hard time really getting the student to function appropriately. And the student had issues with communication and presenting and at the beginning of the semester it was like pulling teeth to get her to give us information about her patient. It was really about her behavior, her affect, her culture…. I was working with the SNCI, trying to coach her in terms of how to draw the student out. And the SNCI was very receptive, but she just really didn't have this knowledge about what to do and how to encourage her and how to support her. So over the course of three or four weeks, I worked with this SNCI giving her prompts and role modeling with her things to say to the student to get the student to be more assertive. (Fiona)

> We noticed that one particular student [from a different culture], her initiative was very low. She would kind of do what she was told, but nothing else. She didn't seek out information. She really wasn't going the extra mile. And one of my SNCIs is pretty brazen and she said to the student at the end of the day, "Is this really what you want to do? Are you sure this is really what you want to do?" And I didn't know. I wasn't there for this conversation… So at that point, it was the end of the day and I decided to let the student cool down. And we talked after the next post-conference and I sort of encouraged her to use that as an impetus to either do something or think about it. She actually ended up getting a lot better because of that conversation. (Abby)

Subtheme: Supporting DEU Processes

The DEU faculty members describe being involved in day-to-day specific problem solving, a more global ongoing evaluation of the DEU as a learning environment, and in the continuous quality improvement for the processes, procedures, and logistics needed

for the success and sustainability of the DEU. The participants shared examples of the more broad operational aspects of this evaluation and improvement support:

> There's a good feedback loop in terms of "We did this - what you think? Should we change this?" between the SNCIs and the managers and me. So we're constantly in communication about the students, about the process, about what their needs are. (Elaine)

> It was me again checking in with the unit, calling. Just saying, "Is everything going okay?" Trying to keep frequent communication open with the nurse manager. And I learned early on that "no news was good news." (Carla)

Carla later described another aspect of her evaluative responsibilities below:

> What's just coming to mind is again back to this data that I have accumulated. And being very purposeful and intentional about collecting it. And that I've read and am continuing to read. That, to me…reading just reinforces that we're doing the right thing. (Carla)

> And we do site evaluations, we do clinical teacher evaluations. We do the DEU evaluation. So we look at all of that, plus their satisfaction with the area. So when sites become "not okay" we make recommendations, too. (Dora)

> A suggestion was made to have a structured communication [process] and it's been followed loosely, but successfully, so that you know we have strengthened tremendously the communication. What needs to occur, how and when, to keep this going smoothly. We have evolved, I believe, to that point, and my role is to be the key communicator with the [person] in that facility who is the major voice for the directors and managers on the clinical units. (Betsy)

She later discussed stakeholder expectations in this way:

> And what are the expectations from both parties? And so if the expectations are not being met, it's really important for somebody higher up to know that before the end of the semester…Know when to holler and scream and know when to just say, "Well, this is all part of the deal." (Betsy)

> There were some gaps in communication between the students and the CIs, so we talked together about how to address those. You know - all the sort of systems pieces. By the time we were in the second semester we had all that done and it's been very smooth this past year. (Fiona)

> Until you're actually on the ground with it, just knowing that there's going to be variances. There's hybrid DEUs, you know, and that's an okay thing as long as the number one goal in my mind is for the - and a probably parallel goal - is for

> the students to be able to get the best learning experience that they can get and the patients to get the safest and the highest quality of care. So, you know if you have variations of how it happens - that's okay. It's not always going to work perfectly and just keep on trying to work it through. (Betsy)

Another aspect of the faculty experience on a DEU is being involved in collaborative problem-solving for unforeseen issues or situations that may arise in the day-to-day operation of a DEU. Three participants gave examples of facilitative interventions as a "matchmaker" of SNCIs and students:

> So I look at this and it's not the prescription or recipe to follow of exactly of how to do this. I look at this as in the beginning it's really just about relationship building. And you just really have to make sure that there's a match with the SNCI and the student. There was a situation year one where there was not - and I needed to remove a student from a SNCI mid-day. So the faculty needs to be really closely monitoring what's going on. Hoping that the students trust the faculty member enough that they will disclose everything that's going on…So it all has to be done very delicately. (Betsy)

> The biggest challenges seem to be all of our SNCIs obviously have different personalities and our biggest challenges seem to be when one of them calls in sick and I need to put a student with a SNCI that they haven't been with and they're not used to that personality. We have a few that sort of are patient and a little quieter and they let the student kind of lead and show their initiative. We have another one that kind of throws you into everything…I mean I would say that for the most part that the expectations are the same, but the approaches are different from both student and SNCI. They just sort of handle situations differently and we have to have the discussion that it kind of takes all kinds to run a unit or a floor. (Abby)

> Well, we have had a couple of experiences where there wasn't a good mix of students and clinical teacher and I had to swap things around pretty quickly. I find always intervening on the student's behalf has worked well. (Dora)

Other unanticipated situations that required participant intervention included exposures and SNCI unavailability:

> The other thing is students splashing themselves with materials and having to intervene. And nearly every semester, no matter what we say, some student gets splashed in the eye, stuck with a needle, or something like that and where we need to send them, you know, to do the rapid response testing, advocate for the student, get them the intervention. (Dora)

> They're assigned to a SNCI, but if there's a low census…you might go in and the SNCI may not be there. So you might be assigned to somebody else. I was getting "drama" calls in the morning, you know, at 6:45, "My SNCI is not here" and like the world is ending, you know. But through my ability to see the bigger picture and understand more and my hopefully being a little bit more experienced as a faculty, I've proactively addressed that and prepared the students for what to do if that occurs. (Betsy)

> But once they have to switch for any reason, because the SNCI has called in or is sick or something like that, and we have to switch it up - there gets to be some issues then because they're expecting, the SNCIs are expecting that their students are at the same level that their regular student is at. And the students are expecting that the SNCI is going to be the same. So I've had to intervene with that. Just sort of remind them they've been with so-and-so and their personality is a little bit different; their strengths are little bit different. And I do it on both sides. (Abby)

Subtheme: Supporting Nursing Practice

Five participants related stories about their involvement in supporting evidence-based nursing practice for students and for the SNCIs of the DEU. The situations described were not initiated by the faculty participants, but rather were typically in response to students' concerns about the nursing practice they were observing or engaged in on the DEU:

> I think I just had some students who had certain expectations. And one of the expectations that they had was that these nurses were going to be practicing perfect nursing. And as I talked to them and listened to the students be very critical of these nurses and of some of the things that they were seeing - I realized that I needed to perhaps do more with the students on the front end about making sure that they understood nursing is not a perfect world and nurses are not perfect people. And even though we have tried very hard to teach them a textbook way of doing something, the reality is that when they go out there - they're going to see many different things. (Carla)

> The student has to trust the preceptor that if they're doing something and they know - especially when they've had more than one preceptor - that every nurse is not going to do it the same. That a nurse who's been a nurse a while is maybe not going to do it exactly like they were taught to do it in their sim lab. You know, I had one student who was reporting something that was probably outside of the parameter of what we like to see in nursing. And so she felt, she trusted me to be

able to report that to me. I've had students report that about other things that they witnessed. (Betsy)

I think safety and process come into account. If it's safe but different - fine, I don't care. There's lots of ways, different ways to do things. If there's a shortcut that makes sense - again, fine. But I also question like, you know, there are some nurses who will give the eight o'clock and 10 o'clock meds at nine - just because for scheduling purposes. So I said, "Okay, that's not wrong, technically speaking, but you want to think about the meds you are giving. Are you giving two cardiac meds at the same time"? Like...Think it through and give them sort of, almost like an epistemological process. So I would say, "Okay, so why are we doing that? Is this a good idea? Knowing what I know, is this okay?" And if it is empirically okay, then okay. (Elaine)

So it's my job to first facilitate their learning and second to sort of connect their theory - what they're learning in the classroom - to practice. So to make sure that what they're seeing or what they're hearing and they're reading in their books and their lectures is seen out in practice. And if there's a difference, we talk about why. So if there's a difference in what they're learning in the lab versus what they're seeing the nurses do or doing, being taught to do themselves, we learn about the differences. If it's something where it's a practice issue and the nurse shouldn't be doing it, we talk about why they shouldn't be doing it and why the student should do it the right way… And it's a total practice issue. I've brought it up. But you, as a clinical instructor, you walk a fine line between sort of you're not their friend; you are not their boss sort of thing. So I tread kind of lightly. (Abby)

I talk to the student and I say, "Okay, let's walk through this. If you think...Do you see the problems with this process?" And they'll be like, "Oh, yeah. I totally do." So then I'll sort of follow up with the SNCI and I'll be like, "Hey, you know what? This is what I'm trying to teach them and this is why. So, I get that you're doing it this way; but, this is what I'm teaching them. So what do you think about that?" I mean we have a conversation about it… It gives me an opportunity to also teach them about evidence-based practice, which is kind of cool. (Elaine)

Theme Summary

The participants highlighted the active role that they must play in evaluating, improving, and ultimately sustaining the new synergy of learning that is the DEU. They support SNCIs as teachers and facilitate their skills of giving feedback and fostering critical thinking. As new student groups enter the unit, they clarify appropriate expectations. They view themselves as ultimately responsible for the students' learning

and promote student engagement. They provide additional support when student issues arise. They are constantly evaluating the synergistic dynamics and procedures of the DEU for overall process improvement and sometimes serve as problem solvers. When practice concerns arise, they take the opportunity to support and improve nursing practice, an endeavor that requires some finesse.

Verifying the descriptions of the phenomenon with the participants.

The verbatim transcripts and the meaning of the overall essence, the descriptions of the three themes and nine subthemes, and the representational diagram were shared via e-mail with the participants for member-checking verification. Six of the participants responded with feedback about the model and/or the transcripts and the researcher reviewed the data analysis to ensure that their comments were integrated:

> Your model has captured my experience with the DEU very well, and in fact I'm amazed that others' experiences are included b/c it could be just mine. That gives me validation that I experience the same thing all your other DEU instructors experience. (Helen)
>
> This is very, very good! As with any innovation, I think the main issue with the DEU is that it is different. You have done a wonderful job highlighting the differences, I would just keep pushing this point hard. I still struggle with the best way to explain the differences. (Betsy)
>
> I feel as though you accurately captured the overall essence of the DEU. I think it was important that you included other faculty skepticism in your summary as that is definitely an issue. Trying to find that fine line between letting go with the students while still being supportive to both students and facility staff as teachers has been a challenge but is critical to the success of the DEU. Collaboration is key was well as recruiting enthusiastic faculty and staff to be involved in the DEU. (Greta)
>
> Regarding the unique culture of each DEU, this also has a bit of "bubble creation" to it as well, to develop something outside the boundaries of the norm, you almost have to insist that the 'norm' stay out before a little bit of reintegration. Letting go of traditional faculty role – really becoming the "guide on the side" vs. the "sage on the stage" – this is what really jams people up, I think, and it's a critical piece of a DEU environment. [Regarding the potential skepticism of faculty

peers] This is HUGE. [Regarding tactfully dealing with SNCI practice issues] I think this is just right. (Elaine)

[Regarding the transcript] This looks accurate. (Dora)

Fiona shared very specific feedback about the conceptual representation of the overall essence, themes, and subthemes. She provided additional insights into which themes she believed pertained the most and the least to her experience:

> Thank you for sharing this summary of your findings with me. Overall I think it is on target and informative. Mostly I want to point out aspects that were not difficult or particularly relevant for me. For example in Theme 1, I did not experience any specific personal preparation steps other than to familiarize myself with the clinical unit. Also, the unit staff and leadership were completely ready to go. The one area that we did work on and continue to fine tune is the logistics and scheduling of various DEU activities. In terms of Theme 2, Lived Body/Embodiment – I did not have any hesitation letting the students go, or having them work directly with the staff. Perhaps this manifested for me in really keeping up with the SNCI's on a regular basis, to make sure they knew their role. I have definitely worked with the various SNCI's over time as a mentor, defining our relationship more clearly. For Lived Space – I am physically present on the unit every week. I think this is important both for the students and the unit staff, for visibility, reference point and consistency. (Fiona)

When completing the demographic questionnaire, Fiona indicated that her most recent experience teaching in the traditional faculty-supervised model was eight years prior to her participation in the study. Her perspective illuminates the need for further research that considers specific variables that may influence the DEU faculty experience.

Chapter Summary

This chapter presented the participant characteristics, the theme analysis procedures, and a diagrammatic model of the structures of the phenomenon of the meaning of faculty experience on a DEU. The overall essence, "The DEU as a New Synergy of Learning: Becoming a Guardian," was identified and the three themes and nine subthemes were described with supporting anecdotes presented.

CHAPTER VI

DISCUSSION AND INTERPRETATION

The purpose of this phenomenological study was to describe, interpret, and gain insight into the meaning of the lived experience of faculty members on a Dedicated Education Unit. Three major themes with a total of nine subthemes emerged that elucidated the overall essence of what faculty experience during the journey to prepare for, adapt to, and ultimately sustain, embrace, and become the guardian of the synergy of learning that underlies the new learning environment that is the DEU clinical model.

Findings Related to the Current Literature

In an effort to expand enrollment capacity and ensure that baccalaureate nursing graduates have the appropriate skills and competencies for 21st century nursing, faculty leaders from at least 30 schools of nursing around the U.S. have undertaken the development of Dedicated Education Units as a new clinical learning model. Although this model is gaining in popularity, there is little research about its effectiveness and no previous studies have focused on gaining an understanding of the faculty experience when engaged as the faculty member for a DEU. This study of that lived experience served to describe, interpret, and capture the essence of this new DEU faculty lifeworld.

The findings of this phenomenological study are limited to faculty experience using the DEU clinical model, specifically to those who are the inaugural faculty members in a new DEU. There are some commonalities with research findings from studies conducted in other practice-education partnerships such as preceptorships. Additionally, there may be some parallels to the faculty experience of those who accept the challenge of using new teaching platforms or learning environments.

Faculty Demographics

The participants in this study all had served as a faculty member for a course within the previous twelve months for a baccalaureate clinical nursing course in a learning environment that was designated as a Dedicated Education Unit. All of the participants had some experience teaching in the traditional faculty-led clinical model, and all had some role in the collaborative development of the DEU and had experienced the process of adapting to the faculty role on a new DEU. Although one participant also taught a clinical section in a senior-level end-of-program precepted capstone immersion experience and one also taught clinical sections using the traditional faculty-led model, this inquiry was limited to their experiences of becoming a DEU faculty member.

Theme: Preparing For a New Synergy of Learning

Each of the participants described the experience of participating in the development of the DEU and the personal preparation involved prior to actual implementation. They emphasized the importance of all stakeholders "being on the same page." Several participants emphasized that each DEU has a unique culture and that no DEU will function exactly like another; therefore, the faculty must work collaboratively with the appropriate parties within the school of nursing and the health care setting to create the framework that will both fulfill the needs of all stakeholders in the DEU and fit with the missions of the two partners as well as the curriculum of the school of nursing.

The majority of the participants explained that broad strategic planning for the DEU had occurred between the highest levels of leadership at the school of nursing and the health care organization prior to their involvement. They perceived this to be a critical antecedent to the success of the DEU. The participants described their roles as integral in

the more specific planning and the logistics of actual implementation at the later phase in the planning. Distinct stages of development of a DEU partnership have been described in Murray and James' (2011) evaluation of a DEU initiative using a strategic alliance framework. Their analysis included the use of a single alliance-key success factors framework in which they suggested that a DEU initiative follows three phases: alliance formation and partner selection, alliance governance and design, and post-formation alliance management. Using that framework, the participants' description of the point of their initial involvement in their DEUs would be consistent with the design phase after the contractual agreements had been signed. Their involvement deepened and they described assuming a very active role in the post-formation alliance management phase.

To prepare for engagement in the DEU partnership, the participants read the current DEU literature, attended pertinent conference sessions, and shadowed experienced DEU faculty members. These personal preparation strategies align well with those identified in Yonge et al.'s (2003) study of faculty preparation for their role in preceptorships. However, just as a faculty participant in the preceptorship study described the strategy of "just wing it," so did several participants in the current study describe some initial apprehension and uncertainty about their new DEU faculty lifeworld.

Theme: Adapting to a New Synergy of Learning

Several participants initially questioned the true nature of their place in a DEU and gradually came to understand their facilitative role in the partnership over time. Faculty members' uncertainty about their role has been described as underlying other types of clinical curricular changes. Campbell and Dudley (2005) anecdotally described how faculty who were teaching in a newly developed "clinical partner model," that included

both baccalaureate-prepared adjunct faculty and staff nurses across two units experienced initial confusion about expectations.

The participants discussed their experiences relative to the reciprocal nature of trust among the participants and how they learned how to earn trust and to award trust as a DEU faculty member. Glazer et al. (2011) contend that partners in a DEU must forge a relationship based upon trust and mutual commitment. A previous study of the DEU model revealed the value that SNCIs place on being trusted to teach nursing students. Moscato et al.'s (2007) SNCI focus groups revealed that the staff nurses appreciated being accountable for the students and liked that the layer between them and the student was removed in the DEU model.

The participants' views about the importance of trust in the DEU partnership coincide with the trust that is requisite to other successful practice-education partnerships. Warner and Burton (2009) maintain that trust in an emerging academic-service partnership doesn't just happen; it is earned over time and facilitated by "fiercely honest communication" (p.333). Burke et al. (2009) described trust in the "social network" of the academic and service partnerships as reciprocal, personal, and professional.

Several participants expressed concern or even guilt about the workload of the SNCIs with whom they had entrusted their students. A similar sentiment was expressed by Beeman (2001) in a reflection about the faculty experience in a new preceptorship clinical model. Beeson described worry that the workload would be too much for the preceptors, which could result in their attrition from the model in the future. Beeson's reflections about grappling with trust, being concerned about students and patients, and

being willing to relinquish power seem to mirror many of the ruminations of the participants in the current study.

All of the participants expressed some degree of discontent with the limitations they had experienced teaching in the past in the traditional faculty-supervised model. When focusing on the present and future benefits of the students' and SNCIs' engagement in the DEU learning environment, they conveyed feelings of pride and enthusiasm. Several described how they believed they had discovered new ways to make a positive difference in the lives of the students and SNCIs. Murray et al. (2011) analyzed the performance of a new DEU using three partnership evaluation frameworks. They found that faculty who relinquished the traditional approach and embraced the DEU approach were more satisfied with the new model and determined that it allowed them to share "educational know-how" with staff nurses.

The participants all described changes in how they perceived their relationships with students and staff nurses in the DEU model. Some described feeling like outsiders or guests. Kinnaman and Bleich (2004) historically characterizes the relationship between academia and community health care providers as one of toleration or "parallel play" in which information is respectfully shared, but each views the other as outside their boundaries of control and collaborative problem-solving does not occur. Kinnaman and Bleich suggest that even when academia and nursing service organizations coordinate their efforts, the relationships remain transient and ultimately separate. Participants in this study who expressed positive feelings about the evolution of their relationships described them in a manner that coincides with Kinnaman and Bleich's characteristics of the truly collaborative behaviors that are needed to sustain partnerships. Inherent in

collaborations is an interdependence that suspends the “contrived role identities” and focuses on complementary knowledge, skills, and abilities of each of the team members. Several of the participants acknowledged that they held a belief that the SNCIs had superior ability in clinical skills in the technology-laden health care environments, but they had the edge in teaching expertise and knowledge of evidence-based practice. They were able to view these complementary abilities in a positive light for student learning.

Murray et al.’s (2010) evaluation of a new DEU partnership included an anecdotal observation that the new faculty role as SCNI coach was easily grasped, yet it meant “letting go of the individual joy of clinical teaching.” The concept of letting go is echoed by Warner and Burton (2009), who contend that it is the first step in creating the new thinking required for a successful DEU. They suggest that faculty must relinquish the “arrogance” of narrowly focused faculty definitions and give up the intimacy of clinical teaching in favor of mentoring SNCIs. They further point out that faculty members do not have “a corner on wisdom and learning” (Warner and Burton, 2009, p.333).

Some faculty participants expressed feeling a sense of sadness because of the change in their relationships with students. This is consistent with Rhodes et al.’s (2012) finding that one faculty member described the first DEU experience as being “tough” because she no longer felt like a mother hen with her little chickens. Similar feelings during a faculty transition to a new teaching model were a finding of Diekelmann, Schuster, and Nosek’s (1998) study of faculty who changed from teaching in a traditional classroom setting to a distance education model. Some faculty experienced distress because they felt they had lost their familiar landmarks and touchstones of teaching, but they ultimately came to challenge conventional pedagogies and learned from experience. The

faculty in the current study who had expressed sadness ultimately came to embrace the model as a better way to educate this generation of nurses. Although there may be speculation that faculty who are venturing into collaborative partnership models may have difficulty relinquishing control over student learning, the literature suggests another consideration: that faculty need to feel a sense of purpose in their teaching role. Gazza's (2009) hermeneutic study of full-time faculty in a baccalaureate program revealed that faculty relished the feeling they were making a difference in the lives of students and in the profession of nursing. This sentiment was shared by several participants in the current study who described feeling a sense of loss that they were no longer caring for patients or closely involved in teaching students in the clinical setting. The participants eventually came to realize the importance of their role in mentoring and supporting the SNCIs, who were in turn enhancing the practice readiness of the students. The participants continued to utilize various modes of debriefing or post-conferences to maintain a connection with the students. Campbell and Dudley's (2005) study of faculty experiences in a new preceptorship clinical model resulted in their recommendation that, to address the faculty dissatisfaction with the quality of their relationships with students in that model, faculty needed to be very intentional about interacting with each student throughout the semester. The clinical conference, whether it occurs in a physical space or in cyberspace, is an example of a strategy used by most participants in this study that is congruent with this recommendation.

The perceived resistance of some of the participants' faculty colleagues toward accepting the DEU clinical model has similarities to the lack of faculty support described by Haleem, Manetti, Evanina, and Gallagher (2011) when a new precepted senior-level

practicum internship model was implemented. They attributed the initial reluctance to the fact that the most experienced faculty members had not been exposed to an internship model and noted that involvement in using the model led to the ultimate development of "enthusiastic" support. One of the five major themes that emerged in Paulson's (2011) qualitative study of the faculty teaching experience in a new curriculum model emphasizing simulation and clinical immersion was "embracement of change" with related subthemes of "history" and "morphing of mindsets." All seven participants reported varying degrees of reluctance to change. Paulson surmised that faculty of a certain generation had to transcend their previously held notions about certain components of the previous traditional curriculum. Gazza (2009) found that full-time nursing faculty members' perceptions of their relationships with faculty colleagues were more negative than positive and that interpersonal conflicts and discord may be all too common in the faculty experience. In the current study, one participant's description of tension among faculty related to differing perspectives about the value of the DEU clinical model demonstrates that the faculty members who choose to embrace the DEU innovation are not immune to this discord.

Theme: Sustaining a New Synergy of Learning

Several participants noted that SNCIs were not comfortable with giving students feedback or fostering critical thinking, and they shared strategies they used to enhance the SNCIs' comfort with and ability to provide those aspects of the clinical teacher role. This is consistent with Moscato et al.'s (2007) finding that SNCIs were uncertain about their performance and wanted the DEU faculty member to provide expert validation and to support their development as clinical teachers. They also expressed worry about whether

they were properly teaching the students how to critically think. The participants in that earlier study developed teaching sessions on the topic of higher order questioning, just as the participants in the current study recognized and addressed support for SNCIs to acquire this teaching skill.

The participants in this study also mentioned that providing support for the SNCIs influenced their decisions about when to visit the DEU, how long to remain, and the activities in which they would engage. Several expressed concerns that the SNCIs would feel that the students had been dropped off or that faculty weren't available to them. Faculty focus groups in a previous study revealed that DEU faculty found it difficult to find time to mentor and coach the clinical instructors who were too busy providing care and working with students (Moscato et al., 2007). Several participants in the current study identified strategies to overcome this barrier by choosing the best time and optimizing the amount of time spent on the DEU.

The participants in this study reported that they were able to promote meaningful student learning in ways that had been nearly impossible when they used the traditional faculty-supervised model. They were able to spend more quality time stimulating clinical reasoning and fostering problem-solving skills when they interacted with students in a less hectic, more intentional way. Hegge et al. (2010) reported comparable findings in an evaluation of a clinical-academic partnership model with that incorporated nurses as clinical teachers. The faculty mentors recounted how crucial conversations with students grew deeper when they were not distracted by urgent tasks.

In terms of student evaluation, several of the participants shared stories about how they had intervened with students who had experienced difficulties meeting the clinical

course competencies. Luhanga et al. (2008) found that staff nurses who worked with nursing students in the preceptorship model reported feeling emotions such as anxiety and self-doubt when evaluating unsafe nursing students. The preceptors recommended that faculty members make themselves readily available in challenging student situations. This perspective was shared by some participants in the current study. Several reported that they increased both their physical presence on the DEU and their engagement in the teaching-learning process when problematic situations arose. One participant described how she had assumed some of the direct clinical oversight of students who were struggling clinically.

The participants in this study all reported being committed to the success of the DEU and were continually striving to find ways to evaluate, support, and improve the process pieces necessary for sustainability. Similar findings have been reported in two studies of student, SNCI, and faculty perceptions of the DEU model. Moscato et al. (2007) found that faculty focus groups members were ardent supporters of the model and expressed the sentiment of never wanting to return to the traditional faculty-supervised clinical model. Rhodes et al. (2012) reported that DEU faculty focused on positive outcomes and student satisfaction.

Several participants in the current study emphasized that the facilitation of communication among stakeholders is fundamental to the success of the DEU model, and the participants perceived their role in this to be pivotal. Moscato et al. stated that an ongoing focus of their DEU endeavor was the support of strong and consistent communication on all levels of the partnership.

One of the most frequently reported issues encountered by the participants was when students questioned whether what they were observing while working with the SNCIs was consistent with evidence-based nursing practice. Often the participants described explaining how practice may differ among nurses, yet still be safe practice. However, at times the participants had to bring unit practice issues to the forefront, and several found opportunities to facilitate integration of evidence-based practice into the care the SNCIs were providing. Previous studies have reported how the DEU model can influence practice and how a disconnection between didactic learning and actual practice may surface. Moscato et al.'s (2007) SNCI focus groups revealed that the clinical instructors felt that working with students made them look at their nursing practice more carefully and it "kept them on their toes." Those focus group participants also reported that translating classroom content into clinical practice was a challenge. McKown, McKown, and Webb (2011) reported results of a study with students enrolled in a clinical nurse leader (CNL) graduate level entry-into-practice program. The student logs about their DEU experiences revealed that they had discovered several "near misses" in patient care that were reported to patient care coordinators who corrected errors.

Ryan et al.'s (2011) study of a pediatric DEU pilot revealed that SNCI focus group participants reported becoming more aware of the need for practice guidelines as they noted an increase in the need to retrieve the organizational policies and procedures as they worked with the DEU students. Mulready-Shick et al. (2009) reported positive staff responses to DEU students' unit-based quality improvement projects, thus providing another example of how the DEU clinical education model can have a constructive impact on nursing practice. The findings of the current study corroborate that practice

issues may be uncovered with the DEU clinical model and they elucidate how the faculty experience may include capitalizing on opportunities to clarify, improve, and support evidence-based nursing practice and learning tactful ways to address deficiencies. However, this is potentially a very sensitive area for unit leadership and staff.

Implications for Nursing Education

The findings of this phenomenological study contribute to the science of nursing education as faculty leaders strive to engage in models of clinical instruction that are innovative, relevant, and cost-effective and that prepare graduates for the realities of practice. The stories of the participants inform current faculty and faculty leaders who are involved in DEU partnerships as well as those who may be considering participation in this model or a similar hybrid. Those currently involved may experience a sense of validation that they are not alone in their experiences, and those who are considering it will be able to anticipate what they may experience and how they can best prepare for success.

The participants all personally prepared themselves for success by learning from the voices of experience and by seeking information to improve their knowledge base about the DEU model. One lesson learned by the participants was that prospective DEU faculty can learn from a master, but they must make it their own. Each unit has a unique culture and operational processes and logistics must be tailored to meet the needs of all partners to the fullest extent possible.

The participants made a concerted effort to gain the trust of the leadership and the staff of the unit that had been selected to become a DEU, and they approached the clinical partners with tact and respect. Faculty considering engaging in the DEU model

can anticipate that they will experience changes in their faculty lifeworld to which they will need to adapt. Some aspects of this lifeworld may remain unchanged and some changes may be easy to embrace, yet others may be difficult or evoke strong emotions. For faculty members with years of clinical teaching experience, the process of learning to let go of the traditional primarily supervisory faculty clinical teaching role may be eased by focusing on new faculty contributions that serve to cultivate a new generation of nurse educators and the opportunity to engage students in deep clinical learning through dialogue, reflection, and debriefing.

These findings illuminate the critical and pivotal role of the faculty in evaluating, improving, and sustaining the DEU clinical learning model. Successes can be maintained through ongoing support to foster growth of the SNCIs as teachers and continued, diligent collaborative evaluation and support of the student learners. This learning triangle of the faculty, SNCI, and student may offer views that are unseen in the traditional model. Having additional sets of eyes and ears can illuminate both positive and negative perceptions of the participants. Student strengths can be validated but their weaknesses may also become more obvious. To use the words of one participant, "the Klieg lights are on them." Those Klieg lights may also be on the SNCIs as evidenced by the participant reports that students sometimes questioned what they were seeing in practice as they worked side by side with the SNCI. Faculty who are considering a DEU faculty role may anticipate that students may need assistance in thinking practice issues through; however, sometimes they may uncover actual unsafe SNCI practice habits that must be handled with tact and framed as an opportunity for improvement and support of

evidence-based practice. Faculty should be aware that boundary issues may potentially arise.

A somewhat unexpected finding was that several participants felt that they had to prove themselves to their faculty colleagues who did not understand, were unwilling to change, or who remained unconvinced because of the lack of evidence to support the model. This highlights the need for the study of the efficacy and outcomes of the DEU model to provide additional support beyond the affirmations of these study participants. It will be through the continued collection of evidence that this resistance can be overcome.

Limitations

Findings from this study are limited by the small sample size of eight and the lack of gender diversity of the participants who were all females. Although recruitment efforts had been aimed at any faculty member who had taught a baccalaureate clinical course on a DEU within the previous 12 months, all of the participants who agreed to be in the study had been involved in collaboratively pioneering the development of their DEU since its inception in their current health facility. The themes uncovered in this study cannot be generalized to the experience of a faculty member who takes over teaching on a DEU that has been established by a faculty predecessor.

Although the participants had a wide range in the years of experience in the traditional faculty-led clinical model, all of them had at least one semester of immersion in that model. Faculty who are in their first semester of teaching or those without any exposure to the traditional clinical model may experience engagement in the DEU model in a different way than the participants in this study. It should be noted that all

participants held full-time faculty appointments with the associated college or university and therefore their experiences may differ from someone with a part-time appointment, who may have a very different workload. The possibility that only those who viewed their DEU experiences in a primarily positive light agreed to participate must be considered. The perceptions of those who chose not to respond to the recruitment flyer remain unknown. However, even though the participants generally expressed an overall optimistic perspective, their stories of their experiences also offered insights into the challenges and problematic areas that DEU faculty members may face.

Recommendations for Further Research

Although many commonalities were found within the themes and subthemes of the participants' experiences, some striking differences also emerged. In this qualitative inquiry, it was not appropriate or possible to identify relationships, correlations, or contributing factors; however, future research directions to more fully explore the DEU faculty lifeworlds were suggested.

The participants' stories raise some important questions about faculty presence on a DEU. A great amount of variability surfaced in the participants' perceptions of the importance of their physical presence on the DEU, in terms of how much they were present and their interactions and behaviors with SNCIs, students, and patients. These findings suggest that further explorations that include aspects of faculty presence as a variable are warranted. Does faculty presence on a DEU make a difference in student learning or perceived support by the SNCIs? Are quality and quantity of time equally important? What factors underlie a faculty member's decisions about presence and actions on a DEU? Are there differences in student learning outcomes between DEUs on

which faculty engage in some direct supervision of patient care and DEUs on which supervision is limited to the SNCI?

The identified themes of this study revealed variations in the participants' levels of trust and the conditions for awarding or receiving trust, which suggests that the phenomenon of trust warrants further investigation within the context of the DEU clinical model. Are there characteristics of the faculty, the SNCIs, the students, or the learning environment that influence the degree of reciprocal trust that is developed? What are the facilitators or barriers to the development of trust in a DEU?

The identified essence and themes are unique to these participants who all had a role in actively planning and cultivating the growth of their respective DEUs. How the overall essence and themes of the experience might be different for a faculty member who comes into a DEU previously established by another faculty member is a topic for additional inquiry.

Two of the participants shared what they believed to be advantages of having taught on the nursing unit using the traditional model prior to its conversion to a DEU. A research question for further study would be to explore the advantages and disadvantages of such experience to discover if a DEU should be used as a traditional unit prior to conversion or whether it should it be the start of a fresh partnership. All of the participants had at least one semester of experience with the traditional clinical model, although most had used the model on a different unit. Further research is warranted to describe and interpret the experience of a DEU faculty member who has never experienced teaching in the traditional faculty-supervised model.

The level of nursing student engaged in learning on the participants' DEUs ranged from first-semester juniors to second-semester seniors. It is unknown how faculty members' perceptions, level of trust, decisions about presence, or other lifeworld experiences may have been affected by differences in student characteristics. Three of the participants described an application or vetting process that students must complete in order to be chosen to learn on a DEU. Do those processes that may lead to a higher proportion of students on a DEU who excel academically make a difference in the faculty experience or in the reciprocal trust level?

One of the participants used a Klieg light analogy when discussing student evaluation and oversight on a DEU. This raises a question about consistency in student evaluation among the various clinical models. Does having the SNCI as an ancillary evaluator make a difference in how students are evaluated when compared to the traditional model?

Several participants mentioned faculty peers' skepticism or curiosity about the DEU model. Are there faculty member characteristics or teaching and learning preferences that are more favorable for success as a DEU faculty member?

Chapter Summary

This chapter presented a discussion and interpretation of the phenomenological inquiry into the faculty experience on a DEU. Several of the findings about integral components of partnerships, development of trust, embracing change, and perceived challenges and benefits of the DEU model were similar to findings of studies about other types of partnerships or faculty lifeworld transitions. This study provided a deeper understanding of the faculty experience on a DEU. Implications for the science of nursing education and recommendations for further study are suggested.

Conclusion

Eight participants volunteered to participate in this study of the meaning of the lived experience of faculty on a Dedicated Education Unit. The findings resulted in three themes with a total of nine subthemes that provide an exhaustive description and interpretation of the essence of the phenomenon. The findings and the model of the fundamental structures of the overall essence of "The DEU as a New Synergy of Learning: Becoming a Guardian" were validated through member checking with the participants. Gaining insight into the meanings of the experiences of faculty on a DEU has several implications for the science of nursing education. Participants found value in preparing themselves for engagement in the DEU model and emphasized the importance of collaborating with managers and staff at the unit level to develop an infrastructure to facilitate success within the unique culture of the chosen patient care unit or units.

Gaining the trust of the SNCIs and being willing to entrust students' learning to the SNCIs were critical elements for a successful adaptation to teaching within the DEU model. Faculty may anticipate that there will be changes in their perceptions of lived body, lived time, lived relationships, and lived space in the DEU clinical model. Faculty members who are new to the DEU clinical model may face decisions about their own physical presence and the nature of their interactions with SNCIs and students. Learning to reframe the DEU faculty lifeworlds in a positive light with a focus on new contributions to nursing may facilitate a positive teaching adaptation experience for the faculty. Faculty play a pivotal role in evaluating and sustaining a DEU through supporting SNCIs, students, DEU processes, and nursing practice. As the guardians of the new synergy of learning that is the DEU clinical model, faculty nurture the SNCIs as

teachers, facilitate authentic student clinical learning, and elevate evidence-based nursing practice through openness, reciprocal trust, and a mutual sharing of knowledge and expertise.

APPENDIX A

LITERATURE REVIEW OF THE FACULTY ROLE IN DEDICATED EDUCATION UNITS, PRECEPTORSHIPS, AND TRADITIONAL FACULTY-SUPERVISED CLINICAL MODELS

Reference	Description of Study	Results/Conclusions
Dedicated Education Unit Model		
Burke & Craig (2011)	Expository	Describes how current challenges with traditional clinical models led to development of the DEU model and roles. Asserts that assumptions about student to faculty ratios, role definitions, and equal access to clinical placement should be challenged and encourages collaboration with Boards of Nursing to discuss changes in regulation to support innovative new models.
Burke, Moscato, & Warner (2009)	Expository	Describes the relationship building and resource innovations needed to navigate the politics of partnerships. Uses the DEU as an exemplar of how effective communication, shared goals, and trust facilitate change.
Castner, Ceravolo, Tomasov, & Mariano (2012)	Quasi-experimental study comparing third quarter patient satisfaction scores on two DEUs with those on two matched comparison units over a three-year time frame.	No significant differences noted between patient satisfaction scores on DEUs and comparison units. A small temporary drop in scores was noted on the DEU immediately after implementation.
Edgecombe, Wotton, Gonda, & Mason (1999)	Expository	Describes the rationale for and development of a DEU in Australia

Glazer, Erickson, Mylott, Mulready-Shick, & Banister (2011)	Expository	Describes the core requirements for developing a DEU prior to implementation. Key elements are forging partnerships, developing a collaborative plan, setting criteria, and selecting a unit.
Gonda, Wotton, Edgecombe, & Mason (1999)	Descriptive study using semi-structured questionnaires with 49 students and 21 nurses from a DEU.	Themes that emerged were the DEU as a preferred placement, opportunities for learning, workload issues, and positive relationships.
Moscato, Miller, Logsdon, Weinberg, & Chorpenning (2007)	Descriptive study of student, staff nurse clinical instructor, and faculty perceptions in a DEU. Quasi-experimental study of differences in student expectations between traditional and DEU clinical models. Used student expectation surveys, focus groups, faculty time surveys, and meetings to collect data. Sample sizes not reported.	Predominant faculty theme was difficulty maintaining communication. Faculty time surveys revealed most time was spent coaching students and minimal time was spent mentoring or interacting with the staff nurse clinical instructors. Found significant differences ($p < .05$) in student expectations between traditional and DEU students.
Mullenbach & Burggraf (2012)	Descriptive mixed method study of student perceptions before and after a clinical experience on one of five long-term care DEUs (DLUs). Quasi-experimental quantitative component compared student scores on 3 questions about feeling prepared before and after the DLU experience. The qualitative component identified themes in student journals. 61 students were in the fall group; the spring group N was not reported.	Found significantly ($p < .05$) higher scores for student perceptions of being prepared for all 3 questions after DLU experience. Themes gleaned from the journals included skill attainment, perceptions of long-term care, knowledge attainment, communication skills, and career opportunity. All reported comments were positive.
Murray, Crain, Meyer, McDonough, & Schweiss (2010)	Expository Descriptive	Uses a logic model to describe activities, outputs, outcomes, and impact of a new DEU. Anecdotal reports of positive student and faculty feedback.

Murray & James (2011)	Expository	Describes how the single alliance key success model can be used to evaluate a DEU partnership. Explains alliance formation, design, and management components of the model.
Murray, MacIntyre, & Teel (2011)	Expository	Applies an evaluation model to broadly describe how themes of previous successful partnership research are evident in the strategic effectiveness of a DEU.
Parker & Smith (2012)	Descriptive pilot study using the Revised Professional Practice Environment (RPPE) as a measure of readiness for implementation of a DEU. 72 nurses from 9 units within 2 hospitals completed the survey. Cronbach alphas for the subscales 0.76 to 0.95.	Suggests that RPPE may be a reliable instrument as part of an assessment of DEU readiness. Proposed conceptual model for the DEU assessment and planning process.
Ranse & Grealish (2007)	Qualitative study using focus group of 25 nursing students on a DEU using a community-of-practice framework.	Positive student responses with themes of acceptance, learning and reciprocity, and accountability.
Ryan, Shabo, & Tatum (2011)	Includes both descriptive study of staff satisfaction and quasi-experimental study of differences in student satisfaction and achievement of outcomes between 24 students on a new pediatric DEU and 22 students in a traditional clinical. Used focus groups, field notes from conferences, electronic self-evaluations, and clinical course evaluation tool.	DEU students reported providing more hands-on care and higher satisfaction than students in faculty-supervised clinical. DEU staff gave positive feedback.
Mulready-Shick, Kafel, Banister, & Mylott (2009)	Descriptive study of student achievement of QSEN competencies on a DEU. Used focus groups with 16 students and 9 staff nurses.	Both students and staff nurses reported positive perceptions of student achievement of outcomes.

Rhodes, Meyers, & Underhill (2012)	Longitudinal mixed-method descriptive study of perceptions and satisfaction with the clinical learning environment in a DEU pilot with a sample of 85 students and 31 staff nurses. Included focus groups of four DEU faculty members.	Subscale scores 3.4 or higher for student and staff nurse satisfaction with learning environment in a DEU. Faculty reported that the teaching on a DEU is different from the traditional model and they emphasized the benefits for students.
Warner & Moscato (2009)	Expository	Defines a DEU and describes the roles of all stakeholders. Includes tenets, resources, challenges, and successes of the DEU model at one private school of nursing.
Preceptorship Model		
Beeman (2001)	Expository reflection of one faculty member's experience of transitioning from a traditional faculty-led model to a junior-level preceptorship model.	Faculty described as recruiting preceptors, conducting preceptor workshops, conducting student conferences, being available, and managing the experience. Faculty feelings included worry, uncertainty, and relinquishing power. Faculty able to focus on facilitating understanding rather than supervising skills.
Hsieh & Knowles (1990)	Descriptive study of faculty facilitation of a preceptorship in an associate degree nursing program. Sample included preceptors, students, and faculty using naturalistic observations and faculty debriefing. A three-item open-ended questionnaire was given to students and preceptors.	Seven themes that emerged were trust, clearly defined expectations, support systems, honest communication, mutual respect and acceptance, encouragement, and mutual sharing of self and experience. Faculty members considered role modeling and guidance to be facilitative.

Luhanga, Yonge, & Myrick (2008)	Qualitative study using grounded theory. 22 preceptors were interviewed about their perceptions of their needs from faculty when precepting an unsafe nursing student in an acute care setting in which faculty had a limited presence.	Preceptors felt that faculty members should make themselves available, continuously monitor the situation, and become actively supportive when students have difficulties in safety, skills, motivation, or interpersonal communication.
Nehls, Rather, & Guyette (1990)	Heideggerian phenomenological study of 10 students, 11 preceptors, and 10 faculty members in a senior-level preceptorship.	The constitutive pattern was learning nursing thinking. The faculty experience was described as "teaching as nursing."
Udlis (2008)	Integrative review of 16 empirical studies about preceptorships with undergraduate nursing students. Measures identified in the studies included student outcomes, performance, socialization, role concepts, learning styles, and competence.	56% studies supported the efficacy of preceptorships; 44% found no significant difference between precepted and traditional model of clinical
Yonge, Ferguson, Myrick, & Haase (2003)	Descriptive. Telephone interviews with 8 faculty members from a senior-level preceptor-based clinical course. Content analysis of biographical profiles, role preparation, and activities that prepared or hindered preparation for the role was conducted, and the tasks inherent in the faculty role in the preceptorship were described.	Faculty rated their preparation as inconsistent. Reading research, attending meetings, leading workshops, interacting with peers, previous experience, and familiarity with the unit enhanced perceived preparedness. Inadequate information and a lack of an orientation or evaluative support decreased perceived preparedness. The 3 most commonly identified faculty tasks were supporting students and preceptors, communicating curriculum trends, and ensuring knowledge application.

<u>Traditional Faculty-Supervised Clinical Model</u>		
Ard, Rogers, & Vinten (2008)	Descriptive study of the what, why, where, when, and who of clinical nursing education in a sample of 2,218 faculty members and 40 state boards of nursing members. The 51-item instrument had 5 subscales using a 5-point Likert-type format and open-ended questions.	93% of NLN faculty agreed that active involvement of the teacher is required. There was 95 to 99% agreement that teachers develop outcomes and arrange experiences, work with agency staff to provide a positive environment, help students clarify what they have learned, and facilitate, guide, and evaluate student performance. Agreement about faculty presence on the unit was much weaker (58%).
Dickson, Walker, & Bourgeois (2006)	Hermeneutic phenomenological study of the lived experience of learning facilitation in a clinical nursing practicum. The sample included five part-time (sessional) Australian clinical faculty.	The five themes revealed were knowing your limitations, stepping in or stepping back, developing alliances, acknowledging reciprocity, and identifying staff nurses to be "buddies" with students for the day.
Ferguson (1996)	Phenomenological study of the lived experience of four part-time (sessional) Australian clinical faculty members. Subjects were recruited and interviews conducted via telephone.	Themes were being human, having standards, developing one's own teaching style, learning as you go, and not belonging. A conceptual model of a spinning top was used to integrate the themes.
Gazza (2009)	Phenomenological study of lived faculty experience using hermeneutic interviews with eight full-time faculty members. Global view of the total faculty experience rather than clinical focus.	Themes were making a difference in the student, the profession, and the world; being a gate keeper to the profession, balancing multiple roles, using support is vital, can't do it alone, and developing workplace relationships – the good, the bad, and the ugly.
Gazza & Shellenbarger (2010)	Phenomenological study of using hermeneutic interviews with nine part-time clinical faculty members.	Themes were achieving the dream, a group divided, for the love of the students, and jump in and figure it out.

Halstead (1996)	Integrative review of 31 research-based studies exploring faculty-student relationships.	Review framed in the areas of student socialization, power balance, and student-faculty interactions. Faculty role modeling influenced student socialization. Faculty who demand power and control may negatively impact the clinical learning environment.
Ironside & McNelis (2010)	Descriptive study of barriers, clinical teaching activities, challenges, and strategies used to address challenges in a sample of 2,386 nursing faculty using an online survey format with multiple choice items, ranking items, and open-ended questions.	The most commonly identified barriers were lack of sites and faculty, clinical group size, experience restrictions, and learning multiple systems. The top time-consuming instructional activities were supervising skill performance, facilitating student thinking, questioning students, and providing student feedback. The most common challenges were giving appropriate guidance, teaching students to think and use clinical judgment, providing meaningful feedback, supervising skills.
Langan (2003)	Exploratory descriptive study of faculty practice on role perceptions of 22 staff nurses in four hospitals and 15 clinical nurse faculty members in four schools of nursing. Two of the schools required faculty practice and two did not. Participants completed a demographic questionnaire and both staff nurse and faculty job descriptions were reviewed. Tape-recorded focus groups were conducted using the role episode model, which channeled the questions toward role expectations, role overload, role conflict,	Staff nurses reported less role overload and role conflict when working with faculty who maintained a clinical practice. Staff nurse role ambiguity was high regardless of faculty practice. Faculty reported high role overload and role conflict and low role ambiguity for all four groups.

	and role ambiguity. Eight administrators were also interviewed.	
Oermann (1996)	Integrative review of 94 studies of teaching in the clinical setting. Studies of teacher behaviors, clinical teaching methods, student perceptions, and general clinical education were included.	Desirable teacher behaviors were sharing knowledge and competence and being skilled in planning instruction to meet learning needs. Methods included making patient assignments, using written assignments, conducting clinical conferences, and using preceptorships.
Faculty Transitions		
Anderson (2009)	Descriptive study using naturalistic inquiry of 18 faculty members in their first or second year of teaching. The subjects had no formal academic preparation as educators.	Themes that emerged were sitting on the shore, splashing in the shallows, drowning, treading water, beginning strokes, and throughout the waters. The progression of the transition varied among the participants and was filled with eddies and currents that allowed participants to swirl and move backwards or ahead.
Campbell & Dudley (2005)	Expository description of the implementation of clinical partner model that includes a teaching team comprised of a faculty member, a BSN prepared adjunct faculty member, and staff nurses.	Describes the benefits and challenges encountered during implementation of a new collaborative clinical education model.
Danna, Schaubhut, & Jones (2010)	Expository. Three hospital nursing administrators described their experiences of transition into a faculty role.	Authors recommended orientation and ongoing faculty development that include strategies for successful lecturing and clinical instruction.
Diekelmann, Schuster, & Nosek (1998)	Interpretive phenomenological study of experiences of 31 faculty and academic staff who teach distance-education courses.	Themes that emerged were losing familiar landmarks and touchstones, challenging conventional pedagogies, learning from experience, and creating new pedagogies.

Infante (1996)	Expository	The transition from practitioner to teacher of nursing may entail role conflicts. Recommended role models and mentors.
Haleem, Manetti, Evanina, & Gallagher (2011)	Descriptive study of 23 senior nursing students' evaluation of a newly implemented end-of-program precepted internship experience. Used an 8-item questionnaire with a 5 point Likert-type response scale.	Students rated the precepted internship program positively on all 8 items with means ranging from 4.39 to 4.61. Initial lack of faculty enthusiasm was anecdotally reported.
Hegge et al. (2010)	Expository description of a clinical academic partnership (CAP) clinical-education model that includes three levels of collaboration: CAP staff nurse, faculty mentor, and faculty consultant.	Anecdotal reports that faculty mentors reported having deeper conversations with student nurse learners and had more time for scholarly activities.
Janzen (2010)	Expository	Transitional actualization model for novice nurse educator. Uses Carroll's *Alice's Adventures in Wonderland* analogies.
Johnson (2008)	Qualitative study of 12 graduate nursing faculty members who were new to online teaching.	Participants reported the need to rethink or shift teaching and learning philosophies to adapt to distance education. Found that faculty learning style preferences may influence this paradigm shift and the transition feelings.
McDonald (2010)	Integrative review of 21 studies of staff nurse transition to the faculty role.	Studies were categorized into knowledge deficits, culture and support, and salary and workload. Recommended strategies for orientation, mentoring, and retention

Paulson (2011)	Qualitative study of seven full-time faculty members who had transitioned into teaching in a new curriculum that clustered clinical experiences into the senior year with simulation and immersion experiences and used a new grading system.	Themes included perception of innovative teaching, utility of structure, opportunity, valuing, and embracement of change. There were two subthemes within each theme. History and morphing of the mindset were the subthemes of embracing change.
Paulus et al. (2010)	Qualitative study using case study method using a sample 25 faculty who attended all or part of a technology enhanced faculty development series about online teaching. Data collected from attendance records, five post-workshop surveys, needs assessments, archived virtual text chats, discussion forum/blog transcripts, and focus groups.	Six themes emerged from the analysis: plugging in; peer sharing, modeling, and community building; multidimensional learning, role-shifting and meta-learning, paradigm shifting, and sustaining momentum.
Ryan, Hodson-Carlton, & Ali (2004)	Qualitative study using dimensional analysis to create a story matrix. Used teleconferenced focus groups of 19 nursing faculty members who taught online.	Faculty reported having to adjust to new context and moving from an expert in the classroom to a novice in the online environment.
Ryan, Hodson-Carlton, & Ali (2005)	Follow-up study using a 56-item questionnaire with 68 faculty member participants from 28 schools of nursing. Participants had moved to online teaching platform.	Questionnaire items that measured agreement about faculty adjustment to online teaching revealed that the majority of respondents agreed their faculty role had changed (60-85%) and that relationships with students had changed (52-65%).

Schoening (2009)	Qualitative grounded-theory dissertation study of 20 nurses' experiences with transition from the bedside to classroom.	The role transition was described as a journey with no roadmap. Themes included an unfamiliar environment, fear of failure, professional identity issues, boundary issues, and time constraints. The 4-phase Nurse Educator Transition Theory (NETT) model was created: anticipatory expectation phase, disorientation phase, information-seeking phase, and identity formation phase.
Schriner (2007)	Qualitative ethnographic study of cultural similarities and differences among clinical nursing, academia, and the professoriate. Document examination, observation, and interviews were conducted with seven faculty members who had transitioned from clinical nursing to academia within the previous three years.	Six themes included stressors and facilitators of transition, deficient role preparation, changing student culture, realities of clinical teaching and practice, hierarchy and reward, and cultural expectations vs. cultural reality. Recommended the use of mentors, opportunities to learn the skills of pedagogy, and a system of rewards that recognizes clinical expertise.
Siler & Kleiner (2001)	Heideggarian phenomenological study of the meaning of experiences of 6 novice and 6 experienced faculty who were in first year of employment at a SON.	Themes were expectations, learning the game, being mentored, and fitting in. Novice faculty felt poorly prepared. Recommended ongoing dialogue between new and experienced faculty.
Zambrowski & Freeman (2004)	Expository.	Described how the different missions of ASN and BSN programs require transitioning faculty to develop new skills and adapt existing skills to the new setting. A mentorship program was recommended.

APPENDIX B

Biomedical IRB – Exempt Review

Deemed Exempt

DATE: February 2, 2012

TO: **Dr. Patricia Smyer,** Nursing

FROM: Office of Research Integrity – Human Subjects

RE: Notification of IRB Action
Protocol Title: **The Meaning of the Lived Experience of Nursing Faculty on a Dedicated Education Unit**
Protocol # 1201-3998

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:

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

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 895-2794.

Office of Research Integrity – Human Subjects
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047
(702) 895-2794 • FAX: (702) 895-0805

APPENDIX C

Recruitment Flyer

Research Study
The Lived Experience of Nursing Faculty on a Dedicated Education Unit

My name is Deborah DeMeester and I am currently a student in the PhD in Nursing program at the University of Nevada, Las Vegas (UNLV) School of Nursing. I am also a Clinical Assistant Professor at the Indiana University School of Nursing in Indianapolis, IN.

For my doctoral research, I am exploring the meanings of the lived experience of nursing faculty members on a Dedicated Education Unit (DEU). I will be conducting audio-taped semi-structured interviews with interested faculty who teach in baccalaureate programs with established DEUs. You are invited to participate in the study if you:

- Have held a full-time faculty appointment at any rank for at least one year
- Are a licensed registered nurse
- Have been primary faculty of record for at least one completed BSN nursing clinical course on a DEU within the past 12 months

It is estimated that the initial private interview will be approximately one hour in duration. The interview will take place at a location that is convenient for you. A few weeks later, you will be contacted via telephone for a follow-up conversation that may last about 30 minutes in order to confirm the transcription accuracy, descriptions, and interpretations. At that time, you can add or delete information if you so choose.

It is hoped that the themes that emerge from the study may lead to a greater understanding of the meaning of being a faculty member on a DEU. Your participation is strictly voluntary and you can decide to withdraw from the study at any time. You can refuse to answer any question and complete confidentiality will be maintained during and after the study. Your name or other personal identifiers will not be used in reported study findings.

If you are interested in contributing to the growing body of knowledge about DEUs, please feel free to contact me for additional information. I will be happy to answer any questions. Contact information is provided below:

Deborah DeMeester: ddemeest@iupui.edu or demeeste@unlv.nevada.edu
Phone: 317.274.4685
or
Dr. Tish Smyer, Faculty Chair: tish.symer@unlv.edu or (702) 895-5952

APPENDIX D

APPROVED INFORMED CONSENT

INFORMED CONSENT

TITLE OF STUDY: The Meaning of the Lived Experience of Nursing Faculty on a Dedicated Education Unit

INVESTIGATORS: Dr. Patricia Symer, DNSc, RN and Deborah DeMeester, MSN, RN

CONTACT PHONE NUMBERS: Dr. Smyer: (702) 895-5952, Mrs. DeMeester: (317) 274-4685

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to describe, interpret, and offer insight into the meanings of the lived experiences of nursing faculty who teach on an established Dedicated Education Unit (DEU).

Participants

You are being asked to participate in the study because at the time of recruitment you met the following inclusion criteria: (1) you have held a full-time appointment at any rank in an accredited baccalaureate nursing program for at least one full academic year at a private or public college or university; (2) you are a licensed registered nurse; and (3**) you have been the faculty of record for a nursing clinical course on an established Dedicated Education Unit within the last 12months.**

Procedures

If you volunteer to participate in the study you will be asked to do the following: Participants will agree to complete a short questionnaire and agree to a private face-to-face audiotaped interview. The recording will be transcribed by the researcher and sent to you via your preferred method of correspondence. In addition, participants will agree to a follow-up telephone interview that will be used to clarify any errors in the verbatim transcription and misinterpretations of the researchers regarding themes that will allow participants the opportunity to add any additional thoughts about their lived experiences as a DEU faculty member. Participation is completely voluntary and confidential. Each interview will last approximately one
hour and will be held at a private location that is convenient for you.

Benefits of Participation

There may be no direct benefits to you. Participants will have the opportunity to reflect upon the meanings of their experiences as a faculty member on a DEU. The data collected will contribute to the body of knowledge of nursing education and will enhance understanding of how faculty experience their role for all DEU stakeholders, future DEU faculty, and the administrators who support them.

Risks of Participation

There are risks involved in all research studies, although this study involves only minimal risks. There may be some discomfort discussing your experiences as a faculty member on a DEU and the feelings associated with those experiences. You will be assured that you can withdraw from the study at any time. There are no risks if you decline participation in the study.

____Initials

Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1201-3998
Exempt Date: 02-02-2012

Cost or Consequences

There will be no financial cost to you. Participation in the study will take approximately 2 hours of your time.

Contact Information

If you have any questions or concerns about the study, you may contact Dr. Patricia Smyer at (702) 895-5952 or tish.smyer@unlv.edu

For questions regarding the rights of research subjects or any complaints or comments regarding the manner in which the study is being conducted you may contact the **UNLV** Office of Research Integrity – Human Subjects Research at 702-895-2794 or by email at irb@unlv.edu.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or any part of the study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality

All information gathered in this study will be kept completely confidential. No references 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 will be destroyed.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 19 years of age.
A copy of this form has been given to me

____________________________ ___________
Signature of Participant Date

____
Participant Name (Please Print)

Consent for Audiotaping

This study involves audiotaping. I agree to be audiotaped for the purpose of this research study

____________________________ ___________
Signature of Participant Date

____
Participant Name (Please Print) **____Initials**

Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1201-3998
Exempt Date: 02-02-2012

APPENDIX E

Demographic Questionnaire

Please answer the following questions. You are free to omit the answer to any questions that you choose not to answer.

1. What is your age?

    □ 20 to 29

    □ 30 to 39

    □ 40 to 49

    □ 50 to 59

    □ 60 to 69

    □ More than 69

2. What is your gender? □ female □ male

3. What is your highest earned degree? □ BSN □ MSN □ PhD □ EdD □ DNP

    □ Other (Please Specify) ______________________

4. How many years have you been a nurse? _________

5. What is your academic rank?____

6. How many years have you been in your current faculty position?_______________

7. Have you had previous academic appointments elsewhere? □ yes □ no

8. How many total years have you been in academia? ________________

9. How many didactic courses do you currently teach per academic year?

    □ none □ 1 □ 2 □ 3 □ 4 □ 5 or more

10. How many web-based courses do you currently teach per academic year?

    □ none □ 1 □ 2 □ 3 □ 4 □ 5 or more

11. How many clinical sections do you currently teach per academic year?

 none 1 2 3 4 5 or more

12. Do you teach the co-requisite didactic course that is associated with the clinical course in which your DEU students are enrolled? yes no

13. Have you taught clinical using the traditional faculty supervised model?

 yes no

14. If you answered yes to question 13, for how many years? ___________________

15. If you answered yes to question 13, when did you last teach using the traditional faculty supervised model? Month ___________ Year__________

16. When did you first begin to teach on a DEU? Month _________ Year _______

17. Was the DEU already established at that time or were you involved in its development? previously established I was involved in the development

18. How many semesters have you taught on a DEU? __________________

19. When was your most recent experience teaching on a DEU?

Month _____ Year______

20. How would you characterize the patient population on your DEU(s)?

 Adult Medical Adult Surgical Pediatrics_______

 Other Specialty Area (Please specify)__________________________

21. How many and what level of students are on your DEU(s)?

Number of students per DEU unit__________

Level of students (choose all that apply): 1st semester sophomores

 2nd semester sophomores 1st semester juniors 2nd semester juniors

 1st semester seniors 2nd semester seniors

APPENDIX F

Interview Questions

Initial Hermeneutic Interview Question:

What does it mean to be nursing faculty on a Dedicated Education Unit?

Probes to further the dialogue (if needed)

1. Can you share an example of that?
2. Will you tell me a story that will help me understand what that means?
3. Can you elaborate more on that?
4. Do you recall how you felt at that time?
5. What did that mean to you?
6. Will you share what you are thinking now? (After period of silence)

Probes to elicit additional information (if needed)

1. What is it about being a DEU faculty member that is different from other faculty experiences?
2. How did you experience the process of becoming a DEU faculty member?
3. What is the meaning of your relationships with others (students, staff nurse instructors, patients, administrators, unit personnel, members of other disciplines) in the DEU model?
4. What is the meaning of faculty presence in a DEU?
5. Can you share a story as a DEU faculty member that you find personally very meaningful?
6. Can you recall any situations as a DEU faculty member that you felt were especially (rewarding, enlightening, frustrating, disappointing, unexpected)?

APPENDIX G

Participant Profiles

Participant Pseudonym	Age Category	Gender	Highest Earned Degree	Years as a Nurse	Years in Academia	Semesters as Faculty of Record on a DEU	Years Teaching with Traditional Model	Teaches Co-Requisite Didactic Course	Level of Student on the DEU
Abby	30-39	F	MSN	10	2.5	3	1	No	Junior 2 Senior 1
Betsy	50-59	F	DNS/PhD	35	2	4	0.5	No	Junior 1 & 2 Senior 1 & 2
Carla	50-59	F	MSN	35	30	5	27	Yes	Senior 1 & 2
Dora	60-69	F	Other Doctorate	45	5	6	1	No	Senior 1
Elaine	40-49	F	DNS/PhD	16	10	6	3-4	No	Junior 1 & 2 Senior 1 & 2
Fiona	50-59	F	DNS/PhD	26	18	3	8	Yes	Senior 1
Greta	40-49	F	MSN	17	7	1	7	Yes	Junior 1 & 2
Helen	50-59	F	MSN	31	5	2	5	No	Senior 2

APPENDIX H

Demographic Questionnaire Results N = 8

Question	Responses	Choices
1. What is your gender?	8 0	Female Male
2. What is your age?	0 1 2 4 1 0	20 to 29 30 to 39 40 to 49 50 to 59 60 to 69 Over 69
3. What is your highest earned degree?	0 4 0 0 3 1	BSN MSN DNP EdD DNS/PhD Other Doctorate
4. How many years have you been a nurse?	Responses: 45, 35, 35, 31, 26, 17, 16, and 10. Average: 26.9 years of nursing experience	
5. What is your academic rank?	2 4 1 1	Assistant Professor Clinical Assistant Professor Clinical Instructor Lecturer
6. How many years have you been in your current faculty position?	Responses: 18.5, 6, 6, 5, 4, 2.5, 2, and 2. Average: 5.8 years in current position	
7. Have you had previous academic appointments elsewhere?	4 3 1	Yes No No answer
8. How many total years have you been in academia?	Responses: 30, 18, 10, 7, 5, 5, 2.5, and 2. Average: 9.9 total years in academia	
9. How many didactic courses do you currently teach per academic year?	1 2 2 1 1 1	None 1 2 3 3 to 4 5 or more

Question	Responses	Choices
10. How many web-based courses do you currently teach per academic year?	3	None
	1	1
	1	2
	1	3
	2	3 to 4
	0	5 or more
11. How many clinical sections do you currently teach per academic year?	0	None
	1	1
	1	1 to 2
	1	3
	4	4
	1	5 or more
12. Do you teach the co-requisite didactic course that is associated with the clinical course in which your DEU students are enrolled?	3	Yes
	5	No
13. Have you taught clinical using the traditional faculty supervised model?	8	Yes
	0	No
14. If you answered yes to question 13, for how many years?	Responses: 27, 8, 7, 5, 3.5, 1, 1, and 0.5. Average: 6.6 years teaching in traditional model.	
15. If you answered yes to question 13, when did you last teach using the traditional faculty supervised model?	1	2004
	1	2008
	3	2009
	1	2010
	1	2011
	1	2012
16. When did you first begin to teach on a DEU?	1	Spring 2009
	1	Fall 2009
	1	Spring 2010
	1	Fall 2010
	3	Spring 2011
	1	Spring 2012
17. Was the DEU already established at that time or were you involved in its development?	0	Previously established
	8	I was involved in the development

Question	Responses	Choices
18. How many semesters have you taught on a DEU?	1 1 2 1 1 2	1 semester 2 semesters 3 semesters 4 semesters 5 semesters 6 semesters
19. When was your most recent experience teaching on a DEU?	1 7	Fall 2011 Spring 2012
20. How would you characterize the patient population on your DEU(s)?	3 3 2	Adult Medical Adult Medical/Surgical Pediatrics
21. How many and what level of students are on your DEU(s)?	 0 0 3 4 6 4	Number of Students per DEU: 4-5, 6-8, 8, 8, 8-9, 10, 12, and 12-24 Level of Student 1st semester sophomores 2nd semester sophomores 1st semester juniors 2nd semester juniors 1st semester seniors 2nd semester seniors

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