READEINESS FOR STUDENT PRACTICE EDUCATION QUESTIONNAIRE:

CONTENT VALIDATION

by

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Abstract

Student Practice Education is an important topic to clinical education. There has been little to no research assessing whether or not clinical units are prepared to host student practice education, nor has there been much research focused on how to evaluate readiness to host student practice education.

The purpose of this study was to assess the content and face validity of an original questionnaire which will measure readiness to host student practice. The questionnaire includes concepts related to student practice education, such as communication processes, job descriptions, leadership structures, organizational goals, data collection and analysis and support.

Data were collected via five focus groups, in which the items of the questionnaire were discussed with individuals in various leadership roles relating to student practice education. The questions were rated by the participants on a relevancy scale, which were later analyzed by calculating median scores. A thematic analysis was done of the focus group transcripts to identify themes related to student practice education infrastructure and processes.

Median scores were calculated for the relevancy ratings and revealed that the questions of the survey were considered very relevant or essential to assess readiness to host student practice education. Content analysis also revealed four themes specific to student practice education: infrastructure for communication, lack of familiarity with leadership structure amongst health care professionals, job descriptions and lack of familiarity with organizational goals amongst health care professionals.
Student practice education and health care are interconnected. The health care organization and clinical units provide experiential educational opportunities for students, in which effective leadership, communication and educational structures would be beneficial. More research on communication, leadership, and organizational infrastructure, in relation to student practice education could be beneficial in critically examining the health care system and readiness for student practice education.
Preface

This thesis is part of the Placements for learners: assessing capacity and effectiveness of clinical sites (PLACES) study, funded by British Columbia Nursing Research Initiative. The principal investigators are Leanne Currie, Grace Mickelson and Angela Wolff. The purpose of the PLACES Study is to examine the relationship between organizational infrastructure and the quality of the clinical learning environment. The final version of the Readiness for Student Practice Education Questionnaire will be published elsewhere.

I lead or co-lead five focus groups in the British Columbian Lower Mainland, for this study. I verified the focus group transcripts and conducted the data analysis with Dr. Currie. The focus groups were approved by the UBC Ethics Certificate Number H11-03356. This thesis also includes a Framework for Enhancing Clinical Learning for Nurses and Midwives (Henderson, Briggs, Schoonbeek, & Paterson, 2011), with the expressed permission of the principal author.
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Chapter 1: Introduction

Clinical education is a cornerstone to health care professions, as it lays the foundation for future practice, allowing students to develop the fundamentals for safe, competent care (Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Professional members of the health care team require sufficient practical time within the clinical setting during formative education to become safe, competent practitioners (Darcy Associates, 2009). Students partake in patient care, gaining experience and building on existing knowledge, leading to a consolidation of skills and critical thinking (McMullen & McMullen, 2009). In recent years, patient acuity and patient turnover have been steadily increasing (Harrison, 2004). Additionally, the health care provider population is aging with nurses nearing retirement, creating a demand for nurses which has resulted in increased seats in nursing programs; however, the increase in available academic seats has also resulted in an increased demand for clinical experiences (Darcy Associates, 2009).

Student practice education has two components: The academic setting, which provides the theory aspect, and the clinical setting, which provides the practical aspect of teaching and learning; moving from the academic setting in to the clinical setting provides students with opportunities to apply learned theory in to practice (British Columbia Academic Health Council, 2012) (BCAHC). The increase in demand for clinical educational sites has led to difficulties in securing appropriate and adequate clinical placements (Spencer, 2003). Historically, the process of assessing the capacity of the units to host students and determining whether or not the clinical site is prepared to effectively host students for practice education has taken place in an ad hoc manner (Henderson, Eaton, & Burmeister, 2012; Henderson, Forrester, & Heel, 2006). Formal evaluation of readiness to host student practice education may ensure that students are placed in appropriate settings and may facilitate identification of adequate clinical placements.
1.1 Background

Student practice education is necessary for the formation of safe, accountable and knowledgeable practitioners (Darcy Associates, 2009). The BCAHC (2012) asserts that student practice education occurs when individuals are immersed in a clinical learning site. Learning, therefore, occurs by gaining knowledge, skills and attitudes by studying, observing, experiencing, or teaching. Specifically, learning involves three domains: cognitive (acquiring knowledge), affective (values, attitudes and beliefs), and psychomotor (development of skills) (Hand, 2006).

There have been many changes within the health care field, which may have created increased pressures in the workplace, such as increased workloads, complex patient needs, higher patient turnovers and higher levels of stress (Dolmans, Wolfhagen, Heineman, & Scherpbier, 2008; McAllister, 2005). Workplace pressures require nurses to provide assessment and treatment in shorter time frames, informally broaden their roles to include more client, family, community education and health promotion, while striving to provide safe, evidence-informed practice (McAllister, 2005). These pressures are often co-occurring with inadequate staffing levels and a lack of recruitment and retention of staff (McAllister, 2005). These factors may become a barrier to being ready to host student practice education.

Furthermore, there is sometimes resistance by staff to preceptor or mentor students, most likely resulting from factors such as burnout, low staffing levels, and inadequate preparation to preceptor students (Defence Logistics Agency: Phillips Fox, 2008) (DLA Phillips Fox). For nurses, this resistance to preceptor students contravenes the College of Registered Nurses’ core competency of ‘willingness to teach’ (College of Registered Nurses British Columbia, 2012) (CRNBC). Students tend to place high value on a nurses’ educational vigilance and level of
support during student practice education (Brammer, 2008). A nurses’ unwillingness to teach may adversely impact a students’ comfort level and perception of the quality of learning that will most likely take place in the clinical placement (Brammer, 2008). It is important to recognize that students require superior experiences when participating in student practice education, as they are the future of the nursing profession (BCAHC, 2012).

Furthermore, the aging nursing population has created an increased demand for nurses, which has lead to nursing academic programs to open more seats to fill jobs in health care that are vacant because of retirements (Darcy Associates, 2009). However, with an increase in nursing students, clinical placement coordinators are experiencing difficulties finding suitable and appropriate clinical placements for students (Darcy Associates, 2009; Smith et al., 2007). Hall (2006) states that difficulties with securing clinical placements have worsened with an increase in nursing school enrollments. Despite the demand for clinical placements, securing adequate clinical placements is not guaranteed. It has been reported that currently in Canada almost 87% of placements accessed are based on clinical settings that accepted student practice education hours the previous year (Smith et al., 2007). This may suggest that other agencies may be refusing the educational hours or that clinical placements may be chosen either through convenience or pre-existing relationships (Smith et al., 2007). There could also be competition amongst the various educational facilities to confirm clinical placements, which may lead the coordinators to rely on historical use of placements (Smith et al., 2007). Additionally, many clinical sites are experiencing overuse, in which clinical placements are becoming saturated with continuous presence of students, suggesting that there may be some sites that are not being utilized appropriately (L. Thompson, 2005). Therefore, attention focused towards preparing clinical sites to host student practice education hours, which may be done by creating a checklist
of attributes that must be implemented prior to accepting student practice education placements, may be beneficial.

It is unclear if the quality of learning is synonymous with the quantity of time students spend in a clinical setting, however, several measures have been identified to produce an environment conducive to student learning. These measures include an adequate number of effectively educated preceptors, a respectful work environment, staff willingness to teach students, and a positive, non-hostile learning environment, rather than the quantity of time students spend in the clinical placement (DLA Phillips Fox, 2008). Other factors to consider when assessing readiness to host student practice education include knowledge of the number of students requiring clinical placements or an increase in the number of seats in nursing schools, budget cutbacks that impact educational resources at the clinical sites and the increasing acuity of patients (BCAH, 2012). Clinical learning environments may also benefit from strong leadership and effective organizational infrastructure that support student practice education.

In addition to having strong leadership, a clinical site would benefit by having clearly defined roles and responsibilities for frontline staff to facilitate the education (Livsey, 2009). Courses in mentorship etiquette may help staff become more comfortable with providing and receiving feedback, as well as teach proficiency in effective supervision of students and the patient care that is provided (Veeramah, 2012). Maintenance of a respectful and non-hierarchical workplace is also important to ensure a positive workplace atmosphere (Darcy Associates, 2009). A final example of readiness to host student practice education is that the staff are aware that a student or a cohort of students will be present on the site, and what the student’s skill levels are, allowing staff to prepare themselves in whatever way necessary (Smith et al., 2007).
1.1.1 Health Sciences Placement Network

British Columbia and other Canadian provinces, have successfully established a Web-enabled system, known as Health Science Placement network (HSPnet), which is used to track province-wide student practice education hour allocation: both accepted and declined. In terms of student practice education, accepted means that placements were approved for students to complete a specific number of education hours on a clinical unit, and declined means that educational hours for students were not approved, inferring that the academic program would have to find another clinical site to complete the student practice education hours. HSPnet is one of the first systems to track such numbers. Groups in Australia have also voiced interest in adapting similar systems, as they believe that comparable systems will allow different health authorities to identify trends regarding student practice education hours, as well as the efficiency in which a clinical setting is being used (DLA Phillips Fox, 2008). HSPnet may also help identify clinical opportunities amongst units and sites that operate below the target capacity (Smith et al., 2007).

1.2 Problem Statement and Purpose

Effective student practice education relies on clinical sites being able to provide quality learning experiences. These learning experiences are benefited by having an appropriate number of effectively educated and prepared preceptors, a respectful work environment, a willingness to teach, a safe physical environment, as well as available capacity to provide placements given other demands on staff resources. However, readiness for student practice education has not been formally evaluated in nursing. Therefore the current study aimed to assess the face and content validity of a questionnaire designed to measure a clinical educational sites’ readiness to host student practice education. The original questions of the questionnaire were informed by the
British Columbia Practice Education Initiative (Newberry, 2007). This topic is important because the number of students is rapidly growing, and therefore, so is the demand for educational hours (DLA Phillips Fox, 2008). It is important to understand if clinical sites hosting student practice education are ready to effectively support and supervise students.

1.3 Research Question

There are two research questions for this study:

1. What is the face validity of a questionnaire designed to measure a clinical site’s readiness to host student practice education?

2. What factors are related to student practice education?

1.4 British Columbia Practice Education Initiative

The British Columbia Practice Education Initiative (BCPEI) (Newberry, 2007) is a project that aimed to recognize and demonstrate the infrastructure and resources required to sufficiently support student practice education in clinical units. Newberry (2007) defined practice education as the practical learning that takes place in the clinical site, where educated preceptors guide and supervise students through application of theory in to real life practice. The BCPEI (Newberry, 2007) identified seven indicators of quality practice education: leadership, strategic planning, measurement, analysis and knowledge management, workforce focus, facilities and equipment support, process management and results. Newberry (2007) presented potential leadership focused questions to assess each of these quality indicators in the clinical setting. The questions that were presented in the BCPEI (Newberry, 2007) were reviewed for this study and modified to develop questions that would be applicable to frontline staff and nurse educators. Therefore, questions related to leadership structures, available resources, evaluation, infrastructure, knowledge acquisition and sharing, involvement with education and
organizational goals related to student practice education were included in the first of two versions of the questionnaire.

1.5 Framework for Enhancing Clinical Learning for Nurses and Midwives

The Framework for Enhancing Clinical Learning for Nurses and Midwives (FECLNM) (Henderson et al., 2011) was also used to guide this study. In the FECLNM, Henderson et al. (2011) suggest that the clinical setting can be considered a community; a community in which critical thinking, skill consolidation, professional socialization, experiential learning and professional development occurs (see Figure 1.1).

Figure 1.1 FECLNM

![FECLNM Conceptual Framework](image)

Within the clinical setting, there are many factors that play a role in the quality of student practice education. Henderson et al. (2011)’s framework conceptualizes how the different factors of a clinical community interrelate and how to measure the different factors to identify existing strengths and weaknesses, allowing health care systems to determine the degree of readiness to host student practice education.

The top row of the framework displays three components that must be present within a clinical setting: clinical leadership and learning culture, clinical teaching and learning support, and partnership (between health organizations and nursing academic programs). The second row of the framework presents three pre-existing, validated tools that can be used to ascertain whether or not the three main components of a clinical setting are well established. The purpose of the information gained from the tools is to assist the clinical setting to identify gaps for student practice education. By identifying the gaps in the organization’s or clinical unit’s leadership and management or partnerships, the clinical setting can then decide on ‘enabling strategies,’ as presented in the third row of the framework, to promote better education and learning at the clinical site for not only students, but for lifelong learning for staff as well.

The third row of the FECLNM presents enabling strategies. The enabling strategies focus on establishing communication infrastructure between clinical settings and schools to improve communication with and between staff and students, fostering continuous and lifelong learning, managing appropriate workloads, recognizing contributions made to learning from all team members, and building trust and respect amongst all colleagues. Between the second and third row of the conceptual framework there is a dotted box with ‘RSPE Questionnaire’ written in it. The box has arrows that pinpoint four specific areas of the framework: in the second row where the framework assesses unit culture for student practice education and the third row, which
expresses the enabling strategies. The dotted box was added in to highlight where the questionnaire currently being studied fits in. Overall, this framework for enhancing clinical learning for nurses and midwives is designed to improve clinical learning and student practice education, thereby improving the overall quality of patient care (Henderson et al., 2011). The current study focused on gaining feedback from participants in focus groups, regarding whether or not the questions are able to accurately capture the concepts presented within the FECLNM (Henderson et al., 2011), and extends the framework to capture the communication between the concepts in the context of readiness to host student practice education.

There is a large amount of research about nursing burnout, mentorship training, leadership, learning environments, student perspectives on learning, and other factors that can affect learning environments. However, no tool currently exists to measure whether or not communication processes and leadership structures are in place, there is support available for staff, educational resources are available and effective partnerships and relationships exist within and between organizations for student practice education. The questionnaire being examined in this study will serve as a measurement of preparedness to host student practice education on a clinical site. By identifying the strengths and weaknesses, as informed by the Henderson et al. (2011) framework, consideration can be given to which characteristics the clinical sites possess and which ones may be lacking. The face and content validation of the questionnaire will help to ensure the questions are relevant to readiness to host student practice education. Revisions made to the original questions for the second of two versions of the questionnaire were guided by the discussions from the focus groups, as well as the FECLNM and other previous literature.
1.6 Summary

Quality student practice education is important to the development of confident and competent health care professionals. There are a multitude of factors that can create positive or negative learning environments, each of which can influence professional socialization and development of a well-rounded nurse. With increasing nurse workloads and diminishing time left for student practice education, there is a need to improve clinical learning for students and staff in order to allow students to become safe, professional and competent practitioners. Henderson et al. (2011) provide a useful framework to examine learning in the clinical setting, assisting health care providers to gain insight into the quality of practice education that is taking place within the clinical setting, as well as providing potential strategies to rectify identified gaps.

This study examined questions designed to measure readiness for student practice education. The original questions were informed by the BCPEI (Newberry, 2007). The goal was to develop a validated questionnaire that would measure different attributes of a clinical site. The BCPEI (Newberry, 2007) suggested several structures, processes and resources that should be in place at the clinical and organizational levels to facilitate student practice education, which was congruent with the concepts and enabling strategies presented in the FECLNM (Henderson et al., 2011). This research attempts to extend the FECLNM by capturing processes that foster connection between the FECLNM constructs.
Chapter 2: Literature Review

2.1 Introduction

Nursing is a practice discipline and the provision of positive experiential learning for students during nursing education is essential (Atack, Comacu, Kenny, LaBelle, & Miller, 2000). Recently, a lack of clinical sites has been identified as a significant barrier to optimizing student learning during clinical experiences (McNelis, Fonacier, McDonald, & Ironside, 2011). Although there are many factors that influence the quality of student learning, the degree to which a site is prepared to host students for practice education may have a significant impact on socialization of a nursing student (Atack et al., 2000). The FECLNM (Henderson et al., 2011) provides a guide to some of the constructs and processes potentially necessary for quality student practice education. This literature review explored the following topics related to readiness of a clinical site for student practice education: projected staffing shortages and increased student enrollment, health care infrastructure, leadership in student practice education, partnerships and relationships, quality of clinical learning environment, preceptor education and nursing burnout in the context of student practice education. Very few articles were identified that addressed these issues in relation to student practice education, therefore articles that related to nursing in these areas were reviewed.

2.2 Literature Review: Methodology

Google Scholar, PubMed and CINAHL were searched using the following terms: ‘student practice education,’ ‘readiness for students,’ ‘quality clinical training,’ ‘clinical training,’ ‘nursing burnout,’ ‘nursing leadership,’ ‘nursing mentorship,’ ‘nursing shortages,’ ‘learning environment’ and ‘organizational infrastructure’ were inputted. In addition, references from the identified literature were searched.
2.3 Projected Staffing Shortages and Increased Student Enrolment

Staffing shortages in health care have been extensively researched and documented (Hawkins, 2001; MacIntyre, Murray, Teel, & Karshmer, 2009). Basu and Gupta (2007) explored staffing shortages, and presented data regarding the aging workforce, increasing patient acuity, poor working conditions and the high rates of individuals exiting the jobs, as discussed by the Canadian Institute for Health Information (2012) (CIHI). According to CIHI (2012) and Basu and Gupta (2007), there could be a nursing shortage, within Canada, of 113,000 nurses by the year 2022, resulting from the aging nursing population, and the unbalanced ‘supply and demand’ of nurses. The unbalanced ‘supply and demand’ of nurses refers to disparity between the increasing numbers of nurses retiring or leaving the profession (demand) and the number of students graduating from nursing academic programs (supply). Since 2001, the Government of British Columbia has increased funding for nursing school seats to address the future nursing shortage and hence, the number of available seats has grown by approximately 4,500, to accommodate registered nurses, psychiatric nurses, licensed practical nurses, and specialty education, such as perinatal nursing (British Columbia Ministry of Advanced Education, 2013). The impending nursing shortage has also been identified in the United States; in 2002, enrollment in nursing programs had been steadily declining since 1995 leading to a projected shortage of nurses of nearly 400,000 by the year 2020 (Buerhaus, Needleman, Mattke, & Stewart, 2002). To compensate for the projected nursing shortage it is estimated that nursing school enrollments have to increase by at least ‘40 per cent’ (Buerhaus et al., 2002). The aging nursing population and the increase in the number of nurses leaving the profession has lead to an increase in seats in nursing academic programs, which has increased the need for clinical sites to
be prepared for student practice education. Overall, no literature was identified that linked staffing shortages to student practice education.

2.4 Health Care Infrastructure

Health care infrastructure refers to the foundations of an organization, such as leadership structures, communication processes, effective partnerships and quality learning environments, in which health care is conducted and supported (Newhouse, 2007). The leadership structure within a health care system is often hierarchical, which can sometimes breakdown the lines of communication and create ineffective leadership (Newhouse, 2007). Ineffective leadership may compromise the support required by health care professionals to provide high quality patient care and education (Newhouse, 2007). Furthermore, infrastructure within an organization is meant to support and facilitate all aspects of health care, including student practice education (Schatz & Berlin, 2011). As the demands for student practice education increase, the infrastructure of the health care system should be able to expand and grow to appropriately support student practice education (Alexander, Weiner, Shortell, Baker, & Becker, 2006; Schatz & Berlin, 2011). Alexander et al. (2006) suggest that common agreement is needed amongst the entire health care system to allow the different parts to work together effectively.

‘Structural empowerment’ is an important aspect of infrastructure (Moore & Hutchison, 2007). Structural empowerment creates nursing leadership on multiple levels of health care, which fosters trust in the organization, increases job satisfaction, and creates commitment to the organization (Hutchinson, 2003; Moore & Hutchison, 2007). Perceived empowerment in a place of employment correlates with job satisfaction and productivity (Sarmiento, Laschinger, & Iwasiw, 2004). Nurses, for instance, commonly report feeling disempowered due to poor organizational leadership or a perceived feeling of being undervalued (Laschinger, Finegan,
Shamian, & Wilk, 2004). Laschinger et al. (2004) reported that when nurses perceive that they have structural empowerment, there can be up to 36.6% increase in job satisfaction. However, despite knowing the importance of appropriate infrastructure, many organizations do not have the necessary resources or the preparation for any potential leadership needs (Redman, 2006). To build that foundational organization infrastructure, clear role descriptions should be developed to reduce ambiguities and improve the balance of the organization in terms of readiness for health care and education (Acker, 2004; Redman, 2006).

Strategic plans and goals for organizations also need to be clear and readily available to all members of an organization to reduce role confusion, but also to clarify the different leadership roles needed at all levels – clinical to administrative (Acker, 2004; Moore & Hutchison, 2007). Strategic plans should also incorporate clear goals for student practice education, as the organization’s values related to student practice education are important to facilitate the teaching and learning process (Corrigan & McNeill, 2009; Mannix, Faga, Beale, & Jackson, 2006). A descriptive, non-experimental, comparative survey study by Manojlovich (2005) examined clinical-level nursing leadership and its effects on structural empowerment and nursing practice behaviour. The study found that nursing leadership had a strong influence on empowerment and professional practice behaviours amongst medical-surgical nurses, allowing the author to conclude that strong nursing leadership improved practice behaviours. The study was strengthened by the use of validated instruments: Conditions for Work Effectiveness–II, Manager’s Activities Scale, and Nurse Activity Scale (Laschinger, Finegan, Shamian, & Casier, 2000), and the Caring Efficacy Scale (Coates, 1996). The researcher found that nursing leadership and structural empowerment had a strong relationship \( r = 0.64, p < 0.01 \). In addition, participants who perceived to be working with strong nursing leadership had higher
empowerment scores and professional practice scores than nurses who perceived to be working under poor leadership (total possible leadership score = 48 points; nurses with strong leaders mean score = 21.82; nurses with weak leaders = 17.97; t = -9.950, df = 249, P = 0.001) (total possible empowerment score = 240 points; nurses with strong leaders mean score = 192.83; nurses with weak leaders = 187.69; t = -1.756, df = 249, P = 0.04) (Manojlovich, 2005). Overall, no articles were identified that linked health care infrastructure to student practice education, however, from the existing infrastructure literature, inferences for student practice education may be possible.

2.5 Leadership in Student Practice Education

In any organization, there is a fundamental need for structure and leadership. Henderson et al. (2011) state that organizations historically tend to use paths of least stress, indicating that organizations rely on existing systems to complete tasks and people in leadership roles may not be effective, strong leaders. Effective leaders evaluate current practice, create goals and activities and promote evidence-informed ways of practice, all the while providing support for sustainable change, leading to successful and valuable learning (Henderson et al., 2011; Mockett, Horsfall, & O’Callaghan, 2006). Strong leaders can be role models for positive behaviours to demonstrate expectations of their staff (Mockett et al., 2006).

Leadership can begin when the unit manager connects with the unit staff, building a rapport with each member (Schoonbeek & Henderson, 2011). If leaders are not open to communication and improving the learning environment, then the staff will most likely be closed to it as well (Schoonbeek & Henderson, 2011). The leaders’ motivation and enthusiasm for clinical learning can shape staff motivation and enthusiasm for student practice education (Henderson, 2011). By exhibiting characteristics, such as open communication, sharing
knowledge and positive reinforcement, those in leadership roles can effectively foster a positive learning environment, simultaneously providing support to staff who are participating in student practice education (Henderson, 2011). Nurses who participate in practice education require a supportive environment to effectively educate students (Henderson et al., 2012).

Supportive and strong leadership, in regards to student practice education, assists nurses in reducing their risk for burnout and ensures that the teaching and learning taking place is of high quality (Henderson et al., 2012). A supportive environment, clinically and organizationally, directly relates to the quality of teaching and learning that takes place in a student practice education setting, therefore, leadership style or attitude is extremely influential on clinical setting atmospheres, as well as the attitudes and beliefs of the whole health care team (Papastavrou, Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi, 2010; Tomey, 2009).

2.5.1 Frontline Leadership in Student Practice Education

Leadership can also be undertaken by staff nurses and clinical faculty, as individuals in these two roles assist students in practice education (Heller et al., 2004). Strong leadership can assist students and nurses to gain autonomy, improve job satisfaction and learning (Tomey, 2009). Frontline leadership allows nursing to gain a sense of control over their practice, improves interpersonal relationships, improves the clinical learning environment and enhances professional development (Tomey, 2009). Effective leadership also creates a positive work environment in which communication, learning, teaching, patient care, conflict resolution, organization and the level of lateral violence all significantly improve (Heller et al., 2004; Tomey, 2009). The presence of strong leadership, at all levels, also creates environments in which clinical or organizational changes can be more accepted and sustainable (Moore & Hutchison, 2007).
Block and Manning (2007) used a case study methodology to examine the effectiveness of an eight day certificate program aimed to consolidate leadership skills for frontline nursing leaders. The program was four weeks long, consisting of four courses, which included didactic teaching, group discussion, reading materials, experiential learning activities, self-assessment and personal planning tools. The courses were held twice a week for four weeks. The researchers found that the program was effective in building and sustaining leadership skills in frontline nursing and management, with 87.8% (n=80) of the total 91 participants reporting at a three month follow up, that they used the materials that they learnt in the program in their own practice. All of the participants rated their desire to lead positively. Follow up to the courses was done through focus groups with the managers of the original sample and follow up surveys. Focus group discussion revealed that the managers noticed an immediate change in the practice of the individuals that participated in the leadership building courses, which positively affected the practice of their colleagues; however, the managers did note that they had a difficult time filling the vacant shifts so nurses could participate in the courses. Follow up surveys indicated that the participants positively rated their confidence (participants M= 4.12; managers M= 3.16, p= 0.004), awareness of leadership opportunities (participants M= 4.17; managers M= 3.70, p= 0.013), communication skills (participants M= 4.02; manager M= 3.64, p= 0.066), willingness to be leaders (participants M= 4.05; manager M= 3.61, p= 0.030), conflict resolution (participants M= 4.20; manager M= 3.64, p= 0.010) and ability to support their colleagues (participants M= 4.23; manager M= 3.80, p= 0.017) following the courses compared to individuals who did not partake in the leadership building courses. The manager’s ratings for the participants, however, were significantly lower (Block & Manning, 2007). Overall, no articles were identified specific to student practice education and nursing leadership.
2.6 Partnerships and Relationships

Effective teaching and learning is dependent on the development and maintenance of working partnerships between an academic setting and a health care site (Henderson et al., 2011). To optimize student practice education in any clinical setting, there must be open lines of communication between a clinical site and an education facility (Henderson et al., 2011). This can only be done if both parties are willing to participate in the relationship (Henderson, Heel, & Twentyman, 2007). Open lines of communication allow staff and students to identify learning needs and discuss strategies to meet learning needs in the clinical setting (Henderson et al., 2007).

A good working partnership between an academic setting and clinical setting may help clarify expectations for learning, which may maximize learning opportunities (Henderson et al., 2007). A clear understanding of the expectations for learning allows staff to assist students in developing the necessary skills to become safe, competent clinicians (Henderson, Fox, & Armit, 2008). If both the health care facility and academic facility place consideration and planning into the same guidelines and expectations, students will be able to enter a student practice education site with adequate collaboration, consistency and organization, which could allow students to take advantage of every possible learning opportunity, as well as experience high quality learning (Spencer, 2003). In other words, ‘structured guidance’ can help optimize student practice education (Henderson, Winch, & Heel, 2006).

To foster these partnerships, nursing faculty can maintain relationships in the clinical setting, through actions such as networking when on-site and demonstrating high quality teaching (Chrisman, 2007). Through such actions, nursing faculty promote relationships that welcome students to the clinical learning site, as well as fulfill his or her role as an educator,
furthering professional development and socialization of student nurses (Redding & Graham, 2006). Additionally, effective partnerships create an environment in which staff and nursing faculty can easily rectify identified student practice education issues collaboratively, creating a positive learning environment (Redding & Graham, 2006). Overall, it is a joint responsibility of the clinical setting and academic setting to ensure that clinical learning environments are appropriate and ready to host student practice education (Hand, 2006).

Hartigan-Rogers, Cobbett, Amirault, and Muise-Davis (2007) used qualitative methods to describe third and fourth year students’ experiences in their clinical placements by examining the relationships between the student and the preceptoring nurse. The researchers found that students valued clinical placements, as the experiential learning allowed them to consolidate skills. The students also placed high value on their experiences with mentors. The study was strengthened because the interview questions were validated with a pilot study to ensure rigour (Hartigan-Rogers et al., 2007).

### 2.7 Quality of Clinical Learning Environment

The clinical learning environment consists of everything that surrounds the learner: clinical setting, equipment, staff, patients, mentors or preceptors, additional health care professionals and teaching faculty (Papp, Markkanen, & Von Bonsdorff, 2003). In a clinical learning environment, students consolidate their skills and put theory into practice, exemplifying the importance of optimizing the clinical learning environment (Orland-Barak & Wilhelem, 2005). Learning environments can be dynamic, resulting in clinical learning environments that vary from site to site (Papp et al., 2003). This variety can result in both positive and negative experiences, depending on students’ perceptions and a host’s degree of readiness for student
practice education (Billett, 2004). The variance may also create inconsistency in the quality of learning that takes place from site to site (Billett, 2004).

Although there are facilitators to clinical education, there are also barriers. One of the most commonly mentioned barriers to student practice education is the lack of clinical sites that provide high quality learning opportunities (McNelis et al., 2011). Students often describe a good clinical environments as those where they experienced good cooperation between staff members, positive atmosphere, students were viewed as colleagues, patient care was the best it could be, and strong interpersonal relationships amongst staff (Billett, 2004; Papp et al., 2003). These features, as well as minimal hierarchy, knowledgeable teachers, a desire for teaching and learning and appropriate supplies and equipment to accommodate staff and students are highly valued (Henderson et al., 2012; Henderson et al., 2008; Papp et al., 2003). To improve and create the most effective and favourable clinical learning environments elements such as workload, leadership, attitudes and belief systems may need to be altered to make sustainable changes for quality learning environments (Henderson & Eaton, 2013; Henderson et al., 2008; Henderson, Winch, et al., 2006).

Ideally, while a nurse is working with a student, when appropriate, his or her workload should be adjusted to facilitate the teaching and learning process (Henderson et al., 2012). Workload should be adjusted when needed to enable registered nurses to appropriately teach, supervise, assist in consolidating skills, and provide feedback to students to promote student practice education and to prevent the nurse from simply completing the task at hand without explanation or insight in to the critical thinking and decision making process behind the action (Henderson et al., 2012). Furthermore, by adjusting workloads when necessary, clinical supervisors, such as preceptors or mentors, will have more time to monitor and then provide
timely feedback to the learner (Dolmans et al., 2008). Timely feedback is of utmost importance to students, as it allows students to converse about their strengths and weaknesses, and create a plan to reinforce or strengthen their practical skills and critical thinking (Dolmans et al., 2008).

A quasi-experimental study by Henderson, Heel, Twentyman, and Lloyd (2006) assessed the effects of interactive capacity building sessions, aimed at nurses, on students’ perceptions of the clinical learning environment. The intervention involved paying a staff nurse to supervise a cohort of students during a clinical placement, rather than utilizing the traditional preceptor – preceptee model. The study found that students rated the clinical learning environment better during the intervention period than before or after it, allowing the authors to conclude the intervention was successful. Mean scores were calculated from the responses of a survey before, during and after the intervention, which measured six psycho-social factors: satisfaction with individualisation (pre-test: M= 19.46; post-test: M= 20.84, p= 0.517), student involvement (pre-test: M= 18.23; post-test: M= 19.46, p= 0.037), satisfaction (pre-test: M= 24.16; post-test: M= 24.56, p= 0.027), innovation (pre-test: M= 20.42; post-test: M= 20.15, p= 0.116), personalisation (pre-test: M= 19.58; post-test: M= 21.15, p= 0.019) and task orientation (pre-test: M= 22.23; post-test: M= 22.57, p= 0.012). During the intervention, there was an increase in the mean scores for all of the items being measured, when comparing the mean scores before and after the intervention, however, not all of the increases in the mean scores were statistically significant (Henderson, Heel, et al., 2006). The authors suggested that there may have been some organizational changes taking place that accounted for the statistically insignificant changes in the mean scores for some items, but not for others (Henderson, Heel, et al., 2006).
2.7.1 Quality of Clinical Learning Environment: Organization and Leadership

To create and sustain a high quality learning environment, there must be organizational learning, in which the organization continually expands its capacity for learning by encouraging and supporting professional development (Henderson et al., 2007). Leadership and management play a major role in this aspect of learning environments (Acker, 2004). Managers are in a leadership role and have a strong influence on staff morale (Livsey, 2009). A manager’s attitude towards learning can strongly influence the attitude of staff; therefore, the manager must exhibit a positive attitude towards learning (Livsey, 2009). This can be done with positive reinforcement, acknowledgement of positive behaviors and a presence in the clinical setting (Livsey, 2009; Papastavrou et al., 2010). If a manager or a leader is not supportive of positive learning environments, then the learning environment can be negatively affected (Henderson & Eaton, 2013). A manager’s involvement also creates consistency and continuity of practices in the clinical setting (Henderson, Twentyman, et al., 2010). Redman (2006) suggests that leadership structures created at the clinical level would help nursing to gain control over their practice and allow them to better facilitate and foster relationships with individuals in the learning role, as well as create clarity in role expectations and increase job satisfaction.

2.7.2 Nurse-Student Relationships

A nurse’s role as a mentor is fundamental to the teaching and learning process and a student’s quality of learning may be dependent on the rapport that he or she is able to build with a mentor (M. Andrews & Roberts, 2003). The quality of the perceived relationship between a nurse and a student can directly impact the level of learning that takes place (Levett-Jones, Lathlean, Higgins, & McMillan, 2009). If a student believes that he or she is not accepted or respected by the supervising nurse, then the student may experience low self-esteem, stress and
anxiety, which can diminish his or her ability to absorb or retain any new information or knowledge (Levett-Jones et al., 2009). If a positive relationship is established early in the clinical placement, the student may feel more comfortable to ask questions and seek out learning opportunities (M. Andrews & Roberts, 2003). Without mutual respect and desire for teaching and learning, learning experiences can become negative, which may diminish a students’ ability to become a truly competent clinician (M. Andrews & Roberts, 2003; Henderson et al., 2008).

2.8 Preceptor Education

Health care professionals are continuously learning and building on existing knowledge and skills, making their expertise invaluable to students and novice health care professionals (Henderson et al., 2008). Learning in the clinical setting is fundamental to students, as experiential learning in the clinical setting is how skills are consolidated and knowledge is acquired (Henderson, Twentyman, et al., 2010). To teach, educators must not only have clinical expertise, but a thorough understanding of teaching and learning theories as well (MacIntyre et al., 2009). However, mentors and preceptors are commonly chosen according to their clinical experience, clinical abilities, availability and willingness to supervise a student, rather than how prepared they are to facilitate learning (Henderson et al., 2012). A survey conducted in 2010 in a large Australian hospital, with a well established preceptorship model, found that 85% of students felt well supported, and 72% of students felt that they were adequately supported by the preceptoring nurse during their clinical placements (Carrigan, 2012). Clinical educators can have a significant impact on the quality of student practice education (Carrigan, 2012; Veeramah, 2012), therefore it is important to be prepared to supervise student practice education.

Upon graduation, novice nurses commonly have difficulty with critical thinking (Altmann, 2006). This lack in skill might be related to poor education in clinical placements, as
well as ill preparedness amongst nursing staff to effectively teach students (Altmann, 2006; Hautala, Saylor, & O'Leary-Kelley, 2007). Students benefit from preceptors who have a clear understanding of different methods of learning and teaching (Altmann, 2006). For preceptors to effectively demonstrate and explain how to apply theoretical knowledge to realistic practice, they require education about how to teach (Henderson, Creedy, Boorman, Cooke, & Walker, 2010; Papastavrou et al., 2010). Clinical teachers need to know how to accurately and effectively question students to promote thinking, to supervise and not simply take over, role model desired behaviors, and provide constructive feedback in a timely manner (Hutchinson, 2003; Spencer, 2003).

Chickering and Gamson (1987) reported similar principles for educators: promote open lines of communication, foster relationships amongst staff and students, provide feedback in a timely manner, provide support to the learner, and accept different ways of learning. These principles can be adopted in clinical settings and amongst schools of nursing, and should be considered when preceptoring students (Chickering & Gamson, 1987; Hand, 2006; Veeramah, 2012). However, sufficient numbers of skilled preceptors are not always available (Altmann, 2006). Being a qualified and appropriately educated preceptor in the clinical setting may allow the individual in the role of teacher or preceptor to build and foster trusting and respectful relationships with the students, which can help create safe and positive learning environments (Eaton, Henderson, & Winch, 2007).

Researchers suggest that successful completion of preceptor education courses increase nurses’ confidence and their own perceived ability to adequately preceptor students (Nicol & Young, 2007; Veeramah, 2012). Veeramah (2012) used a cross-sectional survey methodology (n = 346), with a response rate of 57.5% (n = 199), to evaluate a mentor preparation course.
Veeramah (2012) found that 54.3% (n = 108) of the individuals who participated in the mentorship education courses were more confident in their ability to adequately support students, and that 49.2% (n = 98) of students felt their supervisors were adequately prepared to support them in the learning environment. With more students seeking clinical placements, it is important for mentors or preceptors to receive support from leaders and colleagues in the clinical setting (Veeramah, 2012), so that quality education can take place, without increasing the risk for burnout amongst nurses. Continued support from leaders can help to build a sustainable platform for student practice education (Block, Claffey, Korow, & McCaffrey, 2005; Hand, 2006; Henderson, Forrester, et al., 2006; Nicol & Young, 2007).

Hautala et al. (2007) used a descriptive, exploratory methodology to examine the stress nurses experience and the level of support they perceive to have when preceptoring. Hautala et al. (2007) distributed an investigator-developed questionnaire to a convenience sample of sixty-five participants from two large hospitals. Descriptive statistics were used to analyse the quantitative data. Fifty-four participants (83%) rated their stress as mild to moderate and seven (11%) indicated they had no stress. The qualitative data were grouped into common themes: preceptor workload, preceptee skill level, organizational support, and preceptor confidence. The researchers found that nurses who preceptored students perceived that they were experiencing greater stress compared to when they were not preceptoring because of the increased workload and responsibility. Many also noted that there was minimal support from managers, but did receive support from their colleagues (Hautala et al., 2007).

Nicol and Young (2007) evaluated a preceptor education program called Sail Training, which was a pilot study aimed to determine the effectiveness of an education program in preparing nurses to preceptor students and if the students’ learning needs were being completely
met. This one-day education program was implemented in one tertiary hospital. In the program the nurse preceptors participated in an exercise which taught them how to sail a boat. The goal was to remind the nurses what it is like to be a ‘novice’. By placing experienced nurses in to a sail training program, the researchers were able to demonstrate what novice nurses may experience when they first begin working in the clinical setting. Immediately following the sailing experience, the participants had individual debriefing with the facilitators. Overall, participants were satisfied with what they learned and were able to translate their newly acquired skills, such as being a resource person, interpersonal skills and providing feedback, in to their practice of preceptoring students (n = 33, pretest n = 23, post-test n=11). Median values (maximum of 24) were calculated for the pre and post-tests for the intervention. In three of the five categories, the post-test score increased compared to the pre-test score: ‘being a resource person’ (M = 20 to 23), ‘interpersonal skills’ (M = 16 to 20) and ‘feedback and congruency’ (M = 20 to 22), suggesting that the one day sail training improved potential preceptors awareness for student needs. A thematic analysis of the open ended questions revealed two themes: empathy and skill acquisition. Empathy was further described with three sub-themes: being benevolent to being a novice learner, realizing that they are being relied on for positive learning experiences and awareness of the large amount of new information being learned by the student. Skill acquisition was further described with three sub-themes: being aware of one’s own personal habits and being empathetic to a novice learner, providing adequate support to students and facilitating learning.

2.9 Nursing Burnout in the Context of Student Practice Education

Burnout is the process of emotional exhaustion, which can lead to decreased sense of accomplishment and depersonalization, as well as increased use of sick time (Lang, Pfister, &
Siemens, 2010; Patrick & Lavery, 2007). Certain factors and changes in the workplace, such as differing ideologies, a lack of leadership, diminished autonomy, lateral violence and increased workloads, can lead to burnout (Gouva, Mantzoukas, Mitona, & Damigos, 2009). Both nurses and students can experience stress and emotional burnout and this has the potential to negatively impact experiences on the clinical site (Patrick & Lavery, 2007). Students are intuitive to the relationship dynamics of a clinical site, and often determine the type of experience that he or she will have on their first clinical day (Levett-Jones et al., 2009; Rella, Winwood, & Lushington, 2009). This quick judgment can also determine how included or excluded a student will feel when on a clinical site and how likely he or she is to take advantage of a learning opportunity (Levett-Jones et al., 2009).

Dyrbye et al. (2009) carried out a cross-sectional, multicenter study that examined how the learning environment, clinical rotations, personal life events and workloads influence student burnout. The response rate was reasonable, 55% (n = 1701) of the sample (n = 3080) responded. Specifically, 31.7% of the respondents were very satisfied with the learning environment and 3.8% were very dissatisfied with the learning environment, 29% were very satisfied with the faculty and 1.7% were very dissatisfied with the faculty, and 49.1% were very satisfied with their peers and 1.7% were very dissatisfied with their peers. Furthermore, 14.5% strongly agreed and 2.2% strongly disagreed that clinical rotations were organized to promote learning and 9.0% strongly agreed and 3.9% strongly disagreed that constructive feedback was received. The quality of the learning environment was associated with the level of burnout. On univariate analysis OR = 1.39 (1.13 – 1.71), students were more likely to experience burnout if they perceived to have inadequate support from faculty. Overall, students were more likely to be burned out if there was a perceived lack of quality faculty, quality interpersonal relationships and
quality learning environment. Students may enter a clinical placement with many stressors, such as personal conflicts, and academic deadlines, which also puts them at risk for burnout, creating potential for distress, which can adversely affect practice education and openness to learning (Dyrbye et al., 2009). Mindfulness of existing stressors and helping students gain a sense of belonging with friendliness, mutual respect and a positive learning environment can foster learning, and may help decrease burnout experienced by nurses and students (Dyrbye et al., 2009; Levett-Jones et al., 2007).

2.10 Summary

A clinical environment that is conducive to student practice education is important, as student nurses highly value clinical practice and the possibilities it offers in the process of developing into a professional nurse (Papp et al., 2003). The academic program should be providing suitable clinical placements at the correct time to optimize the process of bridging the gap between theory and practice (Papp et al., 2003). Furthermore, students should enter clinical placements that are ready to host student practice education with environments that have well educated nurses, strong interpersonal relationships and leadership, equality amongst all staff and a willingness to teach and learn. Positive role models, ward cultures and attitudes can contribute to positive learning experiences for students (Eaton et al., 2007).

The FECLNM (Henderson et al., 2011), in collaboration with the BCPEI (Newberry, 2007), provided key elements to explore for readiness to host student practice education: strong leadership, support for student practice education and building effective relationships within and between organizations (clinical setting and academic programs). Each of these elements is necessary for effective student practice education. Effective implementation of infrastructure for each of the components can benefit existing organizations, as well as improve future clinical
experiences for staff and students (Henderson et al., 2011; Henderson, Forrester, et al., 2006; Laschinger et al., 2004; Newberry, 2007).

Although there is ample literature about nursing shortages, burnout, mentoring, leadership, quality clinical environments, and infrastructure, few studies have explored the link between those factors to student practice education and if clinical sites are ready or prepared to host student practice education.
Chapter 3: Methodology

3.1 Introduction

The purpose of this study was to perform content validation of questions designed to assess readiness to host student practice education. Two versions of the questionnaire were examined in this study. In the first version, the questions were informed by the BCPEI (Newberry, 2007), which aimed to identify the structures and processes that ought to be in place in health care organizations for effective student practice education. When the questionnaire was revised for the second version, the FECLNM (Henderson et al., 2011) was consulted to develop holistic questions in relation to student practice education and quality learning environments.

3.2 Study Design

This study used descriptive qualitative methods to examine content validity of a questionnaire designed to measure readiness to host student practice education via five focus groups.

3.3 Research Question

There were two research questions for this study:

1. What is the face validity of a The Readiness for Student Practice Education Questionnaire designed to measure a clinical site’s readiness to host student practice education?

2. What factors are related to readiness for student practice education?

3.4 Question Development

The original questions that were included in the questionnaire were informed from the BCPEI (Newberry, 2007). The BCPEI (Newberry, 2007) was considered important to student practice education because of an identified need to focus on how clinical sites can effectively
support student practice education. The BCPEI (Newberry, 2007) was intended to identify the structures and processes that health care organizations ought to have in place to effectively support student practice education. As mentioned previously, the authors of the BCPEI (Newberry, 2007) conducted an extensive literature search, through which the following indicators of practice education quality were identified: leadership, strategic planning, measurement, analysis and knowledge management, workforce focus, facilities and equipment support and process management. Each of these indicators was deemed necessary, and was used to formulate the questions of the first version of the questionnaire. In the current study, following the first three focus groups, the questions were revised to create a second version of the questionnaire. While revising the questions, Henderson et al.’s (2011) FECLNM was also used as a guide for question development and revision. The FECLNM (Henderson et al., 2011) has similar constructs to those of the BCPEI (Newberry, 2007). Both the FECLNM (Henderson et al., 2011) and the BCPEI (Newberry, 2007) recognize the need for leadership and communication infrastructure, as well as support for staff members and student practice education. The FECLNM (Henderson et al., 2011) also provided key elements for readiness to host student practice education, such as rapport building, educational courses to foster learning and positive reinforcement; therefore the FECLNM (Henderson et al., 2011) was used as a guide to ensure the constructs presented in the conceptual framework were also incorporated into the questionnaire.

Steiner and Norman (2008) describe question development, including the different factors to consider when developing questions, such as appropriate reading level, interpretability and relevance to the topic. Firstly, existing research was examined to ensure that there was a need for this study. Once that was done, the original questions, as informed by the BCPEI
(Newberry, 2007), were reviewed to ensure the different aspects of student practice education were included. Questions had been developed to address identified concepts from existing literature, such as leadership structures, to make certain each question related to student practice education and that all aspects were covered sufficiently. Also, because the questionnaire would have been measuring traits of clinical learning environments in relation to student practice education, homogenous questions were important. Therefore, multiple questions were developed to ask about the same constructs, such as leadership structures, awareness of organizational infrastructure, methods of communication, available resources and funding allocation, specific to student practice education.

3.5 Sampling Plan

3.5.1 Sample Population and Sample Plan

The target sample was clinical nurse educators, and individuals in various leadership roles, who had experience with hosting, accepting or declining student practice education requests. These were the individuals invited to participate in the focus groups.

3.5.2 Inclusion and Exclusion Criteria

To be included in the sample the individuals must have been involved in some aspect of student practice education (staff nurse, clinical nurse educator, manager). Individuals were excluded from the focus groups if the site had not hosted student practice education hours.

3.6 Recruitment Methods

To recruit participants, e-mails were sent to clinical sites outlining the purpose of the study and a request to participate in a focus group to review and comment on the questions of a newly developed questionnaire, as well as contact information of the researchers. Consent forms and copies of the survey were attached to the e-mails. For further incentive, potential participants
were informed that fifty dollar gift cards would be provided to each participant at the end of each focus group.

3.7 Ethics Approval

Prior to conducting the study, ethics approval was obtained from each health authority, as well as the Behavioral Ethics Research Committee of the University of British Columbia. Consent forms were sent to each participant via e-mail at least 24 hours before the actual focus group, outlining the purpose of the study.

3.8 Procedures and Data Collection

A series of focus groups were held at three different health authorities within British Columbia, Canada. Before each focus group commenced, a demographics survey (Appendix B) was completed by each participant. All of the participants were also provided with a copy of the questionnaire to make it easier to follow along and provide anonymous written comments. Each focus group was held in a conference room within the hospital in the different health authorities. Before the start of each focus group, each participant was encouraged to ask questions to gain more clarity, if needed. Anonymity was also ensured by encoding the tape recordings and removing all identifiable details from the transcriptions. See Appendix A for the focus group script.

During each focus group, the questions were read out loud by the facilitator and then the participants discussed each question in terms of clarity and relevance to the overall purpose of the study: readiness to host student practice education. If there was minimal discussion to begin with, the facilitator used probing questions to illicit discussion (Appendix A). All of the focus groups were audio recorded to ensure all discussions were accurately captured for data analysis. During the focus groups the participants spoke about the questionnaire, and the facilitators took
detailed notes, taking special note of suggestions and identified ambiguities. The participants were encouraged to make their own notes on their copies of the questionnaire, to ensure all thoughts were accurately captured. The discussion focused on the appropriateness of the questionnaire and whether the questionnaire in fact measured preparedness to host student practice education. The participants also suggested questions to add or delete or combine together, format or wording changes to gain more clarity, and other opinions, such as relevancy to current practice, about the questions.

The cohorts for each focus group consisted of individuals who participated in some aspect of student practice education, such as organizing clinical placements and following up with concerns regarding student practice education, and therefore, the focus groups were purposely homogenous to create a safe environment and facilitate discussion. In the focus groups, ‘cognitive questioning’ (Polit & Beck, 2012) was utilized to gain understanding of how the participants processed the questions for clarity of the words, ambiguities and relevance to the overall purpose of the study. For example, if a statement made by a participant needed more clarification or to facilitate discussion, the facilitator would ask a question about the statement that was made. A specific example of this occurred when the first focus group was discussing organizational goals, only one participant made a comment, so to promote more discussion, the facilitator asked ‘would it be possible that an organization actually needs both, [a plan and goals], or does [an organization] need defined goals,’ which elicited more discussion.

Every questionnaire provided to the participants was formatted as a six-point Likert scale, asking the focus group members to rate the relevance of the question from not relevant to essential to assess readiness to host student practice education. Following the focus group the questionnaires were collected and then reviewed for additional comments. All of the comments
and notes were then grouped together, and written under each question. The audio recordings of the focus groups were transcribed verbatim through a professional transcription service, which provided an accurate record of the thoughts and opinions that were expressed in each session.

3.8.1 Question Revision

After the first three focus groups, the questions were revised to facilitate interpretability, appropriate reading level, ambiguities, use of unnecessary jargon, value-laden words, positive and negative wording, and relevance to readiness to host student practice education (Steiner & Norman, 2008). None of the questions were omitted upon revision, but some were combined together or re-worded. The enabling strategies of the FECLNM (Henderson et al., 2011) were also reviewed and considered when the questions were being revised to ensure the questions were reflective of a quality learning environment. Upon revision, two more focus groups were held in the same manner as the previous ones. The comments and notes from these two focus groups were again listed below each corresponding question, and then reviewed. A team meeting was held to discuss the main themes from the focus groups and the relevancy of each question to readiness to host student practice education leading to the final version of the questionnaire (published elsewhere).

3.9 Data Analysis

Once the professional transcripts were completed, the audio recordings were reviewed and compared to the transcripts to ensure accuracy and identify any potential discrepancies. Following this, comments regarding each question were summarized, including identification of common points and determining the overall relevance to readiness to host student practice education, by calculating a median score.
3.9.1 Content Analysis

Content analysis was done through syntactical and thematic distinction (Polit & Beck, 2012). While reading through the transcriptions, ‘clustering,’ was utilized to group similar words, phrases and thoughts together (Polit & Beck, 2012). Syntactical distinction, of qualitative content analysis, was used to cluster frequently used words or phrases together in relation to student practice education. Phrases like “we don’t have that” and “it would be nice…” were grouped together with similar words and phrases. Once that was done, the content analysis was further refined with a thematic distinction. Themes were derived out of the clustered words, sentences and phrases. For example, from the thematic distinction of the transcripts a theme of lack of familiarity with leadership structures was identified. During this process, consideration was taken for what each clustered phrase was referring to and the perceived relevancy to student practice education.

3.9.2 Survey Validation

During the focus groups, survey validation was performed; each question of the questionnaire was critically appraised by the participants for word clarity, ambiguities, jargon, ease of readability, biases and relevancy to readiness to host student practice education. Critical appraisal was done with the focus group participants through discussion and cognitive questioning. The questions were then reviewed and revised, based on the content analysis of the transcripts. To reduce bias in the answers for the questionnaire, many of the questions were re-formatted to elicit honest answers that were representative of the current clinical environments. Unnecessary jargon was removed to reduce risk of misunderstanding, questions were shortened, negative and positive words were replaced with neutral words, vague terms, such as always and often, were eliminated, identified ambiguities were rectified with specific examples, some
questions were combined with others and some new questions were added. These actions were taken to reduce ‘satisficing’ (providing an answer that is satisfactory, but not the best possible), ‘central tendency bias’ (avoiding the use of the extreme categories of a scale), ‘social desirability’ (providing answers that are the best possible scenario rather than factual) and ‘faking good’ (intentionally providing false answers to make one’s self look good) (Steiner & Norman, 2008), in the answers that will eventually be provided and gain face validity of the questionnaire. For the purpose of content validation, both versions of the questionnaire were developed as a six-point Likert scale, which allowed the participants to provide a relevancy rating to indicate his or her perception of each question in relation to readiness to host student practice education.

3.10 Median Scores

Participants of the focus groups were asked to rate each of the concepts in the questions on a relevancy scale from not relevant to essential. For this study, the relevancy ratings provided for the questions by the participants were calculated as medians. The relevancy ratings were combined in to three categories and then assigned a number: ‘not relevant – to – minimally relevant (1),’ ‘slightly relevant – to – moderately relevant (2)’ and ‘very relevant – to – essential (3).’ Median scores, the point in a distribution of values at which 50% of the cases are either above or below it (Polit & Beck, 2012), were also calculated to provide a general indication of relevancy.

3.10.1 Demographics

To gain an understanding of the participants in the focus groups, demographic data were collected and then analyzed and synthesized with descriptive statistics. Participants were provided with a form asking their sex, age, years of experience in nursing, current job and years
in the current job. Specifically, gender, age and current job were calculated using nominal measurements (frequencies and percentages) and the years of experience as a nurse were calculated with central tendency measurements (mean and standard deviation) (Polit & Beck, 2012).

### 3.11 Summary

This study used descriptive qualitative methodology to examine the content validity of an original questionnaire developed to measure a clinical unit’s readiness to host student practice education. This study had two research questions: what is the face validity of a questionnaire designed to measure a clinical site’s readiness to host student practice education and what factors are related to readiness for student practice education? The study examined two versions of the questionnaire; the first was informed by the BCPEI (Newberry, 2007). The second version of the questionnaire was developed following the first three focus groups and a review of the FECLNM (Henderson et al., 2011).

Both versions of the questionnaire were developed as six-point Likert scales, with the headings *not relevant, minimally relevant, slightly relevant, moderately relevant, very relevant*, and *essential*. Additional space was also provided for written comments. Many of the participants used the Likert scale to provide relevancy ratings for the questions to assessing readiness to host student practice education. The relevancy ratings that were provided were calculated as median scores.

Participants of the focus groups were individuals involved in some aspect of student practice education. E-mails containing information about the study were sent to the target sample for recruitment. Data collection was done by writing notes and audio recording the focus group
sessions. Transcripts from the focus groups underwent content analysis to identify themes for student practice education.
Chapter 4: Results

4.1 Introduction to Results

In this Chapter, demographic data and relevancy of each questionnaire item to student practice education is presented. The content analysis revealed four themes that will be discussed: infrastructure for communication, lack of familiarity with leadership structures, job descriptions and lack of familiarity with organizational goals.

4.2 Demographics

There were a total of 25 participants in the five focus groups; however, only 17 participants provided demographic data. The participants ranged in age, years of practice, level of education, clinical role and experience in their current roles. The demographics of the participants, specifically sex, age and years as a nurse, are illustrated in Table 4.1. The number of years as a nurse was calculated as a mean (m) and standard deviation (sd). All other data were ordinal and are presented in percentages (n%). Of the individuals that completed the demographic survey, there were thirteen female participants and four male participants. The average age group was 41-50 (n=7). The participants had been practicing in nursing between 1 year to 40 years, with a mean of 22.6 (sd +/- 8.96). The current roles of the participants are presented in Table 4.2. The most commonly occurring current role was Clinical Nurse Educator (n=12).
### Table 4.1 Demographics

<table>
<thead>
<tr>
<th>Characteristic (n=17)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex, n (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>Female</td>
<td>13 (76%)</td>
</tr>
<tr>
<td>Age, n (%)</td>
<td></td>
</tr>
<tr>
<td>21 – 30</td>
<td>2 (12%)</td>
</tr>
<tr>
<td>31 – 40</td>
<td>2 (12%)</td>
</tr>
<tr>
<td>41 – 50</td>
<td>7 (41%)</td>
</tr>
<tr>
<td>51 – 60</td>
<td>6 (35%)</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Years as a Nurse, mean (sd)</td>
<td>22.6 (8.96)</td>
</tr>
</tbody>
</table>

### Table 4.2 Current Roles

<table>
<thead>
<tr>
<th>Current Role, n (%) (n=17)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Manager</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Patient Educator</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Clinical Nurse Educator</td>
<td>12 (71%)</td>
</tr>
<tr>
<td>Advanced Practice Nurse</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (17%)</td>
</tr>
</tbody>
</table>

### 4.3 Readiness for Student Practice Education (RSPE) Questionnaire Version 1

The first set of focus groups consisted of three sessions: focus group 1 (n=5), focus group 2 (n=6) and focus group 3 (n=6). The participants ranged in age and experience. At the beginning of every focus group the participants were provided with a copy of the questionnaire. Each question was read aloud by the facilitator and then discussed. At the outset of each focus group participants were reminded that each question was assumed to begin with ‘In this clinical setting…’ In each focus group, the participants were asked to rate the proposed questions on a relevancy scale to determine how appropriate each question was to assess readiness to host student practice education. The results are displayed in Table 4.3, below.
Table 4.3 RSPE Questionnaire Version 1 Question Relevancy

<table>
<thead>
<tr>
<th>1. There is a well-defined leadership structure for student practice education</th>
<th>Not to Minimally Relevant</th>
<th>Slightly to Moderately Relevant</th>
<th>Very to Essentially Relevant</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. There is a well-defined communication process for student practice education</td>
<td>n=1</td>
<td>n=5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Job descriptions specifically address role and responsibilities supporting/providing student practice education</td>
<td>n=2</td>
<td>n=4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Staff performance tools specifically address performance in supporting/providing student practice education</td>
<td>n=1</td>
<td>n=4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5. The organizational strategic plan has defined goals related to student practice education</td>
<td>n=1</td>
<td>n=4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6. Progress on achievement of student practice education goals is measured regularly</td>
<td>n=1</td>
<td>n=4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7. The operating budget has allocated resources in place to support student practice education (e.g.: training and release time for preceptors/field supervisors)</td>
<td>n=1</td>
<td>n=5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8. Data are collected regularly for planning and decision making related to student practice education</td>
<td>n=2</td>
<td>n=3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>9. Staff regularly share knowledge regarding best practices in student practice education</td>
<td>n=1</td>
<td>n=4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>10. There is support for student practice education innovation</td>
<td>n=1</td>
<td>n=2</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>11. There is support for increasing the number of student placements on the unit</td>
<td>n=2</td>
<td>n=1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12. There is support for optimizing student placements on the unit</td>
<td>n=1</td>
<td>n=1</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>13. There is access to learning technologies to improve student practice education effectiveness (e.g.: simulation)</td>
<td>n=1</td>
<td>n=2</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>14. There is access to patient care technologies to improve student practice education effectiveness (e.g.: electronic medical record)</td>
<td>n=1</td>
<td>n=3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>15. Emerging educational models/approaches (e.g.: inter-professional education) are welcomed by staff to improve student practice education effectiveness</td>
<td>n=1</td>
<td>n=2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>16. There is an agreed upon number of staff trained to supervise students (e.g: preceptorship workshops)</td>
<td>n=3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Not all of the participants provided a relevancy rating*
Table 4.3 RSPE Questionnaire Version 1 Question Relevancy (Continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not to Minimally Relevant</th>
<th>Slightly to Moderately Relevant</th>
<th>Very to Essentially Relevant</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. There is an agreed upon number of staff available to supervise students</td>
<td>n=2</td>
<td>n=1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>18. Regular orientation is available to staff addressing their roles and responsibilities related to student practice education</td>
<td>n=1</td>
<td>n=1</td>
<td>n=1</td>
<td>2</td>
</tr>
<tr>
<td>19. There is organizational communication to all staff regarding their roles and responsibilities related to student practice education</td>
<td></td>
<td>n=1</td>
<td>n=2</td>
<td>3</td>
</tr>
<tr>
<td>20. A mechanism is in place to inform staff about students’ level of knowledge/learning objectives in advance of the placement start date</td>
<td></td>
<td>n=5</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>21. Teaching faculty involved with student practice education are satisfied with their orientation to the program/service</td>
<td></td>
<td>n=3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>22. Staff undertake professional development related to student practice education (e.g.: teaching, mentoring, preceptoring, coaching and inter-professional practice)</td>
<td></td>
<td>n=1</td>
<td>n=2</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note: Not all of the participants provided a relevancy rating*

Most of the participants provided a relevancy score for each question. A majority of the participants found that the questions were relevant to measure readiness to host student practice education; however, there were many concerns with wording and phrasing of the questions. A few of the participants found that four of the questions (5, 8, 17, 18) were not – to – minimally relevant to assessing readiness to host student practice. Question 5 asked about strategic plan, question 8 asked about data collection, question 17 asked about number of staff available to supervise students, and question 18 asked about orientation of staff to roles and responsibilities related to student practice education. The remainder of the questions varied from slightly relevant to moderately relevant to very relevant to essential. Although some questions were rated not – to – minimally relevant by some participants, the discussion indicated that the concepts within the questions were important. Therefore, some of the questions were combined with
others, and some were re-worded to create clear, all encompassing questions that would measure readiness to host student practice education.

A median score was also calculated from the relevancy ratings. Each column was assigned a number, and the ratings within each column were given the assigned number value. The median score indicated the average relevancy rating for each question. On average, the questions in the first version of the questionnaire were found to be essential, with a couple of questions being rated moderately relevant. None of the median scores indicated an average relevancy rating of not – to – minimally relevant.

4.4 Readiness for Student Practice Education Questionnaire Version 2

The second set of focus groups consisted of two sessions: focus group 4 (n=3) and focus group 5 (n=5). These questions, as mentioned previously, were revised by consulting existing literature and the FECLNM (Henderson et al., 2011). The revised questions were used for the second set of focus groups. These questions were also rated for relevancy to assess readiness to host student practice education, as shown in Table 4.4. Data from these focus groups were reviewed, literature surrounding question and questionnaire development was reviewed, and the questions were revised a final time.
Table 4.4 RSPE Questionnaire Version 2 Question Relevancy

<table>
<thead>
<tr>
<th>Question</th>
<th>Not to Minimally Relevant</th>
<th>Slightly to Moderately Relevant</th>
<th>Very to Essentially Relevant</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is a known person/team who makes decisions about student practice education</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>2. There is a well-defined communication process between the student and the preceptor during a clinical placement</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>3. There is a well-defined communication process between the clinical unit and the school</td>
<td></td>
<td></td>
<td>n=1</td>
<td>n=2</td>
</tr>
<tr>
<td>4. Job descriptions specifically address expectations of staff, when supervising students</td>
<td></td>
<td></td>
<td>n=1</td>
<td>n=2</td>
</tr>
<tr>
<td>5. Staff responsibilities are clear when supervising students</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>6. Staff performance in student practice education is evaluated regularly</td>
<td></td>
<td></td>
<td>n=1</td>
<td>n=2</td>
</tr>
<tr>
<td>7. The organizational mission statement clearly recognizes the importance of student practice education</td>
<td></td>
<td></td>
<td>n=1</td>
<td>n=2</td>
</tr>
<tr>
<td>8. Data are routinely collected in order to monitor the progress of student practice education (e.g.: number of students, etc.)</td>
<td></td>
<td></td>
<td>n=1</td>
<td>n=2</td>
</tr>
<tr>
<td>9. Data are routinely collected in order to plan for student practice education (e.g.: number of preceptors)</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>10. The operating budget has allocated resources in place to support student practice education (e.g.: preceptor training)</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>11. Staff is regularly updated to best practice for student practice education</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>12. The clinical unit is open to new approaches to student practice education</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>13. There is support to optimize student practice education (e.g.: trained preceptors, increasing the amount of students, etc.)</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>14. There is access to learning technologies to improve student practice education for staff and students (e.g.: simulation, online learning modules, mock codes, etc.)</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>15. Students have access to electronic clinical documentation systems</td>
<td>n=1</td>
<td></td>
<td>n=2</td>
<td>3</td>
</tr>
<tr>
<td>16. Staff workload can be adjusted to facilitate student practice education</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note: Not all of the participants provided a relevancy rating
Table 4.4 RSPE Questionnaire Version 2 Question Relevancy (Continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not to Minimally Relevant</th>
<th>Slightly to Moderately Relevant</th>
<th>Very to Essentially Relevant</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Educational opportunities are available to staff addressing their roles and responsibilities related to student practice education (e.g.: preceptorship workshops, etc.)</td>
<td></td>
<td></td>
<td>n=2</td>
<td>3</td>
</tr>
<tr>
<td>18. There is a mechanism in place for the educational facility to inform the clinical unit for what is expected of students when participating in student practice education</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
<tr>
<td>19. There are clear criteria from the clinical unit for what is expected of students</td>
<td>n=1</td>
<td></td>
<td>n=1</td>
<td>2</td>
</tr>
<tr>
<td>20. There is an orientation process for new clinical instructors</td>
<td></td>
<td></td>
<td>n=3</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note: Not all of the participants provided a relevancy rating

Most of the questions of the second version of the questionnaire were considered very relevant - to - essential. A couple of the participants rated questions 6, 15 and 19 to be not – to – minimally relevant. Question 6 focused on staff performance evaluations, question 15 focused on student access to electronic documentation systems and question 19 focused on criteria from the clinical unit for expectations of students. However, the discussion surrounding the concepts within the questions indicated that they were relevant or could be relevant in the future. For this reason, the questions were revised a final time, and formed the final version of the questionnaire.

The median scores for the second version of the questionnaire indicated that most questions were important for student practice education.

4.5 Median Scores

As described earlier, the median score could have been a maximum of 3. The median was an important calculation because it provides a score of the importance of the concepts of each question, without being influenced by extreme opinions or ratings. Even if the wording of a
question was determined to be ambiguous, it was clear that the concept within the question was valuable to readiness to host student practice education.

4.6 Content Analysis

Upon the second revision of the questions, the transcripts of each focus group were again critically examined. The transcripts were revisited to identify any themes that rose from the discussion in the focus groups. This was deemed necessary to ensure that the final version of the questionnaire included all the concepts that were identified in the dialogue amongst all the participants within each focus group. Four main themes were identified and those were considered when the questionnaire was revised for the final version. The themes included: infrastructure for communication, lack of familiarity with leadership structure, lack of familiarity with organizational goals, and job descriptions.

4.6.1 Infrastructure for Communication

A major theme from the discussion for almost every question was infrastructure for communication. Communication refers to the method of transmitting information from one source to another (Littlejohn & Foss, 2008). Efficient and effective communication processes are important to student practice education, as they may allow individuals and institutions to gain accurate knowledge and information regarding the different aspects of student practice education. This theme that arose from the discussion suggested that the current communication process for student practice education may not be effective. One of the questions asked if there is a well defined communication process for student practice education, and the immediate responses were “communication is one of the biggest things that is going well or not going well” (Focus Group 3), “I’m not saying we have it… We don’t have it; We’ve muddled along without this; We all think it’s essential and we don’t have it” (Focus Group 2), “it depends on the
student; I don’t know if it is well defined; HSPnet is pretty well the communication process, but do I just use that for communication? – No” (Focus Group 5).

The members of the first focus group discussed the different levels of communication as ‘internal and external communications,’ referring to the different places that communication takes place: between ‘practice and academia, within particular units, and within the organization.’ One participant stated that “it took me forever when I started this job, probably a couple years, to figure out that I needed to contact <name> if I had barriers or challenges with the schools about student placements.” This was echoed by another participant who stated that “as a new participant in this hospital, I actually have to agree with <name> because I’m still figuring out who is the person that I need to contact with issues” (Focus Group 2).

4.6.2 Lack of Familiarity with Leadership Structure

In the focus groups, when asked if there is a well-defined leadership structure for student practice education, there were some contradicting opinions. In the first focus group, one participant stated that “it is important to have a clear, well-defined structure,” and another participant stated that “an appreciation for having some structure would be helpful.” Another participant, in the same focus group stated that “a small organization would not really need a very well-defined leadership structure.” This was restated by another participant who declared that “organizational structure does not need to be as clear as it does at the bigger organizational level,” which could mean that this participant believes that organizational structure needs to be clearer at the higher levels of an organization, compared to the lower levels. A participant in the second focus group stated that “it’s not well defined who that is,” referring to the lack of a clear description of who is in the leadership roles and who to contact when there is a concerning issue, especially with student practice education. Another participant stated that “[clinical nurse
educators] don’t lead [students] in their practice education, we provide opportunities for them; we just sign them up, and we get involved when there’s issues or if we’re asked questions; From a leadership point of view, the structure is set up and I guess it’s generally well set up through HSPnet” (Focus Group 3). Another participant voiced the importance of leadership structures by stating “how does anybody know what’s going on if you don’t have somebody who knows who’s making decisions; and to have a known person, that’s like your resource, so you have to have that” (Focus group 4).

4.6.3 Job Descriptions

Some immediate responses to the question of whether job descriptions encompass student practice education were: “don’t hold your breath; I’m not going to be holding my breath for it to happen either; if it’s actually built in from the get-go when you come in, it’s pretty clear; it’s good to define this and articulate it” (Focus Group 1). “Job descriptions are also deliberately vague; They’re generic; Just not something that we do yet; It is something that is lacking in the units; If we put anything like, ‘you will be responsible for students,’ you’ll automatically be classified as a DC2, as an educator role... and that’s why I think [job descriptions] are quite vague and generic” (Focus Group 2). “We don’t emphasize it; There is no formal [description] that you’re going to be preceptoring. It depends on the individual” (Focus Group 3). “The college [CRNBC] came up with specified guidelines we have to follow [when supervising students]; To put that in the job description would be a good idea” (Focus Group 4). “I don’t think it exists now; If it were more clearly stated, it might be easier to feel [that] your unit’s ready” (Focus Group 5).
4.6.4 Lack of Familiarity with Organizational Goals

The organizational strategic plan refers to the organization’s overall plan and set of goals for the organization’s present and future. Organizational goals and initiatives can vary between organizations, depending on the function of the organization, health authority and the population that the organization serves. The participants’ organizations had strategic or mission statements, but not everyone was aware of them. In the first focus group a participant stated that “I don’t know whether there needs to be a defined goal, but the strategic plan of the organization should reference the importance of student practice education.” Another participant mused, “[it could] be possible that an organization actually needs both [defined goals and strategic plan]; Is it naive to think that all organizations will have that in a broad statement?” (Focus Group 1). “I don’t know what our strategic goals are around [student practice education]. It would be nice to know that; I don’t think that most of the people that you’ll ask will have any idea about that... frontline nurses probably have very little idea of what the strategic plans are and where to find that” (Focus Group 2). “We are a teaching hospital, I’m assuming there’s something in there; You have to have this, because you do need the top support going down before you even proceed” (Focus Group 3). “Different hospitals take students for different reasons... so it’s [organizational view on student practice education-] built into the actual organizational statement, [which] hopefully gets translated down” (Focus Group 4). “I don’t know; I don’t think it’s in the mission statement, but I know that it’s in the strategic imperative” (Focus Group 5).

4.7 Questionnaire: Final Version

The final version of the questionnaire was developed by critically examining the discussion from each focus group independently, as well as in team meetings. Through the discussions in the focus groups and the team meetings, it was decided to include the phrases ‘In
this clinical setting…” or “In this organization…” or “In this Health Authority…” at the beginning of each question to reduce confusion. Many of the participants stated that the questions would be more clear if that was included in each question, rather than at the top of each page. The phrase ‘student practice education’ was also italicized to make it stand out and to make it clear that that is what is being measured in the end.

4.8 Summary

The focus groups discussions provided valuable insight into current infrastructure for student education. The discussion that took place provided an opportunity for participants in leadership roles for student practice education to critically reflect on their own clinical units and determine whether the concepts in the questions exist in current practice or if they are pertinent to their clinical setting. Although some participants rated a few of the questions, in both versions, with low relevancy ratings, the median scores for each question suggested that the questions were important to accurately measuring readiness to host student practice education.

A thematic analysis of the focus group transcripts revealed four main themes: infrastructure for communication, lack of familiarity with leadership structure, job descriptions and lack of familiarity with organizational goals. The members of the focus groups stated that current infrastructure for communication may be ineffective, that it is not always clear who to approach with issues about student practice education, job descriptions may be overly vague on purpose and there may be a general lack of awareness about the organizational goals. Although these themes for student practice education may be lacking, and some participants also stated that “we have muddled along this far without them” (Focus Group 1), the participants also voiced that each of these subject matters is important to student practice education.
Chapter 5: Discussion

5.1 Introduction

The purpose of this study was to assess the content validity of a questionnaire developed to measure readiness to host student practice education in the clinical setting. The questionnaire was developed by consulting and revising leadership questions proposed by the BCPEI (Newberry, 2007) and the FECLNM (Henderson et al., 2011) was used to guide question revision for the second version. The final questionnaire included questions about organizational infrastructure, clinical environment characteristics, communication processes relating to student practice education. Through a series of focus groups, the questions were reviewed and amended to create a questionnaire that would capture information relevant to assess readiness of a clinical site to host student practice education. Relevancy ratings for each question were collected to ensure the questions were relevant to assessing readiness to host student practice education, and a thematic analysis of the focus group transcripts was done to understand how the concepts presented in the questionnaire were perceived by the participants. In this Chapter, relevancy ratings and themes that arose from the data analysis and the implications of these findings to nursing practice, policy and research will be discussed.

5.2 Question Relevancy Ratings: Version One

In the first version of the questionnaire four questions had at least one participant provide a not – to – minimally relevant rating. One question asked ‘the organizational strategic plan has defined goals related to student practice education.’ The low relevancy rating for organizational goals relating to student practice education may have arisen from an existing lack of awareness for organizational goals, as evidenced by the discussion from the focus groups and thematic analysis of the transcripts. It is possible that current goals for student practice education may not
be adequately communicated to health care professionals in various roles, as many of the participants of the focus groups stated that, generally, they were not familiar with the current organizational goals. Bryson, Crosby, and Bryson (2009) state that organizational strategic plans and goals are important and necessary for organizations, as clear organizational goals provide an outline for what the organization should be doing and why. Clear organizational goals may also facilitate the decision-making processes for individuals in leadership roles (Bryson et al., 2009). Towers and Spanyi (2004) also state that organizational goals should be clear, as well as effectively and efficiently communicated to the members of an organization. Often, goals are not sufficiently communicated to members of an organization, which can affect the overall value individuals form for the purpose of the organization (Towers & Spanyi, 2004). This is congruent with the BCPEI (Newberry, 2007), which asserts that health authorities need to provide defined goals for student practice education in order to aid in securing adequate clinical placements for students, as well as facilitate clinical units in becoming prepared for student practice education. This finding is important to student practice education because it provides an example of the differing perspectives on student practice education. If the organization develops clear goals regarding student practice education, individual roles and responsibilities related to practice education may become clearer because the organization will have provided specific objectives that will assist staff to effectively supervise students.

Another question asked ‘data are collected regularly for planning and decision making related to student practice education.’ The BCPEI (Newberry, 2007) states that data collection, specific to student practice education, may assist organizations to maximize on resources for student practice education and provide insight into recruitment and retention. Van Barneveld (2008) states that gathering data improves practice education by allowing clinical sites to
develop plans from the collected data, as well as aid decision making that will promote preparedness for student practice education.

It is possible the low relevancy rating for data collection may have occurred because frontline staff or members of a health care team believe that initiating data collection, even for student practice education, may increase their workload by adding an extra task that he or she must complete. This could suggest that nurses might feel over-burdened with the added responsibility of a new task related to data collection and the inevitable policy and procedure changes that will accompany the findings, which may lead to change resistance and eventually to change fatigue (McMillan & Perron, 2013). McMillan and Perron (2013) describe change resistance as behaviours such as negative remarks and refuting the need for change, whereas change fatigue is passive, described as feelings of inequity, stress and burnout, both of which are associated with constant changes in the clinical setting.

Change occurs in health care settings continuously and rapidly (Hansson, Vingård, Arnetz, & Anderzén, 2008; Torppa & Smith, 2011), therefore health care team members may benefit from being involved in the change process to reduce change resistance and change fatigue. McMillan and Perron (2013) continue by stating that because organizational change is inevitable, involving frontline staff in the change process may reduce resistance and increase autonomy. Torppa and Smith (2011) further state that effective communication between leadership and frontline staff is important to the successful implementation of change initiatives, as effective communication may provide frontline staff to become more aware of and more involved with change processes.

Happell (2007) states that information disseminated from the data collection may allow health care to become more ready to host student practice education. This finding is important
because, historically, data collection has been used in health care to implement change to improve patient outcomes and for the provision of best care practices. For example, extensive data have been collected and interpreted to reduce falls amongst the elderly. Studies conducted by Scott, Gallagher, Higginson, Metcalfe, and Rajabali (2011) and Shubert, Altpeter, and Busby-Whitehead (2011), for example, developed evidence-based intervention programs to reduce the number of falls experienced by high risk elderly. If data had not been collected on falls and the associated risk factors, then researchers would not have been able to measure the impact of the intervention programs.

Currently, HSPnet, a tracking system that provides a forum for data collection on clinical placements and trends, has improved access to practice education information and helped raise awareness of clinical site utilization (Newberry, 2007); however, HSPnet does not completely measure readiness to host student practice education. This is important, because it highlights the need to assess existing clinical sites for readiness to host student practice education, as well as the need to lobby for more resources to implement systems for data collection. Clear objectives for data collection should be communicated to frontline staff to ensure all health care team members understand why data are being collected and the plan for the gathered data and to reduce the potential for change fatigue (Hansson et al., 2008; Torppa & Smith, 2011).

Two other questions that covered similar topics and were also rated as not to minimally relevant were: ‘there is an agreed upon number of staff trained to supervise and ‘regular orientation is available to staff addressing their roles and responsibilities related to student practice education.’ Jeggels, Traut, and Africa (2013) state that formal education to prepare nurses to supervise students in the clinical setting can positively influence a student’s learning experience by preparing a preceptor with teaching and learning theory to support a
student and provide constructive feedback. Charleston and Goodwin (2004) also state that preceptor education is important because preceptors play a key role in the development of a student in to a safe, competent practitioner and socialization in to the nursing profession. Therefore, having an adequate number of educated and prepared preceptors is important for readiness to host student practice education (Charleston & Goodwin, 2004; Jeggels et al., 2013). The BCPEI (Newberry, 2007) affirms the need for educated preceptors by stating that health care professionals who supervise students need specialized skills, which can be achieved with a combination of experiential learning and formal education. The BCPEI (Newberry, 2007) also reports that some countries, such as Scotland, have developed specialized educational programs that preceptors must complete prior to supervising students, ensuring best practice for student practice education. The FECLNM (Henderson et al., 2011) supports educational courses for preceptors by incorporating ‘workshops to foster learning in practice’ (p. 197) in the enabling strategies for ‘clinical teaching and learning support,’ (p. 197) as well as ‘support and recognition of staff to supervise and teach through fostering continuous learning’ (p. 197) for ‘partnerships’ (p. 197). This finding is important because it outlines the need for clearer role descriptions, which include expectations for continued education for student practice education. Raising awareness for the need for preceptor education courses may encourage stakeholders to provide more funding for student practice education, as well as raise the quality of the learning environment by preparing all eligible health care professionals for supervision of students.

5.3 Question Relevancy Ratings: Version Two

In the second version of the questionnaire three questions had at least one participant provide a not – to – minimally relevant rating. One question asked ‘staff performance in student practice education is evaluated regularly.’ K. Thompson (2012) states that performance
evaluations can be perceived negatively and be stressful for staff as evaluations tend to focus on aspects of practice that need improvement. However, Borglum (2013) argues that objective staff performances are important for continuous professional development. Regular staff evaluation provides health care professionals with an opportunity to reflect on their current practice and to gain insight into what he or she is doing well and what may require improvement (Agri Marketing, 2011; Borglum, 2013). Staff evaluations, therefore, may improve and facilitate student practice education by raising awareness for roles and responsibilities, as well as individual involvement with practice education. Furthermore, staff performance tools can cultivate positive relationships between leadership teams and frontline staff, as well as align organizational goals with individual practice, specific to student practice education (Ahmed, Sultana, Paul, & Azeem, 2013). Advance discussion of when and what an evaluation will encompass may be beneficial in the effectiveness of the appraisal process as well as the potential reduction of stress that can be associated with performance evaluation (K. Thompson, 2012). The BCPEI (Newberry, 2007) also acknowledges the importance of staff evaluation by providing leadership questions relating to staff performance evaluations. This finding is important because it delineates the need to change the potentially negative perspectives surrounding performance reviews, specifically related to student practice education.

Another question asked ‘students have access to electronic documentation systems.’ Nurses may not believe that access to electronic documentation systems is relevant to student practice education because they are not available in all health care facilities at this time. Additionally, implementation of a new documentation system may significantly increase the risk for change fatigue (McMillan & Perron, 2013). Hall (2006) further states that continuous organizational changes may create barriers to accepting clinical placements because staff may be
experiencing burnout from the change process. This finding is important because it outlines the importance of clear direction when change is occurring and the need for regular follow up with frontline staff.

Barthold (2009) states that currently, in health care documentation is mostly paper-based, with only 0.1 per cent of American hospitals being completely electronic based. Barthold (2009) continues by stating that implementation of electronic documentation systems, with standardized charting forms, can improve efficiency of charting and improve patient outcomes by providing easy and fast methods of documentation and follow-up. Munyisia, Yu, and Hailey (2012) concur that electronic documentation systems enhance efficiency, reduce cost to health care system and increase productivity. Hammoud et al. (2012) state that adequate access to electronic documentation systems, when available, is important to student practice education, because sufficient access provides students with an opportunity to gain proficiency in clinical documentation, as well as fosters the understanding of the importance of thorough and accurate clinical documentation. The BCPEI (Newberry, 2007) discusses the importance of providing students with sufficient access to electronic documentation systems, when available. This finding is important because it addresses the need to sufficiently determine and communicate the link between electronic documentation systems and student practice education. Because implementation of electronic documentation systems is a priority in Canadian health care, Canada Health Infoway (2013) has suggested change management techniques to appropriately support organizations and clinical units through electronic documentation related transitions. Canada Health Infoway (2013) recognizes the importance of strong leadership, effective communication, appropriate resources, continuous follow up, positive reinforcement and
development of a change management plan during the transition period to increase the likelihood of successful change, with minimal resistance.

The final question that was marked as not – to – minimally relevant stated ‘there are clear criteria from the clinical unit for what is expected of students.’ It is possible that nurses may have an expectation that academic programs are responsible for providing clear criteria to students. However, Schaubhut and Gentry (2010) state that collaboration between health care and academia to develop set criteria for student practice education can foster and facilitate the teaching and learning process, thereby improving overall learning and patient care. The BCPEI (Newberry, 2007) furthers this argument by stating that setting criteria for student practice education through collaboration may improve student orientation and communication between the organizations. Furthermore, set criteria may allow health care organizations to create policies and procedures that facilitate student practice education by becoming cognisant of space for students, appropriate resources and adequately educated mentors for students (Newberry, 2007; Schaubhut & Gentry, 2010).

5.4 Infrastructure for Communication

Infrastructure for communication was identified as a major theme for student practice education from the analysis of the focus group transcripts. This refers to the need for appropriate, effective and efficient lines of communication within organizations (between clinical units, between clinical units and administration) and between organizations (between different health care facilities and between health care organizations and academic programs). The focus groups indicated that effective communication is essential to student practice education, requiring clear and easy explanations and methods to be effective. Communication is important to the safe delivery of health care and student practice education (Corrigan & McNeill, 2009; Littlejohn &
Foss, 2008). Murphy and Martin (2013) state that effective communication amongst health care providers improves patient outcomes and reduces health care costs because it allows health care professionals to quickly relay pertinent information regarding patient status. In the discussion, some participants verbalized not knowing who to contact with questions or concerns regarding student practice education, despite being in their current role for more than one year. According to Murphy and Martin (2013), communication can be improved by clearly defining the roles of each member of a health care team providing clarity as to each person’s responsibility relating to student practice education. Having clearly defined roles, which are easily communicated amongst health care teams, might improve ease of communication, and potentially improve reaction time to student practice issues that may arise.

Participants indicated that communication processes may improve with clearer communication processes and more leadership involvement. Individuals in leadership positions can play a key role in effective communication, as he or she may have a strong influence on the general clinical unit culture or attitude (Henderson, 2011; Tschannen et al., 2013). According to Tschannen et al. (2013), improving communication processes can lead to increased job satisfaction by promoting trust amongst colleagues, which may enhance student practice education and patient outcomes. The discussion from the focus groups suggests that effective communication processes may be lacking and may be inefficient. Some of the participants provided anecdotal examples of using more than one mode of communication to relay a single message and of sometimes experiencing delays or miscommunications as a result of multi-modal means of communication. Currently, there is no research regarding communication and student practice education. It has been established that within health care, effective communication is important, therefore Murphy and Martin (2013) and Tschannen et al. (2013) suggest that
identification of the barriers to effective communication and potential strategies to address the barriers should be a priority in health care, in hopes of improving infrastructure for communication.

5.5 Lack of Familiarity with Leadership Structure

The second theme to arise from the thematic analysis was lack of familiarity with leadership structures in relation to student practice education. Leadership is the ability to develop and demonstrate critical thinking, problem solving, ability to guide and direct cohorts of people and create a positive work environment (Curtis, De Vries, & Sheerin, 2011; Kaiser, Hogan, & Craig, 2008). Leadership structures vary between organizations, as does the effectiveness of existing leaders (Kaiser et al., 2008); Therefore, well defined leadership structures may improve existing leadership skills, and clarify roles and responsibilities related to leadership for student practice education. Baker and Denis (2011) state that when a clear and effective leadership structure is lacking, the leadership duties and expectations fall to the individuals working within the organization, who may not be involved with organizational infrastructure, which may slow decision-making and diminish efficient change processes. Baker and Denis (2011) also suggest that incorporating a ‘collective leadership’ style, in which a group of individuals are responsible for the leadership aspects of student practice education, within an organization, may improve and facilitate decision-making and the inclusion of best practice activities related to student practice education.

Effective leadership behaviours are necessary within an organization (Kaiser et al., 2008; Kanste, 2008). In addition to organizational leadership, frontline leaders are also necessary, as leaders can have an impact on the attitude of an entire organization (Henderson et al., 2011; Kaiser et al., 2008). Nursing leaders may have significant influence over a health care team’s
ability to achieve a goal or the development of attitudes or unit cultures (Sieloff, 2004). Effective leadership may influence staff to interact in a manner that fosters learning; over time, the mannerism may become embedded in everyday clinical practice, continuing to support teaching and learning (Henderson et al., 2011; Henderson, Forrester, et al., 2006).

Henderson (2011) states that bedside nursing is one of the main influences on student practice education, therefore frontline nursing leadership supporting positive learning experiences and facilitating learning is important. Nursing leaders can be found in various roles, such as frontline staff, administrative staff and educational faculty (Sieloff, 2004). Nurses in both education and research roles are leaders, because their actions can improve nursing practice and the environment they work in (Sieloff, 2004). Sieloff (2004) indicated that creating more opportunities for nurses to become involved in organizational leadership structure may allow nurses to become more involved in decision-making for student practice education, potentially bringing nursing expertise to the forefront.

The participants of the focus groups discussed the importance of leadership, which is consistent with Sieloff (2004); Baker and Denis (2011); Henderson (2011), who have all discussed the significance of strong leadership. However, limited literature was identified that described leadership structure for student practice education in the clinical setting. There is some research demonstrating the need for leadership and how effective leadership may improve nursing care and learning environments, however, there is limited literature about whether the leadership structures are currently in place (Al-Sawai, 2013; Cliff, 2012; Martin & Waring, 2013). There seems to be an undertone within literature that suggests that leadership structures need to be improved, however, there is little account of how to make improvements, and whether strategies to improve leadership have been successful within health care systems or educational
systems. For instance, Martin and Waring (2013) suggest that health care as a whole needs to improve leadership capacity. Participants in the first focus group stated that a leadership structure is not as important in a smaller organization compared to a larger organization, but Martin and Waring (2013), Cliff (2012) and Kanste (2008) suggests that strong and effective leadership is necessary in all organizations, regardless of size, which is consistent with the discussion from the other focus groups. Good leadership can improve job satisfaction, trust amongst colleagues and student practice education, regardless of organizational size (Curtis et al., 2011; Lankshear, Kerr, Laschinger, & Wong, 2013).

5.6 Job Descriptions

The third major theme identified from the thematic analysis was job descriptions, specific to student practice education. Job descriptions entails the clear definition and expression of all of the roles and duties an individual is responsible for (News, 2003). Participants in the focus groups generally stated that clear job descriptions for nurses are important, but are purposely left generic for pay scale obligations made by union contracts. Another noteworthy point made was that in nursing the expectation of being involved with student practice education is incorporated in to the local regulatory body’s standards of practice, but not in the job descriptions provided by the union. This is important because two separate organizations influence nursing practice, but it is unclear if there is effective communication between the two organizations, and if they both have similar organizational goals for student practice education. Creating continuity between the two organizations may help create clearer and more detailed job descriptions, and may help facilitate stronger leadership structures for student practice education. The participants of the focus groups stated that clear job descriptions are important and agreed that clearer job descriptions may decrease role ambiguities. The discussion, however, also indicated that
budgetary conflicts may prevent the incorporation of appropriate job descriptions for student practice education. Including specific education language in nursing job descriptions may require the health care organization to increase wages in order to abide union contract obligations. There was no literature available regarding the impact of differing languages between the nursing regulatory body and the nursing union on student practice education.

Didovich (2007) indicated that providing a comprehensive job description, which incorporates a job title, purpose of the job, expected activities or duties, clinical and educational responsibilities, clear explanation of whom the individual would report to and who the resource person is before beginning a new position may allow individuals to become familiar with his or her complete role within a clinical unit or organization. This may reduce role ambiguities and prepare health care professionals for student practice education. In nursing, job descriptions should accurately and thoroughly explain current responsibilities, including those for student practice education (News, 2003). For instance, clear job descriptions for student practice education, should include expectations for continuing education and student supervision (Newberry, 2007). Schmidt, Roesler, Kusserow, and Rau (2014) state that inaccurate or vague job descriptions can lead to miscommunication of expectations, role ambiguities and job dissatisfaction, as vagueness may be susceptible to differing perspectives on student practice education. Ingersoll (2005) further states that clear job descriptions that also link to overall organizational goals may improve understanding of roles. This may suggest that individuals who prefer not to supervise students in clinical practice may decide that since it is not expressed within the job description, then he or she does not have to participate in student practice education, as the expectation is not clearly presented in the job description or organizational goals. Fitzgerald and McAllen (2007) state the importance of clear job descriptions for nurses in
relation to student practice education, by suggesting that inclusion of phrases like ‘orients students to nursing care standards’ and ‘commits time and energy to the student’s learning by providing feedback and skills’ may reduce role ambiguity. Clearer job descriptions for nurses are relevant to student practice education because including expectations, as well as roles and responsibilities for student practice education, produces a comprehensive description of duties for nursing staff while supervising students in the clinical setting.

5.7 Lack of Familiarity with Organizational Goals

The fourth theme that arose from the thematic analysis was lack of familiarity with organizational goals in relation to student practice education. Organizational goals refer to the expressed objectives an organization has for itself, its members and the clientele that it serves (Desmidt, Prinzie, & Heene, 2008). Organizational goals can vary from site to site, even within health care; despite this, leaders should ensure that employees are aware of the goals. Desmidt et al. (2008) states that awareness of organizational goals may assist with decision-making, role clarity and set the tone for the organization. The discussion from the focus groups revealed a general lack of familiarity with organizational goals. However, the focus groups conducted with members of a teaching hospital revealed that these participants tended to be more familiar with organizational goals and mission statements. Weech-Maldonado et al. (2012) suggest that teaching hospitals tend to have well-established structures for student practice education, including funding, resources, and flexibility to accommodate changes in practice, creating an environment that may be ready to host student practice. It is possible that the smaller sites in the current study that did not have a tradition of being a teaching hospital would benefit from incorporating infrastructure that is embedded in the teaching hospitals.
Ingersoll (2005) stated that organizational goals that clearly link job descriptions to objectives reduce miscommunications and may improve job clarity, especially for student practice education. Desmidt et al. (2008) indicated that effectiveness of organizational goals is dependent on how well goals are communicated to members of an organization and how relevant the goals are to the health care profession. Moreover, Bryson et al. (2009) propose that appropriate support and shared commitment to the organizational goals is important for effective implementation of the goals. Overall, student practice education may benefit from a clear description within organizational goals, because, if communicated appropriately, readiness to host student practice education may become a priority within health care.

5.8 Conceptual Framework

The FECLNM (Henderson et al., 2011) presents specific attributes that a clinical learning site should possess for effective teaching and learning and the delivery of safe, competent care to patients. The FECLNM specifically aims to identify gaps in the clinical learning site, and then presents potential enabling strategies to rectify the gaps to promote student practice education. The findings of this study demonstrated that there could be multiple existing gaps for student practice education, such as insufficient funding, lack of resources, poor evaluation, unclear job descriptions, ineffective communication infrastructure, lack of familiarity with leadership structures and organizational goals. The enabling strategies suggested by the FECLNM presents general actions that can be undertaken in hopes of rectifying any identified gaps for student practice education within a clinical setting.

The framework adequately depicts which structures would be needed to successfully enact the enabling strategies; for instance, a strong leadership structure would be needed to build a trusting and respectful workplace and there would need to be a good support system in place to
recognize contributions made by frontline staff to improve student practice education. However, although the enabling strategies are relevant to student practice education, and may be useful in becoming prepared to host student practice education, it is not clear which funding models would be appropriate to fund the enabling strategies. Therefore, questions related to budget allocation for student practice education were developed and included in the questionnaire. Furthermore, the framework adequately describes the need for re-evaluation to ensure that the suggested enabling strategies, if implemented, were effective in addressing gaps for student practice education. However, the FECLNM (Henderson et al., 2011) does not address organizational responsibilities related to organizational goals for student practice education; therefore questions about organizational goals and plans for student practice education were included in the questionnaire.

Although the framework provides a model of factors related to effectiveness of student practice education the model would be enhanced if it included the quality indicators expressed by the BCPEI (Newberry, 2007) (leadership, strategic planning, measurement, analysis and knowledge management, workforce focus, facilities and equipment support, process management and results.). Inclusion of these factors may help to ensure that all aspects of organizations are captured when measuring readiness for student practice education.

Henderson et al. (2011) developed the Clinical Learning Organizational Culture Survey (CLOCS) to measure beliefs and assumptions associated with practice education. CLOCS was used to compare two Australian hospitals to a hospital in Singapore (Chan, Chan, Lee, & Henderson, 2014). Chan et al. (2014) found that there was no significant difference between the two geographical areas; however, the authors mentioned that Australian nurses tended to describe supervising students as a burden, while the nurses in Singapore perceived to have
sufficient support from the organization for student practice education. Further research into the differing findings may be beneficial to determining how to adequately support student practice education in Canada. The current questionnaire might be used to fill some gaps in the FECLNM.

5.9 Implication to Nursing Practice and Student Practice Education

Student practice education is interconnected with bedside nursing (Henderson, 2011). This study developed an original questionnaire to measure different aspects of student practice education within a clinical setting. Measuring these different aspects, such as appropriate levels of prepared preceptors, positive learning environment, suitable resources and familiarity with organizational goals for student practice education, may create more awareness of what is going well for student practice education and what may require more attention for changes or alterations in practice. This is important because identifying the different aspects of student practice education will not only raise awareness of the different constructs that need to be in place to appropriately support student practice education, but may also help improve the overall quality of teaching and learning and patient care in clinical sites. Improvements for student practice education may allow clinical sites to participate in practice education with structures of support, communication, leadership and sufficient resources in place. Improvements of the infrastructure for student practice education may allow nursing staff to aptly supervise students, take advantage of the most amount of learning opportunities, as well as create positive learning environments for students. Students may also notice changes in the learning environment, and may experience an increase in their sense of belonging, as well as an enhanced feeling of being a part of the team.

Existing barriers to student practice education may lead to miscommunication, errors, ambiguities, poor patient outcomes, and job dissatisfaction. For example, participants of the
focus groups suggested that there are multiple forms of communication in place, which may seem useful, but at times can be inconvenient when important e-mails or messages end up in incorrect mailboxes, creating delayed response times or miscommunications. Identification of barriers and implementation of strategies to improve readiness to host student practice education requires strong leadership, in which positive attitudes towards student practice education are discussed and role modelled (Henderson, 2011). Nursing practice and student practice education may benefit from clearer communication processes, because with effective communication orientation, early organization of placements and knowing whom to contact with questions or concerns. Clear communication would also come in to play for organizational goals and job descriptions, for student practice education. Both of these constructs need to be written clearly and communicated effectively within an organization, which would require an efficient communication infrastructure. Furthermore, health care faces many changes, which are necessary to maintain evidence informed and best practice. Because of this, it is important to consider change management for nursing practice.

There have also been changes in the mode of care delivery to patients. In recent years, patient acuity and co-morbidities have increased, yet pressure for shorter in-hospital admissions has also increased (Harrison, 2004). To compensate, there has been a shift in care delivery. Health care has begun to adapt an ambulatory day care paradigm for care delivery, rather than acute care (CIHI, 2012). CIHI (2012) asserts that, compared to acute care, ambulatory care provides the largest amount of health care related activities, such as day surgery, emergency room visits and outpatient clinics, to Canadian citizens. Researchers have found that ambulatory care is safe and cost effective. Johansson, Thune, Nelvin, and Lundell (2006), for example, studied ambulatory care for laparoscopic cholecystectomy’s versus overnight stays, and
concluded that there was no significant difference between the two methods of care delivery in terms of post-operative complications and patient comfort. As a result, it may be possible that more health care procedures are or will be offered in the outpatient setting. Traditionally, student practice education has primarily taken place on inpatient wards (Henderson et al., 2011; Henderson et al., 2008). With this shift in care delivery, there may need to be an assessment of appropriate clinical placements for students seeking educational experiences. Overall, upon gaining more knowledge of appropriateness and readiness of clinical units and improvement on the process and infrastructure for student practice education, the quality of clinical learning that takes place may improve for students, which may improve the quality of patient care within the health care system.

5.9.1 Implications for Policy

Policies that might be influenced by this study are clearer role descriptions, changes in funding allocation, improved communication processes, raising awareness of organizational goals and improved leadership structures. Nursing practice policies, relating to student practice education, may also be influenced with the development of detailed, all encompassing job descriptions. Clearer job descriptions and organizational goals from the health care facility could improve potentially poor attitudes towards student practice education, and may open the possibility of CRNBC and BCNU collaborating to develop consistent job descriptions for nurses that outline expectations for student practice education. Improvements or changes in these policies may develop stronger or more effective infrastructure for student practice education by setting up processes that support practice education.
5.9.2 **Implications for Nursing Research**

There is an abundance of existing research that focuses on nurse-physician interactions, nurse-client interactions, and nurse-student interactions, but minimal research focuses on communication processes between organizations and educational programs, nurse-instructor interactions, and successful strategies that have helped improve communication processes in clinical sites. Future nursing research should explore the different aspects of communication: what works, what needs to improve, and critical examination of strategies that have been utilized as a means to improve communication infrastructure.

Future nursing research should also explore the effect of including expectations for student practice education in the job descriptions and organizational goals on readiness to host student practice education. Further research on leadership structures could also be beneficial. Research on whether or not effective leadership structures are in place may help identify potential roles for nursing in leadership, potential roles for students, and identify leadership structures that are effective for student practice education. Furthermore, research exploring funding for student practice education would be beneficial as it may help raise awareness of available funding and resources for student practice education and whether it is adequate or not.

5.10 **Limitations**

The study had some limitations. Not all of the participants provided a relevancy rating for each question, which slightly decreased the amount of data received from the participants for relevancy of each question to assess readiness to host student practice education. Some of the participants did not provide demographics data. Furthermore, the risk for response bias was high because the developers of the questionnaire were involved in the facilitation of the focus groups,
however, measures, such as creating a safe, trusting environment, clear explanation of what the
purpose of the study and focus groups was, were taken to attempt to lower response bias.

5.11 Summary

Student practice education is growing within the field of nursing and health care
education. Health care professionals spend many of their formative years in the clinical or
organizational setting, gaining and maintaining skills to perform high quality patient care (G. J.
Andrews et al., 2006; Kenyon & Peckover, 2008). Clinical sites require adequate infrastructure
to be prepared to host student practice education in order to effectively educate and prepare
health care professionals to provide safe, competent care. Student practice education is
multifaceted, involving many different aspects of health care. Identification of barriers to
effective student practice education may allow health care sites to develop plans to implement
sustainable change for student practice education. For sustainable change, however,
organizations must also focus on effective change management to raise awareness for the need
for appropriate infrastructure for student practice education. Further research is required to gain a
better, holistic understanding of student practice education, and if clinical units are ready to host
student practice education.
References


Appendix A

Focus Group Questions: RSPE Survey

Feb/Mar 2013

Introduction
Good morning/afternoon. Thank you for taking the time to join us today. My name is ___________ and I am a _______________ on this project. And this is ____________, who is ________ on the project.

As indicated in the consent form we are developing an instrument to measure the ‘Readiness for Student Practice Education’ of a clinical unit. This instrument will be completed by people who make decisions about whether to accept placement requests in their clinical setting. The questions in the instrument were created from a checklist that was developed by the BC Practice Education Initiative in 2009.

The purpose of this focus group is to review the questions in the survey to identify if they are relevant, clearly stated, and to identify if there are any other questions that should be added to the list. During this focus group we will walk through each question to gather your perspectives. We will be holding focus groups in the 4 health authorities in the BC Lower Mainland, and in April, we will test the tool in a survey of a random set of clinical settings in the BCLM.

Before we get into our discussion, I’d like explain the process:

- First, as outlined in the consent form you should know that we are audio recording the session so that we can refer back to the discussion when we write our report. If anyone is uncomfortable with participating or being recorded please say so and, of course, you are free to leave. We want to assure you of complete confidentiality regarding anything mentioned during our discussion.
- Please speak up and try to have just one person speak at a time to assure that everyone gets a turn. [Because we are doing this via teleconferencing it will be more difficult to play traffic cop but I will do my best to assure that everyone gets a turn. Also, if you are agreeing and nodding, if you could verbally identify if you agree (or disagree) with comments made that would be helpful].
  - I will try to ask with each question if those on the phone have any other comments or additions, but please feel free to bring us back to a point if you haven’t been able to jump in.
  - Speaker phone on mute if lots of disturbance, and try to turn up the volume.
- Finally, we’re here to exchange opinions and gather the various perspectives on this topic so please say exactly what you think. Don’t worry about what I think or what other members of the group think. The goal is not necessarily to agree or reach consensus, we very much value differing perspectives and would like to hear these.
- If relevant - (Since the group is familiar with one another I’m not going to take the time to introduce ourselves.)

Our session ends at [insert time] so let’s begin.

Interview Guide for Survey Questions:

I. For each question read the numbered question and ask:
1. What are your thoughts about this question?
   Probes
   i. Restate what they’ve said
   ii. Ask – Do you mean……?
   iii. Do others have thoughts on this question?
   iv. Any other thoughts? (leave a pause and watch if someone is starting to talk – then turn to them, and ask their name (if needed))

2. What about the phrasing of the question?
   Probes
   i. Does it make sense?
   ii. Does it sound clear?
   iii. Does anyone have other thoughts about this question?

II. After all questions have been addressed ask the following:

3. Are there any areas that we’ve missed?
   Probes
   i. Do the questions cover all ‘readiness’ aspects that would be relevant for a point of care decision maker

   Probes:
   Is there anything else?
   What I heard you say was…
   Tell me more…
   Would you say more…
   I don’t quite understand…
   Please describe what you mean…
   Can you explain what you mean?
   Would you explain further?
   Does anyone have an example of that?
   Would you give me an example of what you mean?
   Is this anyone else’s experience?
   Does anyone have a similar (or different) perspective?
   I don’t understand.
   You all seem to understand what she is saying, but I’m still confused. Can anyone help me?
   Tell me what it is like.
   You looked puzzled, why?
Appendix B

RSPE Survey Development
Focus Group Demographic Questions

What is your role? (Select all that are true)
- Nurse Manager
- Clinical Nurse Specialist
- Nurse Practitioner
- Patient Educator
- Clinical Nurse Educator
- Advanced Practice Nurse
- Other ______________________

How many years have you been a nurse in this setting/unit? ______

What degrees do you have? (Select all that are true)
- Diploma
- BSN
- MS-NP
- MSN
- PhD
- Post-masters certificate
- Other ______________________

How many years have you been a nurse? ______

What is your age group?
- 21 – 30
- 31 – 40
- 41 – 50
- 51 – 60
- 61 – 70
- ≥ 71
- Prefer not to say

Gender:
- Female
- Male