Facilitating Student Learning in the Acute Care Setting: Nursing Faculty Perspectives

A Dissertation submitted

by

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DEDICATION

To my children, Benjamin David and Emma Rose Flott. I love you with all my heart and the greatest honor of my life is being your mother. Watching you grow and the gifts you have and share with others has kept me going more than you will ever know. I hope accomplishing this goal will instill in you the value of education, the passion to continue learning, and to unceasingly pursue your dreams. Perseverance, dedication, and a positive attitude will always get you far in life. And always remember to never, ever, give up.

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ABSTRACT

Nursing education programs are experiencing many trends impacting the preparation of students including a nursing faculty shortage and a lack of quality clinical sites. In addition, literature is finding new nurse graduates unprepared when entering practice, lacking the required critical thinking, delegation, and prioritization skills necessary to provide safe care. Due to these findings, national nursing organizations and leaders are urging nursing education programs to implement solutions and reverse these trends to ensure students are prepared for demands of the current healthcare system.

To improve the structure of clinical education in this country, gaining faculty perspectives regarding experiences while facilitating clinical learning is vital. Understanding the process utilized by faculty when facilitating learning in the acute care setting while using the traditional clinical model of instruction was the goal of this qualitative, grounded theory study. Semi-structured interviews and discussion of clinical documents were conducted with 14 faculty representing six bachelor in science of nursing programs across two Midwestern states.

After performing coding procedures aligning with the constructivist grounded theory approach, The Flott Facilitation of Clinical Learning in Nursing Theory was developed. This theory clarified the process faculty utilize when facilitating clinical learning while identifying influencing factors impacting this process. In addition, this study determined that the ability for faculty to perform the role of clinical instruction and provide quality learning experiences often influenced satisfaction with the profession.

Based on these findings, recommendations for practice and research brought about from this study could enhance nursing faculty retention and improve the preparation of nursing students. Ensuring solutions to influencing factors are developed while providing faculty an optimal environment and model to deliver clinical instruction can assist in reversing the preparation gap noted in new nurse graduates and allow faculty to provide quality clinical instruction.

Keywords: Nursing education, clinical instruction, nursing faculty, acute care, traditional clinical model

CHAPTER ONE: INTRODUCTION

Nursing education programs are responsible for preparing nursing students for professional practice by equipping students with the skills and knowledge necessary to provide safe patient care. For nursing students to achieve learning outcomes, instruction is provided in both the classroom and clinical learning environment. Students can acquire knowledge and theory in the classroom setting and later integrate and apply this knowledge when providing direct patient care in clinical environments such as hospitals, clinics, and long-term care facilities. Recently, nursing education has experienced multiple trends impacting student preparation for the nursing role, particularly regarding clinical learning environment experiences. First, a nursing shortage, expected to continue for the foreseeable future, has led nursing programs to increase student enrollment and counteract this deficiency (AACN, 2014; Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010). With this response comes another set of challenges as, in conjunction with a nursing shortage, the United States is also experiencing a nursing faculty shortage (AACN, 2012; Benner, Sutphen, Leonard, & Day, 2010; Feldman, Greenberg, Jaffe-Ruiz, Kaufman, & Cignarale, 2015; Rich & Nugent, 2010).

Increasing numbers of nursing faculty are retiring with fewer nurses pursuing an educational career due to salary differences when compared to clinical counterparts (AACN, 2010). For those pursuing a career in nursing education, a lack of education regarding the nursing faculty role remains problematic (Cangelosi, Crocker, & Sorrell, 2009; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013; Schoening, 2013). Many faculty have extensive expertise regarding nursing specialties but no background of educational practices such as proper assessment of student learning. Finally, with an increasing number of students enrolled in nursing programs, quality clinical learning experiences are becoming harder to find and access, all of which impacts preparation of the next generation of nurses (AACN, 2010; Ironside & McNelis, 2010). In addition to these concerns, the healthcare field has experienced many changes including more integration of technology (Ironside & McNelis, 2010; Tanner & Bellack, 2011) and admittance of higher acuity patients to the hospital setting (Tanner, 2006).

Collectively, these trends are impacting the preparation of nursing students, as researchers have found new nurse graduates unprepared for the demands of acute care facilities, particularly hospitals. A lack of time management skills, struggles with delegation, and a failure to recognize symptoms indicating a decline in health status are concerns regarding the performance of new nurse graduates identified in the literature (Athlin, Larsson, & Soderhamn, 2012; Burns & Poster, 2008; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013). In addition, Del Bueno (2005), after reviewing a standardized assessment, discovered only 35% of new nurse graduates over a ten-year period met entry-level expectations regarding clinical judgment skills. This lack of preparation has been associated with high amounts of stress and turnover with several facilities reporting that up to 50% of new nurse graduates are leaving healthcare institutions within the first two years of employment, with some leaving the profession altogether (Bowles & Candela, 2005; Ulrich et al., 2011; Welding, 2011).

These concerns have led organizations such as the National League for Nursing (NLN) and American Association of Colleges of Nursing (AACN) to promote identification and implementation of alternative clinical experiences to better prepare nursing students for work in modern healthcare organizations (AACN, 2002; Ironside & McNelis, 2010; McNelis, Fonacier, McDonald, & Ironside, 2011; NLN, 2005). In response to these statements, researchers have investigated different stakeholder viewpoints regarding students' ability to learn in the clinical environment (Chuan & Barnett, 2012; Dunn & Burnett, 1995; O'Mara, McDonald, Gillespie, Brown, & Miles, 2014; Sand-Jecklin, 2009) and alternative methods to providing clinical education (Campbell & Filer, 2008; Mulready-Shick, Flanagan, Banister, Mylott, & Curtin, 2013). Missing from this literature are perspectives from nursing faculty regarding the effectiveness of clinical education, the process required to facilitate student learning in the clinical environment, and strengths and weaknesses of clinical education models. This study sought to gain this missing faculty insight which could lead to integration of more effective clinical models and better preparation of students for professional practice.

Background and Rationale

Instructing students in the clinical learning environment remains an essential component of nursing education programs. Students spend, on average, triple the number of hours in the clinical environment when compared to the classroom setting (Moscaritolo, 2009; Newton, Billett, Jolly, & Ockerby, 2009). This environment allows students the opportunity to gain real-world practice prior to becoming a professional nurse. Despite the significance of learning in this environment, few changes have been made regarding the model and structure of clinical education in this country. Many nursing programs have conducted clinical education in the same manner for decades despite dramatic changes incorporated into the healthcare field. The traditional clinical model (TCM) can be traced back to the 1930s with no research supporting its use as a beneficial method of instruction (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010). This model typically utilizes one faculty member to supervise eight to ten students on a single clinical unit, usually in a hospital setting. The faculty member assists students in providing patient care including administering medications, performing nursing skills, and promoting the use of critical thinking when assessing patients throughout the shift. After a specified number of weeks, nursing students rotate to a different clinical site with another faculty member and this pattern continues until graduation. At its beginning, nursing students were not only learning in acute care settings but were also included as part of the clinical staff; however, as time progressed, nursing programs became more formalized, with students being removed from the clinical staff and nursing education transitioning into higher education institutions. Even though these changes occurred, the model of clinical instruction remained the same (Ironside & McNelis, 2010).

Minimal research has been conducted on clinical education in nursing even though, for many years, a large portion of nursing education has been completed in clinical settings. Yonge et al. (2005), found only 39 nursing research articles out of 1,286 focused on clinical education in nursing programs. Even fewer have examined faculty perspectives of clinical instruction and those that have are mainly descriptive studies in nature (Ironside & McNelis, 2010). This lack of research predisposes nursing education programs and faculty to continue teaching as they were taught with few insights regarding the

impact this model has on facilitation of student learning and nursing student preparation for practice (Ironside & McNelis, 2010).

With the concerning trends mentioned, researchers have started comparing the TCM with new models, including the Dedicated Education Unit (DEU) model. The DEU pairs one to two nursing students with a nursing staff member oriented to instructor responsibilities. In this alternative model, nursing faculty are not as involved in guiding direct patient care but rather assist in developing and evaluating critical thinking skills needed for practice by rounding with students throughout the clinical shift (Moscato, Miller, Logsdon, Weinberg, & Chorpenning, 2007; Mulready-Shick, Flanagan, Banister, Mylott, & Curtin, 2013; Ryan, Shabo, & Tatum, 2011). Early research has found students and registered nurses preferring this alternative model to its traditional counterpart with both stakeholders agreeing that the DEU model provides more consistent, positive relationships and allows for stronger partnerships between healthcare facilities and nursing education programs (Campbell & Filer, 2008; Mulready-Shick et al., 2013; Nishioka, Coe, Hanita, & Moscato, 2014a; Nishioka, Coe, Hanita, & Moscato, 2014b; Ryan, Shabo, & Tatum, 2011). Even with these promising results, nursing faculty perspectives regarding traditional and alternative clinical models of instruction are lacking from the literature. Faculty perspectives regarding the TCM remain important to understand prior to developing and implementing new clinical models.

A few descriptive survey studies have gathered nursing faculty perspectives regarding challenges the TCM presents when instructing students (Ironside & McNelis, 2010; MacFarlane et al., 2007); however, no studies have investigated positive aspects of this model. The challenges identified with this model also need further investigation, including ways in which the faculty-to-student ratio impacts facilitation of student learning and how faculty provide individualized student guidance throughout the clinical experience (Ironside & McNelis, 2010; Teel, Smith, & Thomas, 2008). Without research investigating the faculty viewpoint regarding these challenges, it will remain difficult to determine whether future clinical models are improving the process for faculty when facilitating learning in the clinical environment.

In addition to understanding ways in which the clinical model of instruction impacts facilitation of learning, faculty perspectives regarding teaching in the acute care environment, or hospital setting, are also lacking. As nursing students continue to have multiple clinical experiences in this environment, it remains important to investigate the impact this setting has on nursing faculty's ability to facilitate student learning.

Researchers have confirmed that educational environments influence students' ability to achieve educational objectives. Moos (1973) formally developed the concept of the classroom learning environment after determining that multiple elements, including relationships occurring in the classroom setting, instructional strategies utilized by teachers, and organization of the physical space, all impact students' ability to learn. While in a different location, the clinical environment also contains elements influencing students' ability to learn and meet outlined objectives (Dunn & Burnett, 1995; Sand-Jecklin, 2009). Multiple researchers have developed tools and definitions to measure and describe components of the clinical environment with these studies primarily occurring in acute care settings (Dunn & Burnett, 1995; Levett-Jones & Lathlean, 2009; Newton, Jolly, Ockerby, & Cross, 2010; Sand-Jecklin 2009).

Based on a concept analysis of the clinical learning environment (Flott & Linden, 2016), four characteristics were found to impact student learning in this setting which are comparable to Moos's (1973) conceptualization of the classroom environment. The clinical learning environment attributes include the physical space, psychosocial and interaction factors, including communication, attitudes, and behaviors expressed toward nursing students, the organizational culture of the institution, and teaching and learning components, including faculty approachability, faculty effectiveness in facilitating learning, and student characteristics such as engagement in the learning process (Flott & Linden, 2016). The attributes composing the clinical learning environment are summarized in Table 1 (Bloomfield & Subramaniam, 2008; Chuan & Burnett, 2012; Dunn & Burnett, 1995; Flott & Linden, 2016; Levett-Jones & Lathlean, 2009; Sand-Jecklin, 2009; Skaalvik, Normann, & Henriksen, 2011).

Table 1

Attributes of the Clinical Learning Environment and Supporting Sources

Element	Supporting Sources
Physical Space -necessary and functioning equipment -orientation to the clinical learning environment	Bloomfield & Subramanium, 2008; Chuan & Burnett, 2012; Dunn & Burnett, 1995; Levett-Jones & Lathlean, 2009; Sand-Jecklin, 2009; Skaalvik, Normann, & Henriksen, 2011
Psychosocial and Interaction Factors -communication, attitudes and behaviors experienced in the clinical learning environment with fellow students, faculty, and healthcare staff	Bisholt et al., 2013; Chan 2002; Chuan & Barnett 2012; Dunn & Burnett, 1995; Henderson, Normann, & Henriksen, 2009; Hosoda 2006; Levett-Jones & Lathlean, 2009; Newton, Jolly, Ockerby, & Cross, 2010; Palmer et al., 2005; Sand-Jecklin, 2009
Organizational Culture -manager and organization's view on importance of nursing education	Bisholt et al.,2013; Chan, 2002; Dunn & Burnett, 1995; Dunn & Hansford, 1997; Hosoda, 2006; Levett-Jones & Lathlean, 2009; Newton, Jolly, Ockerby, & Cross, 2010; Palmer et al., 2005; Saarikoski & Leino-Kilpi, 2002
Teaching and Learning Components - effectiveness of instruction and feedback provided by nursing faculty -approachability of nursing faculty -student engagement in the learning process	Chan, 2002; Chuan & Burnett, 2012; Dunn & Burnett, 1995; Hosoda, 2006; Newton, Jolly, Ockerby, & Cross 2010; Sand-Jecklin, 2009; Saarikoski & Leino-Kilpi, 2002

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Faculty effectiveness of instruction remains a critical component of the clinical environment impacting students' ability to learn (Chuan & Barnett, 2012; Henderson et al., 2009; Skaalvik, Normann, & Henriksen, 2011; Sand-Jecklin 2009; O'Mara et al., 2014). While it is well researched that clinical environments impact student learning, literature is lacking regarding the influence these same clinical environments have on nursing faculty's ability to facilitate learning.

Despite the few descriptive studies mentioned, prior research investigating nursing faculty perspectives regarding teaching in the clinical environment have mainly occurred in countries outside of the United States that employ different clinical models (Chuan & Barnett, 2012; Dickson, Walker, & Bourgeois, 2006; Duffy & Watson, 2001). In addition to different models, many countries utilize staff nurses as primary teachers of nursing students versus faculty employed at educational institutions (Chuan

& Barnett, 2012; Dickson, Walker, & Bourgeois, 2006). Determining ways in which this same environment impacts faculty's ability to facilitate learning remains important to investigate as these perspectives can lead to improvements regarding the clinical instruction of nursing students.

Problem Statement

Based on trends in nursing education impacting clinical experiences and the preparation of nursing students, obtaining nursing faculty perspectives regarding the process utilized when facilitating student learning in the clinical environment was necessary to determine ways in which the traditional clinical model and acute care setting impact faculty's ability to prepare students for practice. While researchers have investigated clinical environmental influences and multiple clinical instructional models with other stakeholders, including nursing students (O'Mara et al., 2014), new nurse graduates (Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007), and registered nurses (Nishioka, Coe, Hanita, & Moscato, 2014a), this viewpoint needed further exploration from the nursing faculty perspective. Due to the lack of an existing framework describing the process faculty utilize when instructing students in the acute care setting, a grounded theory study was conducted to determine influencing factors and phases nursing faculty experience when instructing students in the acute care setting while utilizing the traditional clinical model.

Purpose of the Study

The purpose of this study was to construct an emerging theory describing the process nursing faculty in Midwestern Bachelor of Science in Nursing (BSN) education programs utilize when facilitating student learning in the acute care setting while using the traditional clinical model of instruction.

Research Questions

Due to recent trends, nursing education programs have started investigating alternative clinical education models. Insight from nursing faculty regarding the process utilized when facilitating student learning while using the traditional clinical model in the acute care setting was necessary to identify strengths and weaknesses of this model and environment. Understanding these strengths and weaknesses can shed light on needed improvements to the current structure of clinical education. After integrating

recommendations from Charmaz (2006, 2014) regarding the grounded theory methodology, this study investigated the following central research question and subquestions of interest:

Central Question. What process do nursing faculty at Midwestern BSN programs utilize when facilitating student learning using the traditional clinical model in the acute care setting?

Intrinsic to this question were the following subquestions requiring investigation:

Subquestion 1. How do Midwestern BSN faculty facilitate student learning in the acute care setting when utilizing the traditional clinical model?

Subquestion 2. How does the traditional clinical model of instruction influence Midwestern BSN program faculty when facilitating student learning in the acute care setting?

Subquestion 3. How does the acute care setting influence Midwestern BSN faculty when facilitating student learning?

Subquestion 4. What other factors assist or inhibit Midwestern BSN faculty when facilitating student learning in the acute care setting?

Subquestion 5. How do Midwestern BSN faculty determine when effective facilitation of student learning has occurred after providing instruction in the acute care setting?

Theoretical Influences

Prior knowledge of the literature by the researcher led to the discovery of influencing theoretical perspectives identifying possible concepts impacting the process faculty utilize when facilitating learning in the acute care setting. These perspectives are introduced here and further elaborated on in chapter two. Traditionally, researching and discussing prior developed theoretical perspectives and frameworks when conducting grounded theory studies is discouraged as the goal of this methodology is to construct an emerging theory from data that provides the framework for the study of interest (Charmaz, 2006; Strauss & Corbin, 1998); however, as Charmaz (2006) states, researchers often obtain information, including theoretical perspectives, from the literature pertaining to the research area of interest prior to conducting grounded theory studies. These influencing frameworks provided a starting point for the researcher by introducing “sensitizing concepts” possibly influencing the process of interest (Charmaz, 2014, p. 30).

Grounded theory experts warn that these concepts should not drive the research but rather be utilized as a starting point with the data driving the remainder of the study (Charmaz, 2014; Corbin & Strauss, 2015), which this researcher abided by while conducting this particular grounded theory study.

When initially investigating theoretical perspectives possibly explaining the process faculty utilize when facilitating clinical learning, two theoretical frameworks were found relating to this topic. After further investigation, both frameworks were found to have notable gaps lacking a full explanation of this process. These two frameworks included Social Constructivism (Vygotsky, 1978) and the Behavioral Environment Theory (Lewin, 1936/2015). Social Constructivism focuses on the importance of scaffolding which involves faculty assisting students in building upon foundational knowledge throughout educational programs (Vygotsky, 1978). The goal of nursing faculty is to assist students in applying prior knowledge and theory learned in the classroom into practice when caring for patients which connects well with the concept of scaffolding. The other component of this framework relating to clinical education is the importance of learning in social settings (Vygotsky, 1978). Nursing faculty must negotiate many relationships while instructing students in the clinical environment as collaborating with multiple healthcare professionals is required when providing patient care.

Two branches of Social Constructivism (Vygotsky, 1978) include the Situated Cognition (Hansman, 2001) and Cognitive Apprenticeship models (Brown, Collins, & Dugoid, 1989) which both highlight the importance of engaging students in realistic workplace experiences to promote application of material and prepare students for professional workplace demands. This also relates to nursing faculty as instructing students in the clinical environment involves promoting the application of theory in an actual workplace setting.

In addition, the Cognitive Apprenticeship model (Brown, Collins, & Dugoid, 1989) describes various techniques teachers utilize to foster deep metacognitive thinking processes, including reflection, to assess if students are appropriately applying theoretical knowledge to practice. This model also explains that a lack of workplace learning experiences could lead to students entering the profession ill prepared for practice. Furthermore, this model provides a possible reason for the lack of preparation many

nursing faculty encounter when first entering the role. As stated earlier, many faculty enter the nursing education field with a lack of educational and workplace preparation pertaining to the faculty role, possibly impacting the ability to effectively facilitate learning in the clinical setting (Cangelosi, Crocker, & Sorrell, 2009; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013; Schoening, 2013). Other studies have investigated role strain experienced by nursing faculty while balancing classroom and clinical obligations which could also impact the facilitation of learning process (Oermann, 1998; Piscopo, 1994). Again, these concepts provided a starting point for investigating factors potentially influencing the process faculty utilize when facilitating learning; however, these concepts did not drive the research as concepts brought up by participants were investigated throughout this study (Charmaz, 2014; Corbin & Strauss, 2015).

The second influencing framework, the Behavioral-Environment Theory (Lewin, 1936/2015), describes that environmental surroundings directly impact a person's behavior. Murray (1939/2008) expanded upon this theory by developing the Need-Press model, stating that environmental "presses" can either assist or challenge people in achieving goals, or "needs" (p. 42). As stated earlier, Moos (1973) developed the classroom learning environment concept which was influenced by both Lewin's (1936/2015) framework and Murray's (1939/2008) model, describing that elements including relationships and instructional strategies impact student learning when in the classroom setting. Since that time, multiple researchers have investigated and developed tools to assess the clinical learning environment and its impact on student development (Dunn & Burnett, 1995; Sand-Jecklin, 2009). Though Lewin's (1936/2015) Behavioral-Environment Theory describes that the environment influences a person's behavior, a grounded theory study was necessary to determine specific acute care environmental factors influencing the process nursing faculty utilize when facilitating student learning.

These frameworks, along with the clinical learning environment concept analysis discussed previously (Flott & Linden, 2016), suggested several influencing concepts potentially impacting and describing the process nursing faculty utilize when facilitating learning in the clinical environment. This grounded theory study was conducted to bridge the gap noted with these two theoretical perspectives by investigating strategies faculty utilize when facilitating student learning and determining influential

factors presented by the acute care environment, TCM of instruction, and other additional factors affecting this process.

Operational Definition of Terms

The following list includes operational definitions of terms and phrases frequently used throughout this study. These are explicitly defined to clarify the context of these terms.

Acute care setting. The acute care setting describes a clinical learning environment where Midwestern BSN faculty instruct nursing students who provide care to patients admitted for short-term [acute] purposes, including treatment of medical conditions or trauma, and primarily includes hospitals (Merriam-Webster, n.d.).

Clinical learning environment. For this study, the clinical learning environment involved an acute care setting where Midwestern BSN faculty facilitated learning and nursing students applied theory to practice by conducting patient care. This environment contains elements influencing student learning including the physical space, psychosocial and interpersonal interactions, teaching and learning components, and the organizational culture (Bloomfield & Subramaniam, 2008; Chan, 2002; Dunn & Barnett, 1995; Flott & Linden, 2016; Hosoda, 2006; Newton, Jolly, Ockerby, & Cross, 2010).

Facilitation of learning. Facilitation of learning was defined as Midwestern BSN faculty working with nursing students to apply theory to practice and assist in achievement of learning outcomes. Both parties were expected to work together in a respectful manner while nursing students took part in providing patient care in the acute care setting (Burrows, 1997).

BSN faculty. A registered nurse (RN) with a full-time or part-time appointment in a Midwestern BSN program. Full-time or part-time status was defined as a nursing faculty member having at least a one-year long contractual teaching agreement with a nursing program and meeting the definition of a full-time or part-time employee set forth by the institution of employment. For this study, nursing faculty needed to, for at least a portion of the teaching role, provide clinical instruction in the acute care setting utilizing the traditional clinical model (DeMeester, 2012).

Nursing student. Someone enrolled in a prelicensure Midwestern BSN education program (DeMeester, 2012).

Process. For this study, the term process referred to the series of steps or actions Midwestern BSN faculty utilized to facilitate student learning in the acute care setting while using the traditional clinical model of instruction (Merriam-Webster, n.d.).

Student learning. A growth in nursing student knowledge, skills, and higher-level thought processes demonstrating progression in meeting outlined learning objectives and outcomes that were assessed and evaluated in the acute care setting by Midwestern BSN faculty (NBTPS, 2011).

Traditional clinical model. A clinical model of instruction in which a group of BSN prelicensure nursing students were instructed on one unit in an acute care setting by a nursing faculty member from the same Midwestern BSN program (DeMeester, 2012).

Assumptions, Limitations, Delimitations

The following section describes assumptions the researcher made regarding this study, limitations of the study, and delimitations chosen by the researcher when conducting this grounded theory study.

Assumptions. The researcher assumed all participants would be honest and thorough when providing answers to interview questions for this study. Participation was completely voluntary and measures were put in place to protect confidentiality. Confidentiality and informed consent procedures were shared with all participants and were meant to assist in promoting comprehensive responses needed for the study. Another assumption made was that nursing faculty were influenced by the TCM and acute care setting when facilitating student learning. These assumptions were made based on a review of the literature and prior knowledge of theoretical influences discussed previously. It was also assumed participants would provide examples and describe the process utilized when facilitating learning in the acute care setting while using the TCM of instruction. A final assumption was that nursing faculty participants took an active role when facilitating learning during clinical education experiences and that participants would elaborate on strategies utilized when facilitating learning in the acute care setting.

Limitations. Due to the qualitative nature of this study, generalizability was not obtained nor desired with the results. The goal of this study was to construct a theory representing the process Midwestern BSN faculty utilize when facilitating learning in the acute care setting using the TCM. The findings and theory generated from this study only represent those experiences obtained from the study sample which included full-time or part-time BSN prelicensure faculty from two Midwestern states who conducted clinical instruction in the acute care setting. Recruitment was conducted via email involving selected nursing programs and was dependent upon potential participants receiving and responding to the sent emails. Even though varying levels of experience and multiple acute care unit specialties were represented, all participants were female. No male faculty responded to participate and this perspective may differ from findings generated by this study. Also, nursing faculty from other states may have differing experiences when facilitating clinical learning. Another limitation involved the researcher's ability to accurately represent participants' thoughts and experiences when performing data analysis. Measures were put in place to assist in validating participant accounts of experiences; however, there is always the potential for researcher bias to occur (Creswell, 2013).

Delimitations. The first delimitation was the recruitment of only full-time or part-time faculty members in Midwestern BSN education programs. This study did not seek insight from adjunct faculty, which includes faculty members with short-term contractual teaching agreements, typically a semester in length (Sanderson & Lea, 2012). Adjunct faculty typically include staff nurses who work in a clinical setting while taking on the additional role of instructing students in the clinical environment on a short-term basis (Sanderson & Lea, 2012). Participants did not represent other degree programs including associate degree or licensed practical nursing programs. This was due to a lack of research specifically investigating the process BSN faculty members utilize when teaching in the clinical environment. The participants also needed to have at least one year of teaching experience to be eligible for this study.

The final delimitation involved the need for participants to provide clinical instruction utilizing the TCM in the acute care setting, which primarily includes hospitals. Again, all delimitations were meant to gain consistent information regarding the process faculty utilize when facilitating learning in a specific

clinical environment. This emergent theory could be utilized in the future to determine nursing faculty facilitation processes when instructing in other environments, such as the community setting, and when utilizing other clinical models, including preceptorship.

Significance of Study

With the changing face of healthcare comes a need to re-evaluate the preparation of nursing students especially in regards to clinical instruction (Benner, Sutphen, Leonard, & Day, 2010). Without suitable preparation of new nurse graduates patient care will suffer and the nursing shortage will continue to grow as graduates experience stress and exit the profession prematurely (Bowles & Candela, 2005; Ulrich et al., 2011; Welding, 2011). Even with new clinical models emerging, there was a noted lack of research investigating the process faculty utilize when facilitating learning with the TCM in acute care settings.

Multiple studies highlighted student perspectives concerning influences of the clinical learning environment and clinical models on the ability to learn in the clinical setting (Dunn & Burnett, 1995; Hosoda, 2006; Rhodes, Meyers, & Underhill, 2012). A consistent finding among all studies was that the person responsible for instruction greatly influences students' ability to learn and meet clinical outcomes. It was determined that further insight regarding faculty needs when providing clinical instruction was necessary to provide insight regarding needed improvements in clinical education and ensure students receive the educational foundation necessary for practice. As Budgen and Gamroth (2008) state, "A thorough understanding of current models can support new developments and protect against replication of old problems" (p. 281). This understanding must include nursing faculty perspectives and input.

Organization of Study

The next chapter includes a detailed discussion of the theoretical underpinnings for this study along with an extensive review of relevant literature. This literature review includes studies representing multiple perspectives regarding a variety of clinical education models and research related to the experience of instructing students in the clinical environment. The third chapter describes the study design, including details regarding the grounded theory methodology, information about participants, and

data collection and analysis procedures. The fourth chapter includes results from the study and a detailed description of the developed theory with the final chapter drawing conclusions from the results, tying these back to the literature review, and providing implications for practice and future research.

Summary

This chapter outlined the importance of clinical learning environment experiences in nursing education programs and the need to understand the process faculty utilize when facilitating learning while using the TCM of instruction in acute care settings. Background regarding the problem of interest was provided along with a detailed problem statement, purpose statement, research questions, and study significance. Assumptions, delimitations, and limitations were explained along with operational definitions of terms to offer a context for framing this area of interest. With the evolution of healthcare, researchers need to ensure all stakeholders involved in nursing education, including nursing faculty, have the opportunity to illuminate strengths and areas for improvement regarding the provision of clinical instruction to best prepare students for the nursing role.

CHAPTER TWO: REVIEW OF THE LITERATURE

A lack of research exploring nursing faculty's experience when facilitating student learning in the clinical setting was noted while conducting this literature review. In this chapter, a history regarding the provision of clinical instruction is provided. Next, two influencing theoretical perspectives and frameworks are described. As stated previously, grounded theory studies typically do not reference theoretical frameworks or perspectives; however, it was determined by the researcher that acknowledging these frameworks was important as both alluded to potential sensitizing concepts impacting the process of interest (Charmaz, 2006, 2014). Due to these potential influences, Social Constructivism (Vygotsky, 1978) and the Behavioral-Environment Theory (Lewin, 1936/2015) are discussed in detail. Relationships regarding the research area of interest and concepts provided by these frameworks are described while emphasizing existing gaps these frameworks did not account for, which this grounded theory study addressed.

A review of related literature is then presented that summarizes research conducted on the sensitizing concepts introduced in chapter one, including ways in which the clinical environment impacts student learning, multiple stakeholder perspectives regarding various clinical education models, strategies faculty utilize when facilitating learning, and factors impacting the faculty role when teaching in the clinical environment. Throughout all the literature, multiple viewpoints were represented regarding clinical education, including those of nursing students (Levett-Jones & Lathlean, 2009), managers at healthcare facilities where clinical instruction occurs (Henderson, Briggs, Schoonbeek, & Paterson, 2011), and staff nurses working with students during clinical experiences (Billett, 2007; Hafler, 2011). After conducting this literature review, it was determined that a study was necessary to further investigate this topic from the nursing faculty perspective. Without gaining this perspective, determining whether future clinical models could alleviate challenges presented by current models of clinical instruction would prove difficult.

History of Clinical Instruction in Nursing Education Programs

The structure of clinical education in nursing programs throughout this country has essentially remained unchanged since the 1930s and, as stated in chapter one, no research was found supporting the TCM of instruction (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010). This model sufficed for decades, but, with recent trends in nursing education and changing healthcare systems, nursing programs need to investigate different clinical models and experiences to ensure student preparation for practice (Ironside & McNelis, 2010; Tanner, 2006).

In 1970, Lysaught's book, *An Abstract for Action,* described a national study investigating the state of nursing education programs at that time and provided recommendations for the future. Lysaught (1970) reported the study results from the National Commission for the Study of Nursing and Nursing Education. This involved twelve individuals conducting site visits, meetings, and seminars in nursing education programs across the country. Lysaught (1970) was highly in favor of nursing education programs focusing more on technical skills professional nurses would need to execute, including performing procedures and titrating intravenous medications, while viewing the compassionate and nurturing side of nursing as separate and nonessential (Benner, Sutphen, Leonard, & Day, 2010; Lysaught, 1970). The study also recommended future research should investigate nursing education practices and that curricula be revised and improved based upon those research results (Lysaught, 1970; Gruendemann, 1971).

It was not until 40 years later that another study thoroughly investigating the structure of nursing education programs was completed when Benner, Sutphen, Leonard, and Day (2010) published their seminal book, *Educating Nurses: A Call for Radical Transformation.* This study was part of the Carnegie Foundation for the Advancement of Teaching's Preparation for the Professions Program group of studies. The authors performed classroom observations, interviewed nursing educators and students, and conducted a national survey with members of the National Student Nurses' Association. This text described the many ways healthcare has changed since Lysaught's (1970) publication, emphasizing that nursing programs have done little to incorporate these changes into nursing curricula which has left

students unprepared for the demands of clinical practice. Compared to 30 years ago, nurses today care for patients with complex diseases that often require challenging treatment regimens and "multiple intrusive technologies" (Benner, Sutphen, Leonard, & Day, 2010, p. 1). These advances in technology have increased the average lifespan of individuals over the past few decades. While the nursing profession has incorporated these increasingly difficult responsibilities over the years, the margin for error has simultaneously reduced, with healthcare delivery systems and national organizations requiring that protocols be implemented to reduce adverse patient outcomes including hospital-acquired infections (Benner, Sutphen, Leonard & Day, 2010). With these advanced technologies comes a need for nurses to have both technical skills and the nurturing aspect of nursing, as effective communication is required for nurses to provide safe patient care (Benner, Sutphen, Leonard, & Day, 2010).

As the authors state, "a major finding of our study is that a significant gap exists between today's nursing practice and the education for that practice, despite some considerable strengths in nursing education" (Benner, Sutphen, Leonard, & Day, 2010, p. 4). With more nursing students, fewer nursing faculty, and changes in the healthcare system, reforms in the delivery of classroom and clinical instruction are needed. In regards to clinical instruction, the authors, together with the AACN and NLN, conducted national surveys finding clinical instructors struggling with the number of students in clinical rotations. This number often ranges from eight to ten students, creating difficulty for faculty when trying to spend adequate time facilitating and evaluating student learning, including integrating clinical reasoning, critical thinking, prioritization, and time management skills (Benner, Sutphen, Leonard, & Day, 2010). These findings correlate with a descriptive survey study conducted by Ironside and McNelis (2010) which discovered that faculty felt providing appropriate guidance and supervision to each student was the biggest challenge when providing clinical instruction.

These studies, along with recommendations provided by the NLN (2005) and AACN (2002) conclude that changes are needed regarding the clinical education structure to adequately prepare nursing students for practice while addressing trends that will likely continue into the foreseeable future. Some recommendations provided by the researchers include integrating clinical learning experiences in the

classroom setting. In addition, it was recommended to incorporate multiple evaluation methods when conducting clinical instruction, such as integrating simulation scenarios, which utilizes mannequins and computerized situations that mimic actual patient responses. Also recommended was the possibility of creating a performance aspect of the national nursing licensure examination, as currently, students are only required to take a computerized examination to obtain a registered nurse license (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010; Jeffries, 2005; NCSBN, 2014).

The literature review presented in this chapter summarizes additional research addressing multiple clinical education models, ways in which the clinical environment impacts student learning, and the role of faculty in nursing education programs. In addition, theoretical influences are described that were thought to possibly connect with the process faculty utilize when providing clinical instruction.

Theoretical Influences

As introduced in chapter one, two theoretical perspectives influenced and introduced concepts of interest regarding this research study. These frameworks included the Social Constructivism Theory (Vygotsky, 1978) and Lewin's (1936/2015) Behavioral-Environment Theory. Social Constructivism, particularly the related models of Situated Cognition and Cognitive Apprenticeship, assisted in describing potential teaching strategies faculty utilize when facilitating student learning in the clinical environment. Connecting with this, the Behavioral-Environment Theory (Lewin, 1936/2015), which suggests that a person's behavior is a function of both the state of the person and environment, described the potential impact the clinical environment could partake on a faculty member's ability to facilitate student learning. Separately, these frameworks describe potential teaching strategies and environmental influences faculty utilize and experience when facilitating learning in the clinical environment; however, a gap still existed regarding how these frameworks specifically linked with the process nursing faculty utilized when facilitating learning in the acute care setting.

Social Constructivism Theory. Social Constructivism is part of the overall constructivism learning theory (Vygotsky, 1978). Constructivism is comprised of scaffolding learning which involves faculty assisting students in acquiring new knowledge by building upon foundational concepts (Hafler,

2011). Scaffolding is required in the clinical learning environment as nursing students are given foundational knowledge in the classroom which must be applied and individualized when providing patient care. It is not enough to simply understand disease processes as students must connect that information to specific patient medications, laboratory values, and necessary patient interventions (Nickle, 2007). Social Constructivism also states that learning occurs in social settings which is true of the clinical learning environment (Vygotsky, 1978). Nursing faculty are surrounded by not only students but healthcare staff, nurses, physicians, managers, and patients while facilitating learning, adding to the intricacy of the faculty role. Collaboration among healthcare members allows students to experience different viewpoints and learn from others while applying classroom knowledge to the practice setting (Nickle, 2007) but could provide nursing faculty challenges when facilitating student learning. Two branches of Social Constructivism (Vygotsky, 1978) were determined to possibly apply to nursing faculty when facilitating learning in the clinical environment and included the Situated Cognition (Hansman, 2001) and Cognitive Apprenticeship models (Brown, Collins, & Dugoid, 1989).

Situated Cognition. Hansman (2001) described the theoretical model of Situated Cognition in the context of workplace learning. This model is rooted in Vygotsky's (1978) Social Constructivism theory, which states that the true meaning of a situation should be obtained and learned in authentic and realistic contexts (Hansman, 2001). This model pertains not only to the facilitation of student learning but the preparation faculty receive when transitioning to the field of nursing education.

Facilitation of student learning. Only so much can be learned in the classroom, as true application of nursing knowledge involves interacting with other healthcare professionals and caring for patients in the clinical learning environment (Hansman, 2001; Nickle 2007). The clinical learning environment requires students to bring all knowledge together and place it in the context of a realistic workplace setting when caring for patients as individuals. Nursing faculty must ensure students view patient data in a comprehensive manner while anticipating nursing interventions and promoting positive outcomes (Brown, Collins, & Dugoid, 1989). As an example, Woolley and Jarvis (2007) utilized the Situated Cognition model when teaching skills to nursing students, including proper medication

administration. This involved instructing students to anticipate medication results and patient side effects, promoting application of knowledge and critical thinking, rather than simply reinforcing the kinesthetic procedure of the actual skill. Encouraging application of knowledge and evaluating student performance in this true and authentic environment is, ultimately, nursing faculty's goal, and confirms that students can transition into the professional nurse role safely. Benner, Sutphen, Leonard, and Day (2010) also described the importance of integrating Situated Cognition when providing clinical instruction by including the context of presenting situations into the learning experience.

Nursing faculty preparation for facilitator role. Another perspective of Situated Cognition and its influence on faculty involves the lack of education and preparation many faculty experience when transitioning into the nursing educator role. Many faculty are hired with little education preparing them for the faculty role which was determined to possibly affect facilitation of clinical learning (Cangelosi, Crocker, & Sorrell, 2009; Lasater & Nielsen 2009b; Schoening, 2013). Nursing faculty tend to teach as they were taught, even though today's healthcare environment varies greatly from when faculty received nursing degrees (Ironside & McNelis, 2010). In Schoening's (2013) grounded theory study investigating the transition from clinical nurse to nursing educator, the majority of participants felt formal courses or education would have helped with this transition, better preparing them to facilitate student learning. This aligns with Hansman's (2001) discussion regarding teaching university-level writing courses with no prior experience in the field. Even after attending conferences and workshops meant to prepare the author for a new teaching assignment, it was not until classes were conducted, assignments graded, and discussions with colleagues occurred that the true role of teaching writing to college-level students was integrated into practice. Until experiencing the culture and context of this environment, Hansman (2001) did not fully grasp the role and responsibilities needed to be successful, similar to research investigating the transition from a clinical nurse to nursing educator.

Cognitive Apprenticeship. Another branch of Social Constructivism includes the Cognitive Apprenticeship model (Brown, Collins, & Dugoid, 1989). Traditional apprenticeship involves novices, such as students, learning directly from experts in the workplace of interest (Brown, Collins, & Dugoid,

1989; Collins, Brown, & Holum, 1991). The difference between traditional and cognitive apprenticeship involves the goal of stimulating higher-order thinking while novices gain experience in this workplace environmental context (Brown, Collins, & Dugoid, 1989; Nickle 2007). This is exactly the task set before nursing faculty when bringing students into a clinical learning environment. The goal is for students to not only learn skills or tasks but to dig into the metacognitive, or higher-order, aspects of thinking. This requires students to anticipate potential patient complications, plan interventions, and reflect on the effectiveness of those interventions, all integral aspects of performing safe patient care. Four specific pedagogical items were highlighted with this model and include content, method, sequencing, and sociology (Brown, Collins, & Dugoid, 1989).

Content. Different types of content are acquired throughout educational programs according to the Cognitive Apprenticeship Model (Collins, Brown, & Holum, 1991). Domain knowledge content, or foundational knowledge, is learned in the classroom setting, then carried over into the workplace learning environment where students are provided opportunities to apply this knowledge to real-world experiences (Hafler, 2011). This is similar to nursing programs which teach students foundational concepts in the classroom and anticipate application of this knowledge when caring for patients in the clinical environment. Another type of content, heuristic knowledge content, involves working with experts to problem-solve situations not inherently explained through textbooks (Collins, Brown, & Holum, 1991). Faculty are supposed to guide students through this process when unfamiliar situations arise, as it is impossible to prepare students for every potential situation prior to entering the clinical setting (Nickle, 2007). This heuristic knowledge content should continue to grow with experience and exposure.

Control content includes strategies instructors implement to foster student growth and decision-making skills (Collins, Brown, & Holum, 1991). This control content allows students to determine possible solutions when faced with problems by obtaining expert opinion, anticipating complications, or looking up additional information to determine courses of action (Collins, Brown, & Holum, 1991; Nickle, 2007). Finally, teaching strategies should be used by instructors to continue developing students into problem-solvers, asking students for specific steps necessary when faced with questionable

situations. When connecting all of these content areas together, instructors can then evaluate whether students display appropriate decision-making skills necessary to function in the workplace.

Method. Method involves actual activities and teaching strategies used to enhance student learning and develop higher-level thinking while in the workplace environment (Hansman, 2001; Nickle, 2007). As Taylor and Care (1999) state, "Effective teaching methods depend crucially on interactions between the individual's current knowledge and beliefs, the social and physical environment in which the problem takes place, and the local details of the problem solving itself as it unfolds" (p. 4). This applies to nursing students who must bring foundational knowledge to the clinical setting and apply this knowledge while problem-solving patient scenarios in a social environment.

Coaching is one teaching method described by Collins, Brown, and Holum (1991) which remains the most significant method when facilitating student learning, as the authors stressed, "Coaching is the thread running through the entire apprenticeship experience" (p. 8). Coaching is also described as the signature pedagogy of nursing education (Benner, Sutphen, Leonard, & Day, 2010). The literature cites that faculty should strive to coach students by providing feedback regarding performance and offering simple cues if tasks or patient changes go unnoticed (Collins, Brown, & Holum, 1991; Nickle, 2007). This involves stepping back and observing students go through metacognitive processes when performing patient care and making decisions about interventions. Stepping in and completing tasks for students is counterproductive to coaching and does not assist in developing higher-order thought processes (Nickle, 2007). Development of this metacognitive thinking is vital as competencies professional nurses perform are highly complex in nature and require higher-level thinking (Taylor & Care, 1999). The healthcare industry is admitting higher acuity patients and technology allows for completion of interventions to occur at a much faster pace. Because of these trends, consistent coaching was described as an essential method to foster problem-solving strategies and metacognitive thinking among students (Nickle, 2007).

Other teaching methods besides coaching include modelling, scaffolding, fading, articulation, reflection, and exploration (Brown, Collins, & Dugoid, 1989). Modelling involves students observing experts perform procedures which provides students a frame of reference when first experiencing

situations or processes (Collins, Brown, & Holum, 1991; Nickle, 2007). Hansman (2001) discussed the importance of verbalizing thought processes and reasoning skills while modelling tasks or procedures, again, providing a conceptual base for students to develop further problem-solving skills. Scaffolding and fading involve understanding the amount of support students require when completing tasks. Specific to the Cognitive Apprenticeship Model, scaffolding involves stepping in and assisting students which should eventually lessen as students gain more competence and self-efficacy throughout educational programs. Stepping back and giving students the full experience, termed fading, then becomes the more common approach. Each student is different in regards to the time required in attaining self-efficacy and these individual differences must be acknowledged when providing instruction (Collins, Brown, & Holum, 1991; Nickle, 2007). Due to these differences, instructors may provide varying amounts of scaffolding and fading to multiple students, increasing the complexity of teaching in this environment.

The concept of stepping back and allowing students to become more independent also connects to the Gradual Release framework developed by Fisher and Frey (2014) which is utilized in the field of education. The authors described the need for faculty to gradually decrease support provided to students. After the instructor provides foundational material while modeling appropriate responses and behaviors, students then gradually learn to collaborate with each other when problem-solving and eventually work independently with minimal prompting and support from the instructor. This has application to nursing education, as the goal for faculty is to transition students from dependent observers to independent new nurse graduates.

In addition, scaffolding and fading were methods highlighted in a grounded theory study by Parker and Myrick (2012) who were interested in nursing student and faculty experiences when utilizing simulation as a teaching strategy. Simulation is the use of high-fidelity mannequins that can be programmed to mimic actual patient responses and provides students opportunities to participate in patient care while removing the fear of harming actual living patients (Jeffries, 2005; NCSBN, 2005). Parker and Myrick (2012) discovered that faculty utilized “fading support” and “adaptive scaffolding” when utilizing simulation with students (p. 367). Nursing faculty gradually removed student support as

the learners became more comfortable and confident in carrying out tasks and responsibilities. This research provided some initial concepts to investigate regarding the process of interest in this study; however, key differences regarding the simulation environment and acute care setting were noted. For example, in the simulation setting, faculty have control over mannequin responses and simulated learning experiences which is very different from the acute care setting where patient experiences are often unpredictable (Ganley & Linnard-Palmer, 2012; Parker & Myrick, 2012).

Articulation, exploration, and reflection are the final methods described that promote integration of higher-level thought processes. Articulation involves students verbalizing actions when determining decisions which can be fostered through higher-level questioning and written assignments (Collins, Brown, & Holum, 1991; Taylor & Care, 1999). This method brings to life metacognitive skills and confirms that appropriate problem-solving strategies necessary for practice are present. Exploration involves pushing students through problem-solving processes when faced with complex situations (Collins, Brown, & Holum, 1991; Taylor & Care, 1999). Questioning students about particular strategies utilized when presented with multifaceted circumstances is helpful to foster exploration throughout educational programs. Finally, reflection involves evaluating choices made after completion of assignments and tasks along with discussing meaningful events that occurred during the learning experience. Reflection has been highlighted in the nursing education literature as a teaching strategy that is often integrated into post-conference sessions where faculty and students discuss events of the clinical day as a group (Coddington, 2013; Letizia & Jennrich, 1998; Megel, Nelson, Black, Vogel, & Uphoff, 2013). Journaling, or writing out thought processes, also allows students to reflect on decisions made when caring for patients, and is another teaching strategy promoting reflection practices (Burrows, 1997; Jaeger, 2012). These activities are usually completed after patient care is finished and students are removed from the stressful clinical environment, allowing time for self-assessment (Burrows, 1997; Jaeger, 2012).

Sequencing. Sequencing involves providing learning opportunities appropriate to the level of the learner. This ensures learning experiences challenge students while avoiding overwhelming them which

can be counterproductive to the learning process (Collins, Brown, & Holum, 1991; Levett-Jones & Lathlean, 2009). Assigning overly complex problems to a student struggling with basic theoretical knowledge principles could easily overwhelm the student, leading to undue anxiety and resulting in a decrease in self-efficacy (Levett-Jones & Lathlean, 2009). Collins, Brown, and Holum (1991) described three general principles when sequencing learning experiences including teaching global before local skills, increasing the complexity of skills over time, and expanding the diversity of learning experiences.

Global concepts should be reinforced early on during educational programs followed by application of more specific principles once general concepts are mastered (Collins, Brown, & Holum, 1991). Nursing education literature alludes to this practice as well. For example, many students practice medication administration in a controlled laboratory setting prior to entering the clinical environment. This allows students the chance to master principles associated with a generalized skill before being approached with specific challenges, including administering medications via different routes, such as intravenous drugs (Taylor & Care, 1999; Nickle, 2007). Regarding increasing complexity, it is highlighted that students should not be overwhelmed with intricate skills but should become comfortable with basic concepts and build upon these over time (Collins, Brown, & Holum, 1991). Finally, increasing the diversity of experiences is promoted by ensuring students are comfortable in dealing with familiar situations prior to exposing them to more complex and diverse circumstances.

Sociology. The final component, sociology, involves immersing the student in the "community of practice," which is a group sharing similar interests, and becoming part of the social context of the workplace learning environment (Collins, Brown, & Holum, 1991; Hafler, 2011). Nursing students must communicate with healthcare staff, nurses, patients, and physicians when in the clinical setting as these interactions are required when practicing in this environment (Collins, Brown, & Holum, 1991). Students interact with these individuals in the clinical learning environment, observing and utilizing communication skills, applying problem-solving strategies to patient care, and dealing with realistic time management constraints afforded to professional nurses (Nickle, 2007). Working in this community of

practice (Wenger, 2009) can foster intrinsic motivation for students while highlighting the importance of cooperation when providing care in the clinical environment (Collins, Brown, & Holum, 1991).

The theoretical concepts introduced in the Situated Cognition and Cognitive Apprenticeship models describe some instructional methods that can be utilized when teaching in the workplace environment to foster higher-level, metacognitive thought processes; however, conducting this grounded theory study was deemed necessary to better understand the teaching methodologies and principles nursing faculty employ when facilitating learning in the acute care setting while using the TCM of instruction.

Behavioral-Environment Theory. Lewin's Behavioral-Environment Theory (1936/2015) was developed in the field of social psychology but contained implications for all faculty responsible for student learning. Lewin (1936/2015) states a person's behavior is both a function of the person and his or her surrounding environment. Nursing faculty's ultimate goal includes preparing students for professional practice by utilizing teaching and learning strategies meant to draw out metacognitive thought processes students require when providing patient care. As Lewin (1936/2015) concludes, the effectiveness of these strategies can depend upon the clinical environment where instruction is provided (Lewin, 1936/2015). Lewin (1936/2015) also highlighted the force-field concept which describes that elements in a person's environment either advance people toward achievement of a goal or hinder them from this progress. From this theoretical framework, Murray (1939/2008) developed the Need-Press personality model and Moos (1979) established the overarching concept of the classroom learning environment, both having implications for student learning in the clinical setting.

Need-Press Model. From the Behavioral-Environment Theory (Lewin, 1936/2015), Murray (1939/2008) postulated a Need-Press Model, discussing that both the environmental climate and a person's perceptions of that environment influences behavior (Letizia & Jennrich, 1998; Murray, 1939/2008). The Need-Press Model is broadly known as a personality theory describing that environmental factors or "presses" impact the ability for people to achieve identified "needs" (Murray, 1939/2008, p. 42). These needs vary for each individual; however, a few stand out that correlate to the

role of nursing faculty when facilitating student learning. One need, termed *Ambition*, includes the associated goal of achievement and is described as becoming an expert in a particular field while overcoming obstacles to accomplish goals (Murray, 1939/2008). Another need is termed *Information* and includes the associated goals of education, or informing others, and cognizance, which involves seeking answers through questioning. These needs describe the goal of nursing faculty when working to prepare students for practice either of which may be challenged, or pressed, by the clinical learning environment.

Classroom learning environment concept. Based on the above models, Moos (1973) developed the concept of the classroom learning environment. Subsequently, Trickett and Moos (1973) created an instrument to evaluate this environment called the Classroom Environment Scale (CES). This research solidified that the environment where education was conducted directly impacted student learning. This was important as future research would determine the clinical environment also impacted student learning and the ability for students to meet learning outcomes. Conceptual components of the classroom learning environment included three separate dimensions (Letizia & Jennrich, 1998; Moos, 1973). The relationship dimension describes personal relationships encountered in the environment along with help and support offered to students, while the personal development dimension explains the impact instructional strategies have on student learning. Finally, the system maintenance and change dimension measures ways in which organization of the classroom and clarity of roles and responsibilities impact the learning experience (Letizia & Jennrich, 1998; Moos, 1973).

Clinical learning environment concept. Recently, a concept analysis of the clinical learning environment in nursing education was completed, determining that the physical structure, psychosocial and interaction factors, organizational culture, and teaching and learning components all impact student learning in this setting (Flott & Linden, 2016). Even though the location of these environments differ, Moos' (1973) conceptual elements, including relationships occurring in the classroom and the importance of employing effective instructional strategies, align with components of the clinical learning environment impacting student learning.

In the nursing education literature, Letizia and Jennrich (1998) applied Lewin's (1936/2015) Behavioral-Environment Theory to the post-conference portion of the TCM. Post-conference typically involves students and faculty conversing about events that occurred during the clinical day with faculty pointing out key learnings, providing reflective questioning opportunities, and ensuring students utilize critical thinking strategies to make connections among patient information. The researchers applied subscales of Trickett and Moos's (1973) CES tool to create a specific tool evaluating the clinical post-conference environment. This tool was later re-tested by another group of researchers (Megel, Nelson, Black, Vogel, & Uphoff, 2013), confirming the relevance Moos' (1973) learning environment concept has outside of the classroom setting.

It was evident these two overarching theoretical perspectives of Social Constructivism (Vygotsky, 1978) and the Behavioral-Environment Theory (Lewin, 1938/2015) described concepts possibly explaining the process nursing faculty utilize when facilitating clinical learning; however, with a lack of explanation regarding how these concepts and frameworks connect, this grounded theory study was deemed necessary to bridge this gap and obtain a better understanding of the entire facilitation of clinical learning process from the nursing faculty perspective.

Review of Relevant Research

Traditionally, with the grounded theory methodology, a literature review is discouraged as knowledge of prior studies could influence researchers when analyzing data and constructing the theory of interest (Corbin & Strauss, 2015; Strauss & Corbin, 1998); however, Charmaz (2014) points out that most researchers have an understanding of the literature regarding research topics of interest and that knowledge can assist in preventing the practice of "rehashing old empirical problems" (p. 306). Knowledge of prior research is often unavoidable; however, it remains important for the researcher to, despite this knowledge, remain open and reflexive to avoid letting the literature, "stifle your creativity or strangle your theory" when conducting grounded theory studies (Charmaz, 2014, p. 308).

A review of the literature regarding nursing education and clinical instruction is separated into four areas representing the sensitizing concepts first introduced in chapter one. These four areas include:

1) multiple stakeholder viewpoints regarding various clinical education models; 2) the clinical learning environment and this environment's influence on student learning; 3) research investigating teaching and learning strategies faculty utilize in the classroom and clinical settings; and 4) factors and experiences impacting the faculty role in nursing education. Upon review, there was a noted gap identified in the literature regarding the process nursing faculty utilize when facilitating learning in the acute care setting while using the TCM, prompting the need for this grounded theory study. The areas of the review of relevant literature and associated sensitizing concepts are visually depicted in Figure 1.

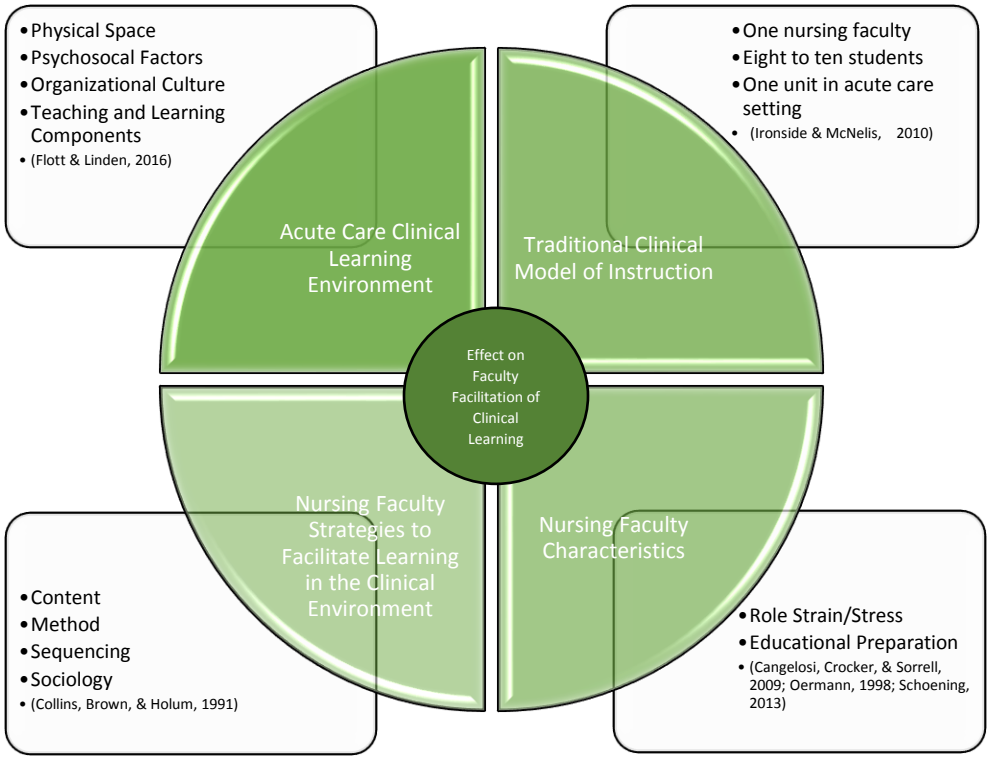

Figure 1. Initial Sensitizing Concepts Related to Faculty Facilitation of Clinical Learning

Perspectives concerning clinical education models. Teaching students in the clinical learning environment remains a major component of nursing education. This section summarizes research studies concerned with clinical education models, including the TCM, and newer models emerging due to changes in the healthcare field and trends impacting nursing education. These studies reflect different stakeholder perspectives and viewpoints, including nursing faculty, staff nurses, and nursing students.

Traditional clinical model. Research studies concerning the TCM are reviewed in two separate sections. The sections include perspectives of the clinical model while students participated in patient care and studies researching pre-clinical and post-conference assignments occurring before and after patient care begins and ends.

Experiences during the clinical day. Some research studies concerning the TCM focused on student and faculty experiences during the clinical day when students provided patient care and faculty instructed and evaluated student performance. When reviewing the literature, nursing faculty perspectives regarding the TCM were mainly evaluated through questionnaires or surveys utilizing a descriptive study design. A major descriptive study providing insight into faculty perceptions of challenges and barriers regarding the TCM was conducted by Ironside and McNelis (2010). A survey was e-mailed to nursing faculty who were members of the NLN. Over 2,300 responses were obtained with the majority of participants being full-time faculty members in associate degree nursing education programs. Nursing faculty were asked to identify barriers, or items faculty were unable to control regarding the clinical environment, and challenges, items partially under faculty control, from predetermined lists. The most frequently cited barrier was a lack of quality clinical sites available for students and most cited challenge was providing appropriate guidance and supervision to each student. Many of the respondents listed that 50-100% of faculty time was spent observing student tasks instead of fostering higher-level critical thinking development. Positive aspects of the TCM were not investigated.

A limitation of the study included the sample, as only NLN members were initially contacted. There was also some confusion regarding faculty's interpretation of survey items as certain answers represented challenges with managing the clinical day versus challenges with facilitation of learning, which was the original intent of the study. This study led to another publication where McNelis, Fonacier, McDonald, and Ironside (2011) explored the most cited barrier which involved a lack of quality clinical sites. This was not a formal study; however, the authors discussed the need for nursing programs to combat this barrier by implementing creative solutions when developing student clinical experiences.

Another similar descriptive survey study was completed in Canada with comparable findings noted (McFarlane, 2007). Nursing school representatives from all programs in the country were invited to complete the survey though not all participants were faculty members. All participants described barriers and strategies to overcoming identified barriers regarding nursing clinical education. Survey results revealed that a lack of quality clinical sites, shortage of nursing faculty, and increased competition when obtaining clinical facilities were common barriers, all similar trends the United States is experiencing. Again, faculty perspectives were not solely gathered and ways in which these barriers related to facilitation of student learning were not investigated.

In addition, the NLN (2008) conducted a descriptive study gathering faculty and board of nursing representative feedback regarding specific elements comprising clinical education, its importance, settings in which clinical education is conducted, and persons involved with clinical education in nursing programs. More than 2,200 responses were obtained with many participants teaching in associate degree nursing programs. Results indicated that clinical education experiences, particularly those involving direct patient care, remain important for the development of student nurses. The ideal clinical learning environment integrates knowledge, attitudes, and skills needed for professional practice and involves all stakeholders in the clinical setting. Opportunities for improvements were revealed, including faculty desiring more collaborative relationships with staff nurses, as these interactions impacted clinical education, though elaboration on this topic was not provided. Limitations included the sample, as only NLN members were invited to participate (NLN, 2008).

Though not a descriptive study, another group of researchers described a pilot project involving faculty developing potential clinical models by utilizing Kotter's change theory (Niederhauser, Schoessler, Gubrug-Howe, Magnussen, & Codier, 2012). Seven clinical challenges presented by the TCM were identified by faculty, but not all related to facilitation of learning and included barriers outside of faculty control, such as increased student enrollment with fewer clinical sites available. This report was interested in the change process faculty went through when developing new clinical models versus the facilitation of learning process faculty utilized in the acute care setting.

Besides faculty views, a number of studies examined student perspectives regarding the TCM. Ironside, McNelis, and Ebright (2014) conducted a qualitative study examining both faculty and student experiences with the TCM by performing observations and interviews. The researchers discovered faculty and students focused more on completion of patient tasks during the clinical day versus developing higher-order thinking skills. Students often identified completion of tasks as indicating a positive clinical experience. These findings also correlated with another qualitative study (Tiwari et al., 2005). The researchers performed focus interviews, finding that students were most concerned with memorizing steps necessary to properly complete skills or tasks that would be assessed by instructors rather than focusing on the importance of integrating theory into practice (Tiwari et al., 2005).

Regarding experiences during the clinical day, the above studies highlight mainly negative factors attributed to the TCM. Research investigating positive aspects of this model were lacking along with the model's impact on faculty facilitation of student learning.

Pre-clinical and post-conference research studies. In addition to direct patient care experiences, there are also pre-clinical and post-conference assignments students are required to complete with the TCM of instruction. The pre-clinical phase allows students to prepare for clinical experiences by researching assigned patient information, including disease processes and medications, prior to caring for patients the following clinical day. A dissertation involving a qualitative study was reviewed that investigated faculty and student perspectives regarding this pre-clinical phase of the TCM (Webster, 2006). Both groups expressed concerns regarding the amount of time needed to complete and grade this pre-assignment paperwork. From the faculty perspective, students appeared more self-confident and prepared when completing pre-clinical assignments. Even though this study did not focus specifically on strengths and weaknesses of the TCM, one finding from this study determined that students wished to spend more time with faculty when providing patient care during clinical experiences. Faculty supported this finding by stating there was not enough time to interact with students during the clinical day.

Regarding post-conference, one study evaluated student and faculty perspectives of the post-conference clinical environment (Letizia & Jennrich, 1998). This portion of the TCM generally occurs

after students have completed direct patient care. Students and faculty gather to discuss key learnings of the clinical day while faculty foster critical thinking by utilizing reflection and questioning techniques. A tool was created and modified from Tricket and Moos' (1973) Classroom Environment Scale to evaluate the post-conference environment and determine how important each element was to the learning experience from both faculty and student perspectives. Student and faculty ratings did not differ, with both groups rating the component of teacher support as most important when in this environment. This study was repeated a few years later with findings confirming that teacher support was the most important element when conducting post-conference sessions (Megel et al., 2013).

These studies highlight the importance of the faculty member in regards to student learning and that faculty availability can influence the student learning experience when in the clinical setting; however, the process nursing faculty utilize when facilitating learning while using the TCM were not fully represented when reviewing these studies. Some components potentially impacting this process were alluded to, including relationships with other healthcare professionals, but it was determined that closer examination of this process from the faculty perspective was necessary to gain insight regarding how this model specifically impacted facilitation of student learning in the acute care setting.

Other clinical models. Besides the TCM, other models of clinical instruction are emerging in response to the nursing faculty shortage, increase in nursing student enrollment, and a lack of available clinical sites (Ironside & McNelis, 2010). These models include simulation, where students care for simulated patients represented by mannequins or computerized scenarios; preceptorship, when nursing students are paired one-on-one with a practicing registered staff nurse for an extended period of time; and the dedicated education unit (DEU), which involves pairing one to two students with a staff nurse oriented to instructor responsibilities while a nursing faculty member facilitates clinical reasoning skills with students (Jeffries, 2005; NCSBN, 2014; Oermann, 2004; Moscato et al., 2007). Research concerning various stakeholders' perspectives regarding these models are presented and discussed.

Simulation. As stated, simulation involves nursing students caring for simulated patients that can be programmed to imitate actual patient responses, which is typically accomplished using mannequins, in

a controlled laboratory setting (Jeffries, 2005; NCSBN, 2014). Simulation can range from low fidelity experiences, such as case studies, to high fidelity, which is becoming more common, and involves the use of mannequins that can realistically respond to student interventions (Meakim et al., 2013). Benefits of this model include the inability for students to cause patient harm and the capability to expose students to complex scenarios that may not occur while in the acute care setting. This also allows faculty to evaluate nursing student critical thinking processes in a controlled manner (Jeffries, 2005; NCSBN, 2014). Due to constraints related to the nursing faculty shortage and difficulty finding clinical sites, more nursing programs are utilizing simulation to assist students in developing clinical and critical thinking skills. As an example, one nursing program increased simulation use to account for 50% of student clinical time which assisted in addressing the faculty shortage issue (Richardson, Gilmartin, & Fulmer, 2012).

Due to recent trends impacting clinical education, The National Council of State Boards of Nursing (NCSBN, 2014) conducted a longitudinal, randomized study involving ten prelicensure nursing programs to evaluate whether replacement of TCM experiences with high fidelity simulation impacted student learning outcomes, including national nursing examination (NCLEX) pass rates. Students from the ten programs were randomly assigned to one of three groups which had varied amounts of simulation hours. The control group had less than 10% of traditional clinical hours replaced with simulation while the experimental groups had either 25% or 50% of traditional hours replaced with simulation. At the end of a two-year period, no statistically significant differences were found when comparing all three groups in regards to learning outcome achievement. In addition to NCLEX pass rates, there were no statistically significant differences in regards to critical thinking development, which was evaluated using the Critical Thinking Diagnostic tool, and clinical competency, which was evaluated using multiple tools with established reliability, including the Creighton Competency Evaluation Instrument (NCSBN, 2014). This study determined that up to 50% of traditional clinical hours could be replaced with high quality simulation hours with no statistically significant impact on student learning outcomes. This has important implications as nursing programs consider alternative clinical experiences and models.

In addition, a dissertation study compared the TCM with simulation experiences by exploring students' perceptions of both models in a qualitative study (Breymeier, 2012). Results highlighted that students appreciated having a clinical instructor readily available in simulation versus the traditional model counterpart where support was more unpredictable and faculty were not always present to view student performance. Students in this study felt both models led to achievement of clinical learning outcomes and preparation for the professional nurse role (Breymeier, 2012).

Another study compared faculty and student perceptions of academic safety when in the simulation laboratory, which was defined as students experiencing a psychologically safe setting allowing for successful achievement of outcomes (Ganley & Linnard-Palmer, 2012). Data was gathered via a researcher-developed survey and results found significant differences between actual and ideal simulation experiences from the student perspective and between students' and faculty perceptions of student comfort in this setting. Students felt anxiety at a significantly higher level than faculty predicted, which often inhibited students' ability to develop critical thinking skills during simulation scenarios. Strategies for faculty were provided to improve learning experiences during simulation and included clearly explaining student expectations and ensuring proper orientation to the simulation setting occurred (Ganley & Linnard-Palmer, 2012).

Regarding faculty perceptions of simulation as a teaching strategy, one researcher conducted interviews with faculty and simulation coordinators discovering most participants perceived simulation as helpful in developing clinical reasoning skills (Jaeger, 2012). This study also discovered most participants felt debriefing was the most important component of simulation, which involves students and faculty reflecting on scenarios students participated in during the clinical day, as faculty discussed that this session further enhanced student learning.

Other studies reviewed focused on faculty acceptance and integration of simulation as a teaching modality in nursing education programs (Akhtar-Danesh, Baxter, Valaitis, Stanyon, & Sproul, 2009; Davis, Kimble, & Gunby, 2014); however, these studies did not address faculty perceptions of the

simulation model and its effect on student learning. Regarding simulation, both positive and negative aspects of this model were noted throughout the literature review.

Preceptorship. The preceptorship model involves students being paired one-on-one with a registered staff nurse in the clinical setting usually over the course of one semester (Budgen & Gamroth, 2008; Oermann, 2004). This is typically completed during the final year of a program to provide a consistent evaluator for the student and assist students in transitioning to the more independent new nurse graduate role (Oermann, 2004).

Regarding nursing faculty experiences with this model, one expository writing by Beeman (2001) discussed the role change involved when transitioning from the TCM into a preceptorship model. This transition involved relinquishing faculty control as students were now primarily taught by registered staff nurses. Even with the need to relinquish control, Beeman (2001) discussed faculty's need to provide increased support for preceptors as many were unfamiliar with how to facilitate student learning in the clinical setting. Having more time to discuss patient care with nursing students was a positive aspect of the model, as Beeman (2001) did not need to oversee all student activities on the unit.

The preceptorship model also aligned with a workplace learning conceptual framework focusing on the staff nurse role when instructing students in the clinical setting. Influenced by workplace learning frameworks developed for novice professionals (Billett, 2007) and frameworks focusing on faculty development in higher education (Caffarella & Zinn, 1999), Hafler (2011) provides suggestions for ways faculty can inform instructors in the workplace on proper teaching of students, including staff nurses taking on the preceptor role. This framework described barriers and supports workplace instructors might encounter when teaching students, including relationship factors, the amount of support provided by the educational institutions, and outside personal factors impacting instruction of students. In this framework, faculty's role involves developing the workplace instructor into an effective evaluator of student learning and assisting in sharing knowledge regarding how to effectively teach students. Hafler (2011) also discusses the influence of the informal, or hidden, curriculum in the workplace environment, by stating,

"the challenge for instructors is to see the strengths and limitations of this environment, acknowledge its presence, and work on optimizing the learning that can occur" (p. 294).

Additional research regarding the preceptorship model was conducted in other countries, including Sweden and Australia, and involved comparing the preceptorship model with other clinical models utilized in these respective countries. Researchers from Sweden performed qualitative interviews with staff nurse preceptors to gain perspectives regarding two types of preceptorship models (Mamhidir, Kristofferzon, Hellstrom-Hyson, Persson, & Martensson, 2014). It was discovered that utilization of a peer learning format where two to three students were paired with a staff nurse fostered better critical thinking compared to the standard preceptorship model. The studies concerning preceptorship did allude to the role change faculty experience when shifting from the primary instructor of students to more of a facilitator providing support for staff nurses; however, it was deemed necessary to determine the process faculty utilize when facilitating learning using the TCM, as literature addressing this process was lacking.

Dedicated education unit. The dedicated education unit (DEU) model started in Australia during the 1990s in response to a looming faculty shortage and the need for better preparation of nursing students, similar to trends this country is experiencing (Edgecombe, Wonda, Gotten, & Mason, 1999). This same model started emerging in the United States during the early 2000s (Moscato et al., 2007). With the DEU model, staff nurses are educated and oriented to the instructor role and paired with one to two students during a clinical rotation (Moscato et al., 2007). The nursing faculty member's role becomes one of evaluating and facilitating development of critical thinking and clinical reasoning skills while supporting staff nurses in the instructor role (Mulready-Shick, Flanagan, Banister, Mylott, & Curtin, 2013). Very few research studies have investigated faculty perspectives regarding this model, with many focusing on student and staff nurse perspectives.

One study solely investigating faculty experiences in the DEU was conducted by DeMeester (2013), whose dissertation explored the lived experience of faculty working in the DEU setting. This study focused on the transition faculty went through when shifting away from the TCM. This transition involved the need to enhance relationships with staff nurses and managers on units where the DEU was

implemented. Out of this study came stated advantages and disadvantages regarding the nursing faculty role when compared to the TCM. Disadvantages included relinquishing full control over the student learning experience, much as Beeman (2001) discussed in regards to the preceptorship model, and being unsure of the amount of time needed to spend on the acute care unit, as faculty were no longer required to stay with students the entire clinical shift. Advantages included spending more quality time with students and the one-on-one consistency and attention students received from staff nurse instructors.

A few other studies compared the DEU and TCM; however, nursing faculty were either not represented or had minimal input in the corresponding research. One study utilized a convenience sample of nursing students with random assignment to either a TCM or DEU model (Mulready-Shick, Flanagan, Banister, Mylott, & Curtin, 2013). Upon completion, all students finished a researcher-developed survey investigating student satisfaction with the clinical experience. Students in the DEU had significantly higher scores linked with instructor quality and opportunities provided in the clinical setting; however, no significant differences regarding examination scores were found when comparing the groups.

Similarly, another study distributed a survey evaluating key learnings after implementing a DEU model. Staff nurse and student perspectives of the TCM experiences were compared to responses concerning the DEU model (Moscato et al., 2007). No faculty responses were included in the reported results. Students described higher satisfaction rates with the DEU model feeling it was a more supportive environment for learning. Staff nurses also enjoyed teaching in the DEU model but were uncomfortable with the evaluation process due to inexperience. Comparatively, another mixed-methods study found students and staff nurses more satisfied with the DEU versus the TCM (Ryan, Shabo, & Tatum, 2011). Again, the faculty perspective regarding strengths and weaknesses of both models was found to be missing after reviewing these studies.

Regarding the DEU, Nishioka, Coe, Hanita, and Moscato (2014) completed two publications from one study summarizing student and staff nurse perspectives of a newly implemented DEU model. When compared to the TCM, students rated higher satisfaction levels with the DEU due to consistent mentoring provided by assigned staff nurses (2014a). Staff nurses felt the DEU model offered a positive

and welcoming environment for students while offering good learning experiences (2014b). Even though faculty perspectives were not highlighted in these publications, staff nurses did state a lack of knowledge regarding structure of the acute care unit by nursing faculty often led to fragmented learning experiences when utilizing the TCM.

One study that included faculty responses investigated satisfaction with a DEU model using a mixed-methods design (Rhodes, Meyers, & Underhill, 2012). Student, faculty, and staff nurse perspectives were elicited and all reflected high satisfaction with the model. Faculty questions and comments focused on strategies utilized to develop staff nurses into their new role as nursing student evaluators. Only four faculty were represented and responses revealed relinquishing control of student learning and assisting staff nurses in becoming comfortable with facilitating learning were necessary adjustments when transitioning to the DEU model. Again, no investigation regarding perspectives of faculty when facilitating student learning with the DEU or TCM was investigated.

A study focused on sustainability of the DEU model conducted focus group interviews with DEU staff nurse instructors, staff nurses who were not instructors, and nursing faculty (Mulready-Shick & Flanagan, 2014). Themes assisting with sustainability included successful interactions among stakeholders, displaying mutual respect when experiencing shifting of roles, and building relationships. Faculty representation was minimal as only three participated in the study.

Similar to studies concerning simulation and the TCM, faculty responses regarding studies interested in the DEU alluded to benefits and challenges of this model while mainly focusing on the role change faculty experienced when switching from one model of instruction to another (DeMeester, 2013; Rhodes, Meyers, & Underhill, 2012). Still missing from the literature was an understanding of the process nursing faculty utilize when facilitating learning using both models. Again, due to a lack of investigation involving nursing faculty perspectives of this process, this grounded theory was deemed necessary to fulfill this identified gap.

Miscellaneous models. In addition to the clinical models discussed, other miscellaneous models are being implemented and investigated. For example, one study described a pilot project involving

implementation of a new clinical model comprised of one full-time nursing faculty member assisting two staff nurses with each nurse assigned eight to ten nursing students (Delunas & Rooda, 2009). Both groups were located on different acute care units in the same healthcare facility. High mean scores from students were obtained from a satisfaction survey indicating that students appreciated having a faculty member and staff nurse present when help was needed. This allowed for increased student support in the clinical setting. In this study, no faculty perceptions of the new model were evaluated.

In another study, a group of researchers compared outcomes with three different student groups undergoing various pediatric clinical experiences (Kubin, Wilson, & Wilson, 2013). New experiences were created due to concerns that the TCM was decreasing students' opportunities to provide direct patient care. Students were randomly assigned to either a traditional clinical group, hybrid group containing both traditional and community pediatric experiences, and a non-traditional group that took part in community experiences, observations, and alternate clinical activities. Student satisfaction was similar among all models with students in the traditional group rating comfort with assessing children significantly higher than those in other groups. Clinical reasoning scores did not significantly differ among the groups which was measured using a computerized examination and a Clinical Reasoning Tool completed at the end of the experiences. This study suggests the TCM can provide students more opportunities in completing certain patient care activities, including patient assessments, which were deemed beneficial for student learning.

Another study described implementation of a Clinical Academic Partnership (CAP) model which involved mentoring staff nurses in healthcare facilities to become adjunct, or interim, clinical instructors (Hegge et al., 2010). The clinical instructors and staff nurses became primary supervisors of students and were supported by faculty. The researchers discovered faculty had more time to capture learning moments experienced by students. Students were also able to provide patient care more efficiently due to decreased time spent waiting for an instructor. This was not a formal study, but a report of a pilot project, with no description provided regarding how these comments were obtained.

Similarly, another group of researchers described implementation of the Oregon Clinical Education Model in a nursing program which incorporated both direct patient care utilizing the TCM and structured clinical activities, including case studies and skill-based learning activities, to offset the somewhat random learning opportunities nursing students experience with the traditional model (Nielsen, Noone, Voss, & Mathews, 2013). Again, this was not a formal study but a pilot project integrated into a nursing education program.

To investigate successful integration of new clinical models, Teel, McIntyre, Murray, and Rock (2011) explored innovative models nursing education programs developed that involved partnering with healthcare agencies. Researchers discovered that communication, supportive relationships among nursing programs and healthcare facilities, and flexibility, assisted in effective implementation of these models. Nursing faculty, staff nurses, administrators, and students were all interviewed as part of this investigation. Faculty feedback described that the new models allowed students more opportunities for clinical experiences due to an increased amount of time spent in the clinical environment; however, a few faculty described wanting to return to the TCM of instruction and were not completely satisfied with the new models although elaboration regarding these comments was not provided.

Additionally, another researcher (Ruth-Sahd, 2011) implemented student nurse dyads while conducting clinical in the acute care setting. This involved pairing students starting out in acute care clinical experiences together to care for a single patient. The researcher conducted qualitative interviews with students after implementing this model, finding that students' anxiety decreased and transitioning from the classroom to the clinical setting improved as students worked together to provide patient care. This also created a more realistic experience as the researcher described that students would be working as part of an interprofessional team after graduation (Ruth-Sahd, 2011).

It is obvious many new clinical models are being developed and implemented; yet, without an in-depth investigation of the process faculty utilize when facilitating learning while using the TCM, these newer models may not capture the needs of faculty as they strive to prepare students for practice.

Acute care clinical environment influence on student learning. This section reviews studies interested in the clinical learning environment and ways in which this environment affects student learning. Also included in this section is a summary of developed instruments that can be utilized to assess the clinical environment. These studies represent multiple countries and reflect similar findings highlighting that some clinical environmental factors impacting student learning are global in nature. It is important to note that, even though all articles discuss evaluating the acute care setting, it was not specified in multiple studies which clinical model was utilized when instructing students. Also, the person responsible for clinical instruction varied, as not all instructors were faculty employed by nursing education programs.

Environmental influences on student learning. One qualitative study reviewed was conducted in Canada and examined students' clinical experiences in acute care settings deemed challenging. In this study, supervision of students was provided by staff nurses employed by the educational institution (O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). Nursing students defined a challenging clinical learning environment, discussed ways in which these environments impacted learning, and described responses to these challenges. Components demonstrating a challenging environment included large amounts of classroom assignments which took time away from patient experiences, and relationships, including a lack of communication regarding student expectations and feeling ignored by staff nurses. These experiences ultimately led to a loss of learning opportunities. Students responded by finding support with peers and avoiding those responsible for the challenging relationships.

An additional study conducted in Canada investigated new nurse graduate perceptions of clinical learning opportunities considered most beneficial to prepare them for the professional nursing role (Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007). Qualitative interview themes determined that experiencing supportive relationships, gaining real-world experience on clinical units, and being provided multiple opportunities to practice skills during nursing programs led to higher satisfaction with preparation for the role. For future research, recommendations included gaining faculty perspectives regarding this topic and that nursing educators should evaluate clinical sites prior to students arriving.

Again, descriptions of the specific clinical models the new nurse graduates experienced were not provided.

Another descriptive survey study conducted in Greece evaluated nursing student perspectives of an actual versus ideal clinical environment experienced in an acute care setting (Papathanasiou, Tsaras, & Sarafis, 2014). Findings showed students wished for a more positive environment than what was experienced which may have impacted achievement of student learning outcomes. Supervision of students was provided by a "clinical instructor" with no further information provided regarding credentials or experience required of this role (p. 59). Implications to improve student experiences included reducing the student to instructor ratio and providing more psychosocial support to students in the clinical setting.

Similarly, a mixed-methods study conducted in Australia utilized focus group interviews and a questionnaire to determine student perspectives of an acute care environment (Dunn & Hansford, 1997). It was determined that positive relationships with staff nurses along with student attitudes towards the clinical experience often determined satisfaction with clinical learning opportunities. The clinical model used was not specified although students did participate in hospital-based experiences similar to the TCM utilized in this country. Other studies support these findings, identifying that students often look to faculty and staff nurses as potential role models (Donaldson & Carter, 2005; Felstead, 2013). When good role models were lacking, both student confidence and learning was negatively affected.

An additional study evaluated nursing student, staff nurse, and nurse tutor perspectives of the acute care environment in Malaysia, having all participants identify factors both contributing and hindering student learning using a descriptive survey design (Chuan & Barnett, 2012). The researchers stated that students were either supervised by staff nurses or clinical instructors, which is assumed to be another term for the word tutor, but details regarding differences between these terms were not provided. The researchers stated that staff nurses cared for patients while supervising students and clinical instructors only evaluated student performance. It was not stated whether clinical instructors were nursing faculty or staff nurses. Survey findings evaluated overall satisfaction with the clinical environment and

were compared among all three groups, with students and tutors finding the environment less learner friendly than staff nurses. This was possibly due to the familiarity staff nurses had with working on the unit. An additional open-ended item allowed for written comments to describe factors contributing to or hindering the student learning experience. Contributing factors identified by nurse tutors included student attitude towards the clinical experience as positively impacting student learning. Items hindering learning were summarized from the student perspective and included experiencing negative attitudes from staff nurses and having insufficient time to learn clinical skills.

Also interested in the effect of the clinical environment on student learning, Levett-Jones and Lathlean (2009) developed the Ascent to Competence Framework that described nursing student needs when placed in the clinical setting. Researchers collected both survey data and conducted student interviews in Australia determining environmental factors impacting achievement of competence and nursing student belongingness when in the clinical setting. This framework was modified from Maslow's hierarchy of needs and concluded that students should have environmental components addressed for learning to occur. This included the need to feel psychologically safe and being a respected and valued team member when in the clinical setting. Only after these are achieved can the next step, learning, actually occur. Competence, the final level, is achieved after learning outcomes are met. For faculty, suggestions promoting an optimal clinical environment were described and include providing an orientation session for students and ensuring staff nurses are aware of their impact on student learning.

In support of this framework, researchers from the United Kingdom provided similar suggestions in an expository writing concerned with student learning in the clinical environment (Sherwin & Stevenson, 2010). Maslow's hierarchy of needs was also used to model faculty or instructor interventions needed to optimize clinical learning experiences for students, including providing orientation to the unit and enhancing relationships through weekly meetings with students to discuss progress.

This discussion of relationships and influences on student learning was also reflected in other studies. A cross-sectional survey study conducted in Canada investigated whether nursing students experienced incivility while in the clinical setting and how this incivility related to student burnout

(Babenko-Mould & Laschinger, 2014). It was discovered that multiple students experienced negative and uncivil behaviors, especially from staff nurses, when in the acute care setting, causing affected students to question pursuing a career in nursing. These findings have great implications on worsening the already present nursing shortage. Comparatively, researchers conducting a qualitative study in Norway determined student relationships with staff nurses were highly predictive of students' clinical experiences (Dale, Leland, & Dale, 2013). Although the specific clinical model was not stated, students described that feeling welcomed and valued were important in building self-confidence and improving the learning experience.

From the healthcare facility and manager perspective, Henderson, Briggs, Schoonbeek, and Paterson (2011) developed a conceptual framework to assist healthcare facility leaders and managers in providing a positive clinical environment for nursing students. Developed in Australia, the researchers determined that a facility must create a culture fostering learning. This involved providing professional development opportunities for staff regarding effective teaching strategies and intentionally promoting positive relationships with nursing education programs.

A final qualitative study utilized a participatory action research design investigating faculty, student, and staff nurse perceptions of the acute care setting (Young et al., 2014). Three questions were asked, including what participants liked and disliked about the setting along with elements needing improvement in the acute care environment. Results included all stakeholders appreciating the variety of patient experiences the clinical setting allowed with dislikes including a lack of collaborative relationships among all groups on the unit. Faculty wanted to protect students from negative staff behaviors, students often felt they were invading staff nurse space, and staff nurses disliked having unengaged students caring for patients. Regarding elements to change, faculty desired more collaborative relationships with staff nurses and all groups wanted to change the start time of the clinical day. The researchers discussed connecting these responses to the impact on student learning, yet no discussion of these implications was included.

Many findings from these studies provide suggestions for faculty regarding how to promote a positive clinical environment for students but do not discuss the optimal environment faculty require to properly facilitate learning. This lack of literature investigating faculty experiences when facilitating learning in the acute care setting supported the need for this grounded theory study.

Clinical learning environment evaluation tools. Multiple evaluation tools have been developed to assess the clinical learning environment based on feedback regarding areas that impact student learning. Of importance is that only one tool was developed in this country as the remaining were formed in various countries across the globe. These tools assess important factors regarding the clinical environment and its impact on staff nurses and nursing students but lack insight and perspectives from nursing faculty.

Student perspective. Instruments have been developed internationally that assess ways in which the clinical learning environment impacts student learning experiences. The first tool was created in Australia by Dunn and Burnett (1995) and is entitled the Clinical Learning Environment Scale (CLES). A factor analysis confirmed strong face validity and content validity while reliability coefficients ranged from 0.63 to 0.85 among the tool items (Dunn & Burnett, 1995). This tool measures the impact staff-student relationships, nurse manager commitment, and student satisfaction have on the overall clinical learning experience. Another tool, the Clinical Learning Environment Inventory (CLEI), was developed in Hong Kong and evaluates faculty effectiveness in providing relevant learning opportunities which often correlated with student satisfaction regarding clinical experiences (Chan, 2002). Reliability coefficients were acceptable and ranged from 0.63 to 0.84 among the measurement items. Discriminant validity was also computed and, for all subscales, ranged from 0.39 to 0.45 confirming that scales measured separate components of the environment, although some overlap was apparent (Chan, 2003).

A third tool was based on student experiences in Japanese clinical nursing education programs (Hosoda, 2006). The Clinical Learning Environment Diagnostic Inventory (CLEDI) evaluates similar elements mentioned, including support provided by instructors and staff nurses and the quality of patient learning opportunities provided by the clinical setting. Cronbach's reliability coefficients were computed

with subscale results ranging from 0.65 to 0.77, indicating good reliability. Criterion, construct, and content validity were also established among nurse faculty experts (Hosoda, 2006). This tool also evaluates quality of patient care provided by staff which was determined to impact student learning outcomes (Hosoda, 2006). Saarikoski and Leion-Kilpi (2002) developed the Clinical Learning Environment and Supervision Instrument (CLES) which focuses on the impact organizational culture, including management leadership style, has on student clinical experiences. Content validity was established with a panel of experts and construct validity was found to be good after conducting an exploratory factor analysis. Reliability of the tool was completed using Cronbach's coefficients and all subscales showed good reliability ranging from 0.73 to 0.94 (Saarikoski & Leino-Kilpi, 2002). These same researchers collaborated with other individuals to add a nurse teacher component to the CLES and developed the Clinical Learning Environment, Supervision, and Nurse Teacher Scale (CLES+T) (Saarikoski, Isoaho, Warne, & Leino-Kilpi, 2008). The addition of this subscale measured the nurse teacher's role in supporting students during clinical experiences. Construct validity was, again, explored utilizing a factor analysis and reliability coefficients were also good with subscales ranging from 0.77 to 0.96 (Saarikoski, Isoaho, Wane, & Leino-Kilpi, 2008).

One tool was developed based on student clinical experiences in this country and is entitled The Student Evaluation of Clinical Education Environment (SECEE). This tool evaluates instructor effectiveness, relationships among staff and students, and whether the environment provided adequate resources and appropriate patient learning opportunities (Sand-Jecklin, 2009). Reliability of this scale was strong with coefficients ranging from 0.82 to 0.94. Validity was also found to be acceptable after completing a factor analysis (Sand-Jecklin, 2009). Similarities among measured elements impacting the student clinical learning experiences are apparent and reflected in the sensitizing concepts discussed previously and represented in Figure 1 (Charmaz, 2014).

Healthcare facility perspective. Regarding healthcare facilities, the Nursing Student Contribution to Clinical Agencies tool can be utilized by staff nurses to identify the impact nursing students have on management of the clinical day. Elements measured include nursing students impact on staff nurses'

ability to provide quality patient care and how students influence personal satisfaction with being in the staff nurse role (Grindel, Bateman, Patsdaughter, Babington, & Medici, 2001). In addition to providing clinical instruction to students during clinical experiences, staff nurses must also provide full patient care, increasing the complexity of the staff nurse role. Reliability coefficients were strong at 0.95 and the tool also had established content and face validity. A group of researchers conducted a study utilizing this tool which revealed that student preparedness and organization of the instructor often impacted staff nurses' ability to organize patient care throughout the day (Matsumura, Callister, Palmer, Cox, & Larsen, 2004).

Another tool developed for healthcare facilities was entitled the Quality Clinical Placement Evaluation Tool (Courtney-Pratt, Fitzgerald, Ford, Johnson, & Wills, 2014). This assessment tool can be utilized by both students and staff nurses to evaluate the clinical learning experience. Construct validity of the tool was established and reliability coefficients of the various scales ranged from 0.64 to 0.88. Students can rate effectiveness of staff nurse instruction and if constructive feedback was provided while staff nurses can evaluate if students met learning objectives, making this an ideal tool to use with the preceptorship and DEU models.

Nursing faculty perspective. No assessment tools reflecting the nursing faculty perspective were found in the literature, which was also confirmed by Hooven (2014). Any of the tools mentioned could be modified and used by faculty but would lack representation of the faculty viewpoint regarding environmental influences impacting facilitation of clinical learning. Again, this lack of insight regarding the faculty perspective when facilitating clinical learning validated the need to conduct this grounded theory study.

Facilitation of student learning in the clinical environment. This area reviews research studies focused on teaching and learning strategies faculty utilize throughout nursing education programs. Also reviewed were studies investigating specific approaches to clinical teaching that researchers have examined. Again, there was a noted gap regarding an understanding of the process faculty utilize when actively facilitating learning in the clinical setting.

Strategies to facilitate student learning. For this section, research studies investigating development of critical thinking skills, both in the classroom and clinical setting, are discussed. Specific strategies faculty utilize to facilitate learning and develop critical thinking are detailed along with factors impacting the implementation of these teaching techniques. Also, studies examining specific teaching methods utilized in the clinical setting are discussed.

Critical thinking and clinical reasoning development. Throughout the literature, differing terms were utilized to describe the development of higher level thinking, including clinical judgment and critical thinking. Despite these differing terms, researchers described this type of thinking in similar ways, which involved the ability of nursing students to appropriately recognize and respond to situations after analyzing patient data (Kaddoura, Van Dyke, & Shea-Foisy, 2016; Tanner, 2006; Twibell, Ryan & Hermiz, 2005). Regarding the facilitation of higher level thinking, one group of researchers investigated strategies utilized by faculty to develop this trait in nursing students through a qualitative study (Twibell, Ryan, & Hermiz, 2005). It was discovered faculty integrate strategies such as questioning strategies, completion of case studies, and participation in clinical conferences to develop critical thinking skills. A research implication included determining barriers faculty face when attempting to implement these teaching strategies in the clinical setting. Even though this study discusses teaching strategies to develop critical thinking skills, the process faculty utilize to facilitate learning and how these strategies are integrated throughout the clinical day were not addressed.

Similarly, another study explored the development of clinical judgment using concept mapping (Kaddoura, Van Dyke, & Shea-Foisy, 2016). This activity involved baccalaureate nursing students graphically making connections of patient data and nursing interventions to better understand relationships among these elements. Students developed concept maps based on case studies and after completing patient care in the clinical setting. After completing concept maps for clinical courses, students reported benefits of this activity regarding the development of clinical judgment skills. Students felt this activity assisted in their ability to prioritize patient needs and determine the most pertinent patient information to focus on when providing care.

Several studies have investigated barriers faculty face when attempting to facilitate critical thinking. One researcher conducted a descriptive survey study investigating faculty perceptions of barriers when teaching critical thinking skills in both the clinical and classroom environment (Shell, 2001). Although this was not specific to the clinical setting, faculty identified student resistance to active learning as the most common barrier followed by time constraints when implementing active learning strategies. Again, this included more implications for classroom strategies when fostering critical thinking development but did explore the faculty perspective regarding facilitation of learning.

Similarly, another study explored faculty and student perceptions of obstacles present when attempting to facilitate critical thinking skills in nursing education programs (Mandeni & Chabeli, 2005). Even though this was not specific to the clinical setting, qualitative themes determined that a lack of educator understanding regarding definitions of critical thinking and hesitancy of moving to a student-centered teaching style interfered with facilitation of critical thinking development.

Another researcher compared faculty barriers to teaching critical thinking with nursing faculty critical thinking scores obtained using a valid and reliable tool (Blondy, 2007). This quantitative ex-post facto study determined there was no significant relationship between perceived barriers to fostering critical thinking and critical thinking scores among participants. Again, even though this was not specific to the clinical setting, faculty did state that the lack of a consistent evaluation tool and definition of critical thinking were the most common barriers to fostering its development.

Other studies were interested in the student experience of developing critical thinking, including Moran (2000), whose dissertation involved asking students their perceptions of how critical thinking skills were developed while in the clinical setting. Students described learning critical thinking by observing role models, being exposed repetitively to the nursing process, receiving feedback from peers and faculty, and going from simple to complex learning opportunities throughout the program.

Comparatively, another researcher employed a qualitative case study design while interviewing and observing nursing faculty, students, and staff nurses to better understand how all stakeholders defined critical thinking and how faculty integrated critical thinking teaching strategies in the classroom and

clinical setting (Hobus, 2008). The researcher discovered that, for the nursing educator, the critical thinking process was displayed by students who constantly questioned and desired to learn more while reflecting on the outcomes of prior decisions. Instructional strategies to achieve these attributes included use of case studies and role-playing scenarios in the classroom. In the clinical setting, the educator discussed that promoting a supportive clinical environment and discussing progress with students assisted in the development of critical thinking. Throughout observations, the researcher identified potential barriers to facilitating critical thinking, particularly in the clinical setting, which included a high faculty-to-student ratio and lack of communication with staff nurses regarding student assignments and responsibilities.

Although facilitation of critical thinking remains important when preparing students for the professional nurse role, investigating the process faculty utilize when facilitating all aspects of student learning, and identifying elements interfering with this process, was lacking in the literature, further supporting a need for this study.

Approaches to clinical teaching. Another group of research studies was interested in faculty approaches to clinical teaching. One researcher conducted a qualitative, phenomenological study concerning this topic (Forbes, 2010). All instructors practiced clinical teaching in Australia, and, after conducting interviews, two different teaching approaches were determined to be utilized by instructors in the clinical setting. These included a patient-centered approach and a nurse-centered approach. It appeared those utilizing a patient-centered approach were more likely to facilitate higher-level thinking by ensuring students integrated information into a broader holistic representation of the patient while those using the nurse-centered approach were more focused on execution of tasks.

Another study focusing on teaching styles was conducted in Iran (Hossein, Fatemeh, Fatemeh, Katri, & Tahareh, 2010). The researchers interviewed fifteen faculty members regarding teaching strategies used in the clinical setting. Emerging themes included the necessity to use multiple teaching styles due to the constantly changing nature of the clinical environment although these different styles were not specifically described.

An additional study conducted in Sweden evaluated student perspectives regarding facilitating and obstructing factors impacting student learning in the clinical setting (Lofmark & Wiklad, 2001). This qualitative study required students to complete weekly diaries with specific questions to answer regarding clinical learning experiences. Factors enhancing student learning included receiving timely feedback from clinical instructors, having multiple opportunities to practice tasks, and promotion of independence, while obstructing factors included staff nurses relying on students to provide basic patient cares and a lack of supervisor continuity. Similarly, another researcher investigated preceptor perceptions of student learning outcome achievement when utilizing specific teaching strategies (Krichbaum, 1994). Both preceptors and students performed self- and peer evaluations. Teaching behaviors significantly impacting knowledge gain and performance level included setting clear objectives and providing constructive feedback to the students.

Furthermore, a qualitative study interested in staff nurse perspectives discovered that staff nurses motivating students to learn in the clinical setting often modelled clinical competencies correctly and communicated clinical knowledge professionally (Nasrin, Soroor, & Soodabeh, 2012). Nurses displaying powerlessness often did not motivate students to perform well in the clinical environment. Finally, researchers in Belgium developed a framework to utilize in workplace learning environments that focused on student development of competencies in the clinical setting (Embo, Driessen, Valcke, & van der Vleuten, 2015). The authors described that faculty should incorporate appropriate learning strategies and frequently assess student performance throughout clinical experiences. Activities including fostering reflection and discussing needed competencies in the workplace setting with managers were emphasized to enhance student competency development in the clinical setting.

This area of research highlighted possible strategies faculty may utilize when teaching students in the acute care setting. A gap regarding teaching strategies faculty integrated while actively providing clinical instruction was noted, substantiating the need for this grounded theory study.

Faculty role in the clinical learning environment. Research studies reviewed in this final section were interested in the nursing faculty role and address role strain experienced by faculty members,

the lived experience of being a nursing faculty member, preparation for the role of teaching, and the role of faculty when instructing students in the clinical environment.

Role strain as a clinical faculty member. Several studies investigated the stress faculty are under when balancing clinical obligations, classroom obligations, and other additional responsibilities of teaching. Compounding this role strain is the increased workload faculty are taking on due to the nursing faculty shortage (Roughton, 2013). Oermann (1998) conducted a descriptive survey study regarding work-related stressors among faculty members teaching in the clinical setting. Faculty in both associate and bachelor's degree programs responded with the most common stressors including coping with job expectations of the clinical faculty role, feeling drained at the end of the clinical day, and stress with balancing learning needs of students with requirements of the clinical agency. Even with these stressors, faculty typically did not rate individual stress at a high level.

Another study focused on role strain experienced by faculty investigated how the overall climate of the healthcare organization and communication with managers and staff impacted faculty stress (Piscopo, 1994). Surveys were distributed and nursing faculty responses were compared to corresponding managers of the same clinical units. There was no significant difference regarding perceptions of the organizational climate; however, faculty viewed communication in a significantly more negative manner than the corresponding nurse managers. There was also a positive correlation found between organizational climate and role strain with a positive climate leading to less nursing faculty role strain. Providing faculty with orientation to the clinical unit and assigning faculty to clinical units long-term were recommendations to improve these experiences.

Comparatively, another study determined that part-time clinical adjunct faculty work stressors included dealing with clinical issues such as working with failing students and balancing outside obligations with clinical responsibilities (Whalen, 2009). Adjunct faculty typically have full-time staff nurse positions and are hired by nursing education programs to provide clinical instruction for a contracted period of time, typically one semester in length. Through this descriptive survey study, a positive correlation between job dissatisfaction and role strain was determined.

Due to the role strain multiple faculty experienced, Gazza and Shellenbarger (2005) brought up the importance of orienting and enculturating nursing faculty to improve retention, as the faculty shortage is contributing to the overarching nursing shortage. Ensuring faculty, especially those new to the role, receive proper orientation to policies, connect with a mentor for assistance, and are offered opportunities to reflect on the role were suggested to assist in supporting and retaining new faculty. Another study (Roughton, 2013) also highlighted the importance of addressing role strain to retain faculty and assist in reducing the nursing shortage. This survey study found that nursing faculty with intent to leave the profession during the subsequent year or the next five years were mainly dissatisfied with compensation, workload, and opportunities for advancement. It was determined that 19% of those surveyed were at risk of leaving the profession within a year and 49% within the next five years. The researcher recommended nursing programs incorporate mentoring courses, investigate alternatives to tenure tracks, and offer higher salaries for nursing faculty.

Lived experience as a clinical faculty member. To better understand the nursing faculty role, several studies investigated the lived experience of faculty when facilitating learning in the clinical environment. One study incorporated a phenomenological, qualitative design that involved interviewing ten participants who described five themes when instructing students in the clinical setting. These themes included knowing limitations as an instructor, stepping in and fading back when students cared for patients, developing alliances with staff nurses, identifying clinical buddies, and understanding the reciprocity of the learning experience (Dickson, Walker, & Bourgeois, 2006). This study took place in Australia where clinical instructors were staff nurses hired by educational institutions.

In addition, two researchers conducted an interpretative qualitative study interested in investigating everyday experiences of nurse teachers in the clinical practice setting (Duffy & Watson, 2001). This study was conducted in Scotland and 18 nurse teachers participated. The clinical model described is different than the traditional model and appears similar to that of a DEU model. Three themes emerged but only findings from the first theme, which involved the role pattern of nurse teachers, were described. This theme involved being a supporter for both students and staff nurses and being a networker

which included building and maintaining relationships with clinical staff. Two other themes identified consisted of experiencing the role of a nurse teacher, including benefits and difficulties experienced in the clinical setting, and role dilemmas, including being a 'hands-on' participant and envisioning the future. Again, only results for the first theme were provided and perspectives regarding benefits and challenges of facilitating learning were not discussed.

In a similar study, Gazza (2009) investigated the lived-experience of being a full-time clinical faculty member through a qualitative, phenomenological approach. This study not only focused on clinical responsibilities of faculty, but also classroom and other responsibilities, such as committee work and research requirements. Balancing these tasks was the main theme considered a challenge while making a difference in nursing students was the rewarding theme identified.

Investigating the clinical experience from another country, a study conducted in Chile explored the lived experience of being a clinical nurse teacher by interviewing eight faculty using a qualitative phenomenological approach; however, only five interviews were utilized for analysis with no explanation provided for not including the remaining three participants (Bettancourt, Munoz, Merighi, & Fernandes dos Santos, 2011). Qualifications of faculty were not described but all were employed at a Chilean university. One theme included being a teacher at the hospital, which highlighted faculty experiences with students in the clinical setting, including the need to be aware of potential student errors and patient safety. The second theme involved working with nurse practitioners in the clinical setting and described positive and negative interactions with these healthcare professionals. The third theme, being a teacher of care education, seemed similar to the first theme, as positive and negative teaching experiences were highlighted. No discussion regarding facilitation of learning or in what way the environment impacted learning was provided.

Focusing on a slightly different topic, another researcher conducted a qualitative phenomenological study with undergraduate nursing faculty to better understand wisdom acquired after working with students in difficult clinical situations (Paton, 2007). It was discovered that faculty encountering difficult student situations had to determine an immediate response with the knowledge that

their decisions could impact multiple relationships in the clinical environment. Themes elicited in this study included preserving the ideal, salvaging learning, and sustaining self, which highlighted that educators were satisfied when the best effort was given to solve difficult situations. Faculty were found to always try and enhance learning experiences for students regardless of the situation. Practice implications included better preparation of nursing faculty to the role as many have no experience or prior knowledge of how to address these difficult situations. Paton (2007) also stated clinical faculty should, "have opportunities to voice their concerns and create strategies that support their teaching in practice" (p. 494).

Another researcher conducted focus group nterviews with both faculty and staff nurses involved in clinical teaching to explore each group's perceived role regarding student learning in the clinical setting (Langan, 2003). Also of interest was whether faculty still maintaining a staff nurse role impacted these perceptions. Findings primarily concentrated on staff nurse perceptions determining that staff nurses working with faculty maintaining practice as staff nurses felt less role conflict regarding responsibilities for student learning. Staff nurses felt faculty continuing clinical practice were more aware of changes in the healthcare system leading to a smoother working experience and clearer communication.

Finally, another qualitative study explored the lived experience of all stakeholders involved in the preceptor clinical model, including students, staff nurse preceptors, and responsible faculty (Nehls, Rather, & Guyette, 1997). The overarching theme from all participants was that of "learning nursing thinking" which described the need for nursing students to tie elements of the patient picture together to provide safe patient care (p. 222). Students stated the one-on-one attention provided by preceptors enhanced the learning experience which was lacking in the traditional clinical model.

Preparation for the faculty role. Along with investigating role strain and the lived experience of nursing faculty, multiple studies investigated the education, or lack thereof, faculty obtained to prepare for this role. For example, one study described strategies that a nursing program implemented to prepare faculty for clinical experiences (Krautscheid, Kaakinen, & Warner, 2008). Faculty viewed recorded and actual simulation scenarios presenting difficult student interactions to prepare faculty when dealing with these situations in the clinical environment. The researchers also presented suggestions for faculty when

facilitating learning including using therapeutic communication techniques and appropriate questioning strategies to develop critical thinking in students.

Another study investigated preparation of faculty for the clinical teaching role by utilizing a descriptive survey design (Suplee, Gardner, & Jerome-D'Emilia, 2014). Findings determined that faculty in associate degree programs were more likely to receive support and faculty development opportunities focused on clinical teaching than their bachelor's degree program counterparts. Most reported a lack of formal education in preparation for the clinical teaching role which could create difficulties when facilitating learning in the clinical setting.

Numerous studies focused on adjunct faculty preparation for the clinical teaching role. Adjuncts described difficulties transitioning to an instructor role due to juggling other life responsibilities, lack of communication with full-time faculty, and lack of integration into the university, including having insufficient knowledge regarding curriculum elements (Gazza & Shellenbarger, 2010; Volk, Homan, Tepner, Chichester, & Scales, 2013).

Influence of faculty member on student learning. A final aspect exploring the faculty role involved studies reinforcing the important influence faculty members have on student learning experiences. Without an effective clinical instructor, learning may be nonexistent for students. For example, one study investigated the instructor-student relationship and its impact on the learning experience in the clinical setting (Yaghoubinia, Heydari, & Roudsari, 2014). This grounded theory study determined that the theme of "seeking a progressive relationship for learning" impacted both instructor and student experiences (p. 69). Specifically, learning was obstructed for the student when instructors were stressed, leading to a negative relationship and impacting achievement of learning outcomes. Another study examined this same relationship and, again, determined the student-instructor relationship influenced student learning (Shahsavari, Yekta, Houser, & Ghiyasvandian, 2013). In addition, another study determined that clinical faculty behaviors and interactions toward nursing students also impacted student stress levels while in the clinical setting, with negative interactions contributing to higher stress and negatively impacting the learning experience (Cook, 2005). These studies confirm the important role

faculty have when facilitating learning in the clinical setting. Themes impacting this relationship after interviewing both stakeholders included competency of the student, respect for the instructor shown by staff members in the clinical unit, and students and instructors being in close contact with each other.

Related to this topic, Teel, Smith, and Thomas (2008) completed a descriptive survey study interested in faculty perspectives of the instructor-to-student ratio and the impact this ratio had on student learning and patient safety. This survey was completed in Kansas where the ratio can be no more than one instructor for every ten students. Faculty agreed this ratio was not optimal for student learning or ensuring patient safety as faculty reported being spread thin when trying to evaluate students in the clinical setting. One limitation of this study was the lack of examples illustrating patient safety or student learning concerns regarding this ratio. For future recommendations, the researchers stated, "Faculty fears about compromised student learning and patient care must be examined more closely" (p. 5). Another study also focused on the role of staff nurses and faculty when facilitating student learning discovering both groups felt the faculty-to-student ratio led to role overload and an inability for students to meet objectives, warranting further investigation (Langan, 2003).

All of these studies describe the multiple responsibilities faculty face when providing clinical instruction for nursing students. Also, many studies alluded to instructional model and acute care environmental factors potentially impacting facilitation of student learning. It was evident that a missing component from this body of research involved investigating the entire process faculty utilize when facilitating learning in the acute care setting while integrating the TCM. This review of the literature illuminated potential starting points and sensitizing concepts affecting and influencing this process, including elements of the acute care environment and TCM impacting instruction, possible strategies faculty utilize when teaching in the clinical setting, and other factors influencing facilitation of learning, including role strain and the amount of preparation for the nursing faculty role (Charmaz, 2014); however, a definite gap was noted regarding the interaction of all identified sensitizing concepts and the impact on faculty facilitation of clinical learning. After conducting this literature review, this grounded

theory study was deemed necessary to bridge this gap by identifying faculty needs when facilitating clinical learning and better understanding the facilitation of learning process.

Summary

To conclude, this chapter discussed two overarching theoretical perspectives alluding to strategies faculty utilize when facilitating clinical learning while acknowledging potential environmental elements that can impact nursing faculty's ability to facilitate learning. This literature review highlighted a gap concerning a lack of knowledge regarding the process faculty utilize when facilitating student learning in the acute care setting while using the TCM. A grounded theory study was necessary to understand this process and identify factors that assist and interfere when faculty instruct students in the clinical setting. The next chapter describes details regarding the methodology, participants, data collection, and data analysis techniques that were implemented during this study.

CHAPTER THREE: METHODOLOGY

Nursing faculty play an important role in preparing students for professional practice. A lack of research investigating the process faculty utilize when facilitating learning in the clinical environment was apparent after conducting the literature review. Investigation of this process was essential to better understand influencing factors nursing faculty encounter when teaching students in the acute care setting. The purpose of this study was to develop a theory striving to explain the process and actions nursing faculty utilize when promoting application of knowledge in the acute care setting. This chapter details the research design and rationale for this study along with providing explanations of procedural elements including sampling techniques, data collection and analysis measures, ethical considerations, demographic data, and the role of the researcher.

Qualitative Research Methodology

Due to the lack of a guiding theory providing an explanation for the research questions of interest, a qualitative research methodology was chosen to better understand the process nursing faculty utilize when teaching in the acute care setting. According to Creswell (2013), qualitative research aims to explore issues or problems that are often complex in nature by inductively gaining perspectives from multiple individuals experiencing specific phenomena; thus, assisting the researcher in understanding the surrounding context regarding the issue of interest. By conducting interviews and observations, the researcher can hear stories and observe behaviors of individuals impacted by certain phenomena resulting in rich descriptions that traditional statistical analyses utilized in quantitative methodologies cannot uncover (Charmaz, 2014; Creswell, 2013). Because this study was interested in the process nursing faculty utilize while facilitating student learning in the acute care setting, the qualitative research methodology was deemed suitable for investigating and further understanding this area of interest.

Grounded theory approach. The grounded theory approach was the specific qualitative methodology utilized for this study as this design was consistent with the research questions of interest (Charmaz, 2006, 2014; Creswell, 2013; Strauss & Corbin, 1998). The goal of grounded theory research is to generate a theory describing processes and actions experienced by individuals (Creswell, 2013). As this

study was interested in the process nursing faculty utilize when facilitating learning in the acute care setting, and there was a lack of theoretical explanation in the literature describing this phenomena, the grounded theory design was determined to be appropriate for this study. Grounded theory was first described and implemented by Glaser and Strauss (1967) who were interested in developing theory through objectively analyzing participant responses and explanations when experiencing certain events. This type of research challenged quantitative research counterparts by illustrating that grounded theory, a qualitative methodology, can inductively lead to theory development (Strauss & Corbin, 1998).

Grounded theory develops theoretical explanations by drawing from participant experiences; thus, the constructed theory is "grounded" in the data (Strauss & Corbin, 1998, p. 9). Grounded theory involves the researcher obtaining information from participants, determining possible categories from this data that describe processes and relationships occurring with the phenomena of interest, and returning to the field to clarify and saturate these categories. The categories are then applied to an overarching theory describing the issue of interest, representing multiple perspectives of participants' experiences (Charmaz, 2014; Strauss & Corbin, 1998).

Constructivist grounded theory. Along with utilizing grounded theory, this researcher specifically employed the constructivist grounded theory approach developed by Charmaz (2006, 2014). After Glaser and Strauss (1967) first described grounded theory, differences between the two researchers and their philosophies surrounding this method soon became apparent (Charmaz, 2014). Glaser remained rooted in positivist assumptions and highlighted an objective stance when describing grounded theory, detailing the importance of a neutral researcher and the need to discover theories representing an objective reality (Charmaz, 2014). Strauss was influenced by symbolic interactionism and pragmatist theoretical perspectives which focused on integrating social context and subsequent interactions when examining participant experiences (Charmaz, 2014; Strauss & Corbin, 1998). Strauss began collaborating with Juliet Corbin and, together, they developed specific procedures and predetermined categories for researchers to utilize during data analysis when generating a grounded theory versus viewing categories as emerging from the data (Charmaz, 2014; Creswell, 2013; Strauss & Corbin, 1998). Strauss and

Corbin, similar to Glaser, also held to an objective stance regarding grounded theory methodology by describing the need to adhere to procedural guidelines and explaining that discovery of the theory represented an objective reality (Charmaz, 2014).

The constructivist approach still employs the underlying principles of grounded theory first developed by Glaser and Strauss (1967) including the need to inductively analyze participant data and identify categories representing participant experiences; however, Charmaz's (2014) constructivist viewpoint acknowledges that theories are not discovered, but constructed, by both participants and the researcher. Researchers must remain open when analyzing data but will bring theoretical perspectives and knowledge of the research subject which cannot be erased during data collection and analysis. This leads to an interpretive approach to theory development as the grounded theory represents an interpretation of participant experiences by the researcher versus discovering an objective theory which Glaser and Strauss (1967) emphasized (Charmaz, 2014). The constructivist approach also discusses the need to remain flexible and open during analysis and not subscribe to technical procedures when analyzing participant data. Charmaz (2014) is influenced by social constructivism theoretical views, including Vygotsky (1978), which highlight that knowledge and learning are influenced by social interactions and social contexts brought to data collection and analysis procedures by both participants and the researcher (Charmaz, 2014).

Research Design

The constructivist grounded theory design was chosen for this study. Charmaz (2006, 2014) emphasizes the underlying principles guiding grounded theory methodology including the need for rich data collection, intensive interviewing, theoretical sampling, and making constant comparisons when analyzing data, while acknowledging that the researcher brings subject knowledge and values when constructing the theory of interest. The social constructivism framework influencing Charmaz (2006, 2014) also aligned with the researcher's perspective and theoretical influences brought into this particular study. In addition, the researcher agreed with the perspective that it remains impossible to separate the

researcher from the topic of interest when gathering and analyzing participant data due to underlying knowledge, values, and theoretical influences (Charmaz, 2014).

Study Participants

Participants for this grounded theory study included nursing faculty employed at six different BSN programs in two Midwestern states. Participants had to be teaching in some type of prelicensure BSN program which typically includes traditional and accelerated programs. Traditional programs involve students attending classroom and clinical requirements over a three to four-year period while accelerated programs recruit students who have obtained a bachelor's degree in a different field and wish to return and gain an additional BSN degree. These programs typically last one to two years in length. Nursing faculty teaching in non-prelicensure programs were not included. These programs are comprised of students that have already obtained a nursing degree and return to pursue further nursing education, including registered nurse (RN) to BSN programs. All participants needed to have at least one year of teaching experience and provided student clinical instruction in the acute care setting while using the TCM for at least one semester anytime during the prior two calendar years. As the development of this grounded theory was interested in the process faculty utilize when facilitating student learning in the clinical environment, it was essential to recruit participants experiencing this particular process and phenomenon (Charmaz, 2006, 2014; Creswell, 2013).

Sampling procedure and size. Participants in this study were selected utilizing both purposive and theoretical sampling techniques (Charmaz, 2006; Creswell, 2013; Strauss & Corbin, 1998). This type of sampling is unique to the grounded theory methodology and starts with a purposive sample to gain viewpoints from participants experiencing the research topic of interest. For this study, the sample included BSN program faculty facilitating student learning in the acute care setting while utilizing the TCM. After analyzing data from the initial purposive sample, theoretical sampling may be employed by adding new participants from different settings or interviewing initial participants a second time to saturate identified categories and determine emerging relationships among those categories (Charmaz, 2006). Theoretical sampling also involves reviewing interview questions after conducting initial

interviews to determine if new questions or prompts should be developed when investigating emerging concepts. The process of analyzing data and returning to the sample continues until saturation of categories is complete. When utilizing grounded theory, no specific number of participants is recommended or required; rather, theoretical sampling continues until categories are saturated, meaning no new properties of identified categories are recognized (Charmaz, 2006; Strauss & Corbin, 1998). Per the grounded theory methodology, participant recruitment ceased after no new properties of emerging categories were discovered in the data.

For this study, the researcher initially utilized purposive sampling methods to recruit participants meeting the eligibility criteria provided. After completing approximately four to five participant interviews at a time, the researcher would then return to the data, conduct initial analysis on those interviews, evaluate potential categories to pursue, and determine whether theoretical sampling was needed. Recruitment of participants continued until a total of 14 participants was reached. When recruiting new participants, eligibility criteria did not change based on data analysis; however, theoretical sampling procedures were utilized to recruit participants from all six nursing programs initially contacted, ensuring that varying experiences of Midwestern BSN faculty were represented. In addition, theoretical sampling was conducted by interviewing three participants a second time to gain feedback regarding the final developed theory and ensure no new properties or emerging categories needed further investigation (Charmaz, 2006, 2014; Strauss & Corbin, 1998).

Eligibility criteria. All participants had to meet the following criteria to be eligible for study participation:

1. Have a part-time or full-time appointment as a nursing faculty member in a BSN program in one of the institutions utilized for participant recruitment.
2. Have at least one year of teaching experience in a nursing education program.
3. Provide clinical instruction to nursing students in a prelicensure program, which included traditional and accelerated BSN programs.

4. Have provided clinical instruction for nursing students in the acute care setting for at least one semester anytime during the past two years.
5. Have utilized the traditional clinical model when providing clinical instruction for nursing students in the acute care setting over the course of at least one semester.
6. Be willing to share experiences of facilitating student learning in the acute care setting when utilizing the traditional clinical model.

Exclusion criteria. Participants were excluded if the eligibility criteria were not met, which included adjunct faculty and staff nurses participating in facilitation of student learning. Adjunct faculty are those with short-term contractual teaching agreements, usually a semester in length, that typically have employment as staff nurses in addition to their teaching obligations (Sanderson & Lea, 2012). These individuals most likely have different experiences when facilitating learning in the clinical environment as their primary profession is typically not academic in nature. Also, faculty teaching in non-prelicensure programs were excluded as students enrolled in these programs often have prior working experience as a nurse. This prior experience could greatly impact the process those faculty utilize when facilitating learning compared to those teaching in prelicensure programs. The eligibility criteria were established to ensure the process of interest was similar and representative of participants.

Research study setting. Participants were recruited from six BSN programs in two Midwestern states. All six programs were private educational institutions located in urban settings. Four programs were located in one Midwestern state with the final two programs located in the second Midwestern state. All institutions were accredited by various organizations and offered multiple nursing programs. Table 2 summarizes characteristics of all six nursing programs where participant recruitment occurred including student enrollment at each institution, the types of nursing programs offered, and accreditation organization information. Again, only faculty teaching in prelicensure BSN programs were recruited from the institutions.

Table 2

Nursing Program Institution Information

Nursing Program/Institution	***Student Enrollment***	***Nursing Programs Offered***	***Accrediting Institution***
Institution One	1,000	Trad BSN, RN-to-BSN, MSN	ACEN
Institution Two	1,200	Trad BSN, RN-to-BSN, LPN-to-BSN, MSN, DNP	ACEN
Institution Three	1,000	Trad BSN, ANC, RN-to-BSN, LPN-to-BSN; MSN, DNP	CCNE
Institution Four	700	Trad BSN, RN-to-BSN, MSN, DNP	ACEN
Institution Five	800	Trad BSN, RN-to-BSN, ADN	CCNE
Institution Six	2,200	Trad BSN, RN-to-BSN, MSN	CCNE

Note. Trad BSN = Traditional Bachelor of Science in Nursing program; RN-to-BSN = Registered Nurse to Bachelor of Science in Nursing program; MSN = Master of Science in Nursing; ACEN = Accreditation Commission for Education in Nursing; LPN-to-BSN = Licensed Practical Nurse to Bachelor of Science in Nursing program; DNP = Doctor in Nursing Practice; ANC = accelerated Bachelor of Science in Nursing program; CCNE = Commission on Collegiate Nursing Education; ADN = Associate Degree in Nursing program

Role of the Researcher

According to Charmaz (2006, 2014), it is impossible for the researcher to remain completely objective when conducting a grounded theory study as all researchers bring some type of prior knowledge either concerning the research topic of interest or theoretical and philosophical perspectives that can influence data collection and analysis. Charmaz (2006, 2014) stresses that theories developed utilizing the constructivist grounded theory approach are constructed by both the researcher and participants. With this in mind, Charmaz (2006, 2014) states that researchers must examine and reflect upon different perspectives, experiences, and values brought to the research when conducting a grounded theory study.

In regards to this study, the researcher brought her work experience as a registered nurse in an acute care setting, both as a staff nurse and clinical lead. Interactions and observations with multiple nursing faculty and students took place while the researcher maintained these positions. The researcher

observed the multiple responsibilities nursing faculty assumed when facilitating student learning in the acute care setting, including communicating with staff nurses, students, and managers, along with ensuring patient safety was maintained while simultaneously facilitating student learning.

After working in the acute care setting for approximately six years, this researcher took a nursing faculty position and has since taught at two different academic settings, a community college and a private, Catholic university in an urban setting. Over the past seven years, this researcher has facilitated learning in multiple acute care settings utilizing two different clinical models, the TCM and the DEU model. With these experiences, the researcher brought her own understanding of potential factors influencing facilitation of student learning. This researcher has felt the struggle of balancing facilitation of student learning while ensuring proper communication occurs among staff nurses, patients, and students. Other challenges experienced included ensuring multiple students were evaluated appropriately throughout the clinical day and were simultaneously developing critical thinking skills. During facilitation of student learning, unexpected patient situations often arose causing the researcher to stop the learning process and ensure patient safety was achieved. As Charmaz (2014) states, these along with other "sensitizing concepts" discussed in chapters one and two, give researchers a starting point on topics to pursue with participants (p. 30). These concepts assist the researcher when collecting participant responses initially but should not drive the data collection and analysis procedures.

Charmaz (2014) discusses that researchers often have considerable knowledge in the research area of interest which must be recognized. This researcher completed an extensive literature review on the topic of facilitating learning in the clinical environment and discovered theoretical perspectives supporting initial concepts potentially impacting this topic of interest. Knowledge of these perspectives and the literature could have influenced the researcher during data collection and analysis. In addition, the researcher has also published a concept analysis focusing on the clinical learning environment in nursing education (Flott & Linden, 2016).

During a grounded theory study, the researcher must remain attentive to what the participants are saying about their experiences regarding a specific phenomenon (Charmaz, 2006, 2014; Strauss &

Corbin, 1998). The concepts discussed in the first chapter and literature review provided a starting point for data collection; however, this researcher shifted the focus to ensure concepts brought up by participants were investigated thoroughly (Charmaz, 2014). The researcher remained open and attentive, investigating concepts that participants highlighted, while acknowledging potential assumptions and biases that could be brought to the data collection and analysis stages. This researcher was careful to listen and remain attentive during participant interviews while ensuring biases brought to the study did not influence or override emerging concepts and categories grounded in participant data.

Data Collection Procedures

To address the research questions and purpose of this study, demographic data, interviews, and documents were collected and analyzed to construct a grounded theory representing the process nursing faculty utilize when facilitating learning in the acute care environment. This section highlights the data collection procedures used during this study including methods for participant recruitment, details regarding participant characteristics, and data collection instruments utilized to answer the research questions of interest.

Participant recruitment. Prior to Institutional Review Board (IRB) approval from the researcher's educational institution, the dean or director of the nursing programs of interest were contacted via email (see Appendix A) and, if interested, were asked to send a written statement affirming that recruitment of eligible BSN faculty was allowed for purposes of this study. Written approval to recruit participants from all six institutions was received. Next, approval from the IRB was initially obtained from the researcher's educational institution (see Appendix B) followed by any additional approval required from the six recruitment sites. After proper IRB approval was obtained from each institution, a second email (see Appendix C) was sent to the dean or director of each program with instructions to send an invitation to participate letter via email to all eligible faculty encouraging participation in the study (see Appendix D).

All deans or directors of the programs were asked to re-send the invitation to participate email (see Appendix D) one additional time as, after a two-week period, the researcher was still in need of

participants. Faculty who were eligible and interested in participation contacted the researcher directly via information provided in the recruitment email. The researcher contacted the interested participants to ensure eligibility criteria were met. Any further questions about the study were addressed and an appointment was set to perform data collection at the participants' location of choice.

It should be noted that on the researcher's initial IRB application, a maximum participant limit of 12 was set. Due to the need for theoretical sampling and interest exhibited from an additional two participants representing the sixth nursing education program, the researcher contacted the IRB chair where initial approval was granted to ask permission to include the additional two participants. This ensured participants from all six institutions were represented in the study. The IRB chair granted this request and no further documentation was required as this did not change the purpose, procedures, or eligibility and exclusion criteria described in the initial IRB application.

Participant characteristics. As mentioned, a total of 14 participants took part in the study. All participants were female and, even though grounded theory does not strive for generalizability, this sample does reflect the population characteristics of nursing faculty in this country, as approximately 95% are female (AACN, 2015). All participants held at least a master's degree as their highest degree obtained with one obtaining a doctorate degree. The participants represented all six programs utilized for recruitment and represented varying experience levels and acute care specialty areas, including medical-surgical, obstetrics, mental health, and pediatrics. A total of 11 faculty taught in one Midwestern state while the other three represented the second state. A summary of the participant's demographic data is provided in Table 3. All participants were given a pseudonym to ensure confidentiality was preserved.

Table 3

Demographic Data of Participants

Pseudonym	Age Range	Years of Nursing Experience	Years of Faculty Experience	Years of Clinical Teaching	Level of Student/ Program	Specialty Area
Mean	*44.5*	*19.6*	*9.1*	*9.4*	*N/A*	*N/A*
Sue	51-60	11-15	6-10	6-10	Junior, Senior/Trad	M-S, Cardiac, Oncology
Emma	31-40	16-20	11-15	11-15	Junior/Trad	M-S, Acute Rehab
Catherine	31-40	11-15	1-5	1-5	Freshmen, Senior/Trad	M-S, Post-Intensive
Lois	31-40	11-15	1-5	1-5	Junior, Senior/Trad	Pediatrics
Leah	31-40	11-15	6-10	6-10	Senior/Trad	M-S, Oncology
Phyllis	51-60	> 30	11-15	11-15	Junior/Trad	Obstetrics
Jennifer	51-60	> 30	21-25	21-25	Freshmen, Soph, Senior/ANC	Acute Rehab, Cardiac
Rebecca	41-50	26-30	1-5	1-5	Soph/Trad	Obstetrics
Mary	41-50	16-20	6-10	6-10	Freshmen, Junior/Trad	Obstetrics
Melissa	41-50	21-25	16-20	16-20	Junior/Trad	Obstetrics
Rose	41-50	21-25	11-15	11-15	Soph, Junior/Trad	M-S
Tiffany	31-40	16-20	6-10	6-10	Junior/Trad	Psychiatric/Mental Health
Mandy	51-60	16-20	1-5	1-5	Soph, Junior/Trad	Critical Care, Cardiac
Sharon	31-40	11-15	6-10	6-10	Junior, Senior/Trad	M-S, Pediatrics

Note. Trad = traditional BSN program; M-S = medical-surgical; Soph = sophomore; ANC = accelerated BSN program, N/A = not applicable

In Table 4, a summary of the participants' clinical instruction information is provided. This includes the average number of students faculty instructed in the clinical setting, the average number of hours faculty taught in the clinical setting each week, and the average number of semesters participants instructed students over the prior two years. For semesters taught, there was the potential faculty could provide clinical instruction over three semesters during one academic year accounting for instruction in

the fall, spring and summer. This information was compared between the two Midwestern states represented in the study and demonstrates comparable results. It should be noted that all participants, as nursing students, were taught by faculty utilizing the TCM in their own nursing education programs, making this model very familiar to participants. As faculty, all participants had taught clinical instruction utilizing the TCM; however, of interest, was that all participants also reported the use of simulation instruction which students took part in prior to having clinical experiences in the acute care setting.

Table 4

Clinical Instruction Information of Participants

Midwestern State	Average Number of Students in Clinical Group	Average Number of Hours Providing Clinical Instruction Per Week	Average Semesters Instructing Clinical Over Past Two Years
State One (11 Participants)	7	13	5
State Two (3 Participants)	7	14	4

After ensuring participants met eligibility criteria, the researcher arranged to meet with each participant at a meeting place of their choice for the data collection portion of the study. Many participants wished to meet in their offices located on the campus of the associated nursing program with one participant preferring to meet at her residence and another at a local café.

Data collection instruments and procedures. When meeting with each participant, the study was reviewed and any further participant questions regarding the study were clarified. Prior to any data collection occurring, each participant received and signed the informed consent document (see Appendix E) and all participants were given the *Rights of Research Participants* form (see Appendix F). After these steps were taken, data collection was completed and involved collecting demographic data, conducting interviews, and discussing the use of clinical documents which assisted in answering the research questions of interest. Details regarding each data collection item are discussed in the following section.

Demographic information. After obtaining informed consent, each participant was asked to fill out the demographic form (see Appendix G). This took approximately five minutes for participants to complete. Information gathered included the amount of experience the nursing faculty participant had and details regarding the acute care unit(s) where clinical instruction occurred. Other items, including highest degree obtained and education received preparing participants for the faculty role, were also gathered as this information related to the research questions of interest. This form was completed and collected by the researcher prior to beginning each interview. Results of the participants' demographic data are provided in Table 3 and Table 4 of this chapter.

Interviews. After completing the demographic form, a semi-structured audio recorded face-to-face interview took place with each participant and was directed by a semi-structured interview guide developed by the researcher (see Appendix H). Interviewing remains the primary method of data collection in grounded theory research as interviews allow the researcher to inductively construct a theory representing certain phenomena (Creswell, 2013). Charmaz (2014) discusses that "intensive interviewing" assists in gathering rich, thick descriptions of participant experiences (p. 56). This type of interviewing allows for a, "flexible, emergent technique" granting participants opportunities to provide in-depth explanations of experiences while guiding the direction of future questions (Charmaz, 2014, p. 58). Both the demographic information and semi-structured interviews assisted in answering the central research question and all five research subquestions of interest. During each interview, the researcher and participant faced each other with a table in between where two recording devices were placed. The interviews lasted 40 to 65 minutes. The researcher also provided prompts and clarified answers throughout the interviews to ensure understanding of participant responses.

Due to the iterative process of obtaining and analyzing data with the grounded theory methodology, not every participant was asked the same interview questions. Interview questions did evolve for purposes of theoretical sampling based on emerging categories identified in participant interviews. After the first four interviews, the researcher began data analysis by performing initial coding and identifying potential categories to pursue. This same process was also conducted after an additional

five participants were interviewed, or after a total of nine interviews were completed. When potential categories were identified, interview probes and questions were adjusted to investigate and saturate properties of potential categories. Prior to adjusting any interview questions or prompts, input and approval was received from the researcher's dissertation committee. This process aligns with Charmaz's (2014) constructivist grounded theory approach and principles of theoretical sampling which involves refining interview questions to clarify and develop possible categorical properties and dimensions. The interview question and prompt additions and changes are indicated on the interview guide (see Appendix H) with a sample of these adjustments provided in Table 5. Data collection was completed and participant recruitment ceased after no new properties of emerging categories were discovered in the data.

Table 5

Interview Question Changes Based on Theoretical Sampling

Sample of Interview Prompts Added After Four Participant Interviews	How do you determine which students to focus on when facilitating learning during the clinical day? How do you individualize facilitation of learning for students in the clinical setting? How did you develop a trusting relationship with the nurses on the acute care unit where you provide clinical instruction?
Sample of Interview Prompts Added After Additional Five Participant Interviews	How does the number of students influence your ability to facilitate critical thinking or clinical reasoning skills?

As described, theoretical sampling procedures were employed during this study and did involve three participants taking part in a second interview to validate and provide feedback regarding the developed theory. The informed consent (see Appendix E) included an explanation that this additional interview may be necessary and the researcher informed all participants of the potential for a second interview. After the theory was constructed, three participants were contacted via email to take part in the second interview (see Appendix I) as this number represented approximately 20% of the initial participants interviewed. The researcher determined this was a sufficient percentage of participants to

obtain feedback regarding the developed theory. These three participants were chosen randomly by the researcher; however, the researcher did ensure all three participants partaking in the second interview included faculty from three different nursing programs. This was done to ensure adequate representation of participants when gathering feedback for the developed theory. All three agreed to participate and were sent an email containing information detailing the theory and a visual diagram depicting the theory. This information was provided one week prior to the interview to ensure participants could formulate any questions or ideas in advance. When meeting face-to-face with the participants, the researcher utilized a separate semi-structured interview guide approved by the researcher's doctoral committee chair (see Appendix J) to gain feedback regarding the theory. Also, to ensure protection of the theory, participants were advised in the email correspondence and verbally by the researcher to refrain from sharing the documents, as the theory, at that point in time, was a work in progress and not yet finalized. The researcher met with the participants at a location of their choice and interviews were audio recorded utilizing the same two devices used in the initial interviews. The researcher met with all participants in their offices at the affiliated nursing programs and each interview lasted from 20 to 30 minutes.

Documents. Charmaz (2014) encourages the use of documents if they enhance understanding of the process of interest. To assist in answering the central research question along with the first and fifth research subquestions, participants were asked to bring a document during the initial interview that a nursing student completed as part of a clinical assignment. While all participants were advised to bring a document, some did not provide an example, but all could speak to required assignments and how those documents assisted in facilitating and evaluating clinical learning experiences. Faculty were asked ways in which the document assisted in facilitating and evaluating learning when instructing students in the acute care setting.

Because participants represented multiple BSN programs, these documents differed in structure, content, and specific requirements requested of students; however, the intention was consistent as all documents were meant to enhance both facilitation and evaluation of student learning in the clinical environment. Examples of documents ranged from reflection assignments, which required students to

connect key learnings to future practice, to concept maps that involved students diagramming and connecting patient information into a cohesive picture. All documents utilized by participants assisted in facilitating and evaluating clinical learning experiences.

Data Analysis Procedures

All participant interviews were audio recorded on two devices which included a digital recorder and a standard tape recorder. The interviews were transcribed by utilizing the software *Dragon: Naturally Speaking* developed by Nuance Communications, Incorporated which is a voice recognition program that aided in quicker transcription of data. All digital recordings were uploaded and the software transcribed the data onto the researcher's computer. To ensure accuracy, the researcher reviewed each transcript while listening to the audio recordings and made any necessary edits or corrections missed by the voice recognition software. Participants were emailed their individual transcript along with the initial coding completed by the researcher. This allowed participants to review needed changes regarding the transcribed data and ensured accurate interpretation of the participants' experiences by the researcher. The email instructed each participant to review the transcription and initial coding within two weeks of receiving the email and to reply if any necessary changes, edits, or corrections were needed. Only one participant replied that any corrections were necessary which involved a minor wording change noted in the initial coding section.

After interviews were transcribed, all transcriptions were uploaded into the *NVivo 10* software program created by QSR International. The researcher's educational institution provided access to this program for graduate students. The software program allowed for organization and storage of data when determining categories and codes, aiding in theory construction (Creswell, 2013).

Initial coding. As Charmaz (2014) states, "Coding is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you *define* what is happening in the data and begin to grapple with what it means" (p. 113). The first step of data analysis involved initial coding as described by Charmaz (2014). Initial coding involves coding line-by-line and then using initial codes to compare across similar incidents (Charmaz, 2006, 2014). Line-by-line coding involved analyzing

each line of data and naming each line, assisting in breaking data apart to develop initial ideas regarding the process of interest. The names of initial codes involved the use of gerunds, or active verbs, instead of describing data with topical themes, again to assist in understanding the participant's views, experiences, and actions taken throughout the process of interest (Charmaz, 2006, 2014). These initial codes lead to theoretical sampling and identification of categories needing investigation.

As the grounded theory methodology involves going back and forth between data collection and analysis, incident-to-incident coding, the next phase of initial coding, was completed after a group of participant interviews was conducted. Comparing incident-to-incident involves the process of constant comparative methods, a defining feature of grounded theory (Glaser & Strauss, 1967; Charmaz, 2014; Creswell, 2013). Due to the numerous interviews and approximately 200 initial codes determined from the data, the researcher compared similar participant incidents and evaluated for potential patterns and early categories providing explanations for processes and actions. During this constant comparative method, the researcher collapsed and combined similar initial codes found throughout participant interviews, decreasing the overall number of these codes. Throughout this phase, the researcher stayed open and reflexive while coding to avoid inputting personal assumptions and biases when analyzing data (Charmaz, 2014). As stated, theoretical sampling procedures, including interview question adjustments, were approved and implemented for future participant interviews to continue identifying and saturating properties of potential categories.

Focused coding. After initial coding of all interviews was completed, focused coding began, assisting in identifying frequently appearing initial codes and illuminating patterns in data that lead to the emergence and description of categories (Charmaz, 2006, 2014). Focused codes are often more conceptual in nature and encompass numerous initial codes that reflect similar processes or actions. Again, constant comparative methods were instituted by comparing focused codes both to initial codes and the data, allowing for clarification of emerging conceptual categories (Charmaz, 2006, 2014; Creswell, 2013). The researcher initially developed 30 focused codes; however, this was reduced and collapsed further to a total of 25 after determining similarities in the conceptual properties and dimensions

of certain codes. During the focused coding phase, each code was evaluated and analyzed for specific dimensions, properties, and outcomes. *Properties* assist in determining defining characteristics of the code while *dimensions* describe variations in responses embedded in each code (Charmaz, 2014; Strauss & Corbin, 1998). After determining the focused codes and associated defining properties and dimensions of each, the researcher returned to the literature two additional times during the study to evaluate additional research focused on these emerging codes and categories. Again, theoretical sampling was utilized throughout the focused coding process, including revising interview prompts, to further identify properties and dimensions of possible emerging categories (Charmaz, 2006, 2014).

Memo-writing and diagramming methods. Memo-writing and diagramming methods were used throughout all phases of data analysis (Charmaz, 2006, 2014). Memo-writing involves recording thoughts, ideas, questions, and possible connections about identified codes emerging in the data. Memo-writing was started early on to assist in comparing across participant data and to clarify codes. As Charmaz (2014) states, "Memo-writing encourages you to stop, focus, take your codes and data apart, compare them, and define links between them" (p. 164). After performing initial coding on each participant's transcribed interview, a detailed memo was written with ideas regarding potential categories to pursue, possible adjustments to questions for future interviews, and ideas regarding emerging categories. Memos were also written after comparing incidents-to-incidents, making notes of potential emerging categories, subcategories, and relationships among those categories appearing throughout the data. As Charmaz (2006, 2014) describes, memos may initially be short and contain questions about potential categories to pursue and possible relationships emerging among codes. The researcher found this to be the case with the initial memos created for this study as well.

Later, Charmaz (2014) encourages that memos become more analytical by determining categories from focused codes which aids in theory construction. This was also the case as the researcher continued memo-writing throughout the focused coding procedures. Each focused code was accompanied by a detailed memo clarifying potential properties, dimensions, influencing factors, and outcomes of the focused codes. These memos were then compared to determine potential overlapping codes that needed to

be differentiated into subcategories or collapsed into larger theoretical codes. Memos were dated, titled, and categorized to ensure the researcher could track thought processes and emerging ideas. After focused coding was completed, the initial transcripts and initial coding memos were reviewed to gain a fresh perspective and ensure all possible codes and categories were accounted for throughout the process. After focused coding, memos were completed for each of the overarching theoretical categories which included detailing the properties, dimensions, and determined subcategories included in the overarching category. The researcher completed approximately 55 memos throughout the entire data collection and analysis process to track decisions and determine relationships for the developed theory. Memos are an integral component of the theory development process with Charmaz (2014) stating, "Memos record your path of theory construction. They chronicle what you grappled with and learned along the way" (p. 164). The memos recorded throughout the data collection and analysis process were vital in developing a theory representative of participants' actions and experiences.

Diagramming is a form of memo-writing meant to assist in visualizing possible conceptual categories, subcategories, and relationships evolving from the data (Charmaz, 2006, 2014). One specific type of diagram Charmaz (2014) describes includes clustering. Clustering is a type of conceptual map that involves starting with a central idea and connecting other codes and ideas together to determine possible relationships among and between categories. This method can also assist in determining properties and dimensions of categories (Charmaz, 2006, 2014). Clustering and other types of diagrams were utilized after focused coding was completed to determine possible relationships among codes and potential categories. After theoretical categories were determined, diagramming assisted the researcher in determining the best way to visually depict the developed theory (Charmaz, 2014).

Theoretical coding. After using memos and diagrams to determine potential categories, subcategories, and properties and dimensions of each, theoretical coding was conducted to determine final relationships between and among those determined categories (Charmaz, 2014). This assisted in construction of a grounded theory representing participants' "stories", including experiences and processes embedded in this specific phenomenon (Charmaz, 2014, p. 150). This step, which also involved

utilizing memos and diagrams, brought categories and subcategories together, ensuring determined relationships emerged from the data. From the focused codes, 11 overarching theoretical categories were developed by the researcher. Some focused codes became theoretical categories while others were determined to represent subcategories of these overarching categories. The use of memos and diagrams throughout the data analysis process assisted the researcher in determining final category and subcategory decisions along with detailing relationships between and among the categories.

Theory construction. The next step of the data analysis process involved theory construction describing the process of interest which, in this case, involved the process nursing faculty utilize when facilitating learning in the acute care setting while using the TCM. The 11 overarching theoretical categories each contained multiple subcategories and further defining *properties*, or characteristics. Final relationships among these categories were determined to best represent the process of interest. Using the interpretive definition of theory, this overarching theory was co-constructed by participants and the researcher (Charmaz, 2006, 2014). This approach emphasizes that the developed theory does not represent causality and generalizability, but rather achieves to explain "patterns and connections" that emerge from "multiple realities" represented by participants and the researcher (Charmaz, 2014, p. 231). As Charmaz (2014) states, "Studying a process fosters your efforts to construct theory because you define and conceptualize relationships between experiences and events. Then you can define the major phases and concentrate on the relationships between them", which was the ultimate goal of this study (p. 245). The developed theory is further described in chapter four.

Validation of the theory. As discussed previously, three faculty members took part in a second interview to provide feedback and validate the constructed theory of interest. Data analysis of these interviews involved the same process as described for the initial interviews. All interviews were audio recorded utilizing the same two devices. The same voice recognition software was used to aid in the transcription process and, again, to ensure accuracy, the researcher reviewed each transcript while listening to the audio recordings, making any necessary edits or corrections missed by the software. Participants were emailed their transcripts to ensure all information was correctly documented and were

asked to reply with any needed changes within two weeks of receiving the email. No coding was completed as no new emerging categories were identified by participants. No faculty participants recognized any need for edits or corrections on the transcripts.

All feedback concerning the theory was taken into consideration; however, as stated to participants, any changes made needed to represent the faculty participants' experiences and be supported by participant data. The researcher ensured any changes were grounded in the initial data collected (Charmaz, 2006, 2014). Adjustments made to the theory based on participant feedback are discussed in chapter four.

It is important to note that when utilizing grounded theory, data collection and analysis do not occur separately, as the purpose of theoretical sampling is to refine and focus data collection after analyzing initial participant data. Data collection and analysis procedures are described somewhat separately here, but the researcher went back and forth between collection and analysis to address gaps in categorical dimensions and properties by both refining interview questions and interviewing participants a second time (Charmaz, 2014; Strauss & Corbin, 1998; Creswell, 2013). This data collection and analysis cycle continued until saturation of categories occurred. Figure 2 diagrams the data collection and analysis procedures incorporated during this grounded theory study.

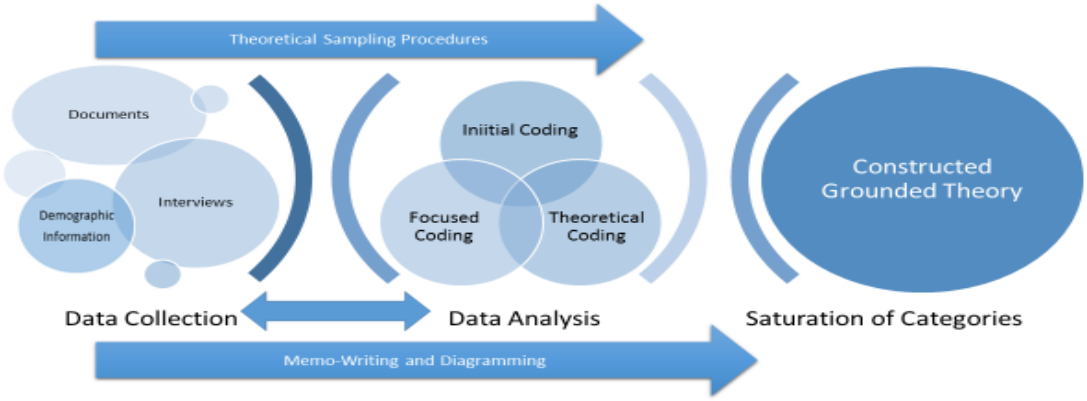

Figure 2. Grounded Theory Data Collection and Analysis Procedures. Adapted from definitions developed by "Qualitative Inquiry and Research Design: Choosing among Five Approaches" by J. Creswell (2013) and "Constructing Grounded Theory" by K. Charmaz (2014).

Data Validation Measures

Ensuring measures were in place to verify the accuracy of participants' stories and experiences was essential (Creswell, 2013). While it remains impossible to completely separate a researcher's prior knowledge, values, and perspectives when collecting and analyzing data, the researcher still had a responsibility to ensure strategies were in place confirming participant perspectives were represented accurately throughout the study (Charmaz, 2014; Creswell, 2013). This researcher incorporated several strategies to ensure accuracy of data interpretation.

Clarifying researcher bias. Creswell (2013) describes clarifying bias as a "validation strategy" which this researcher provided earlier in the chapter (p. 250). Charmaz (2006, 2014) also promotes self-awareness of the researcher regarding interpretations and theoretical perspectives possibly influencing data collection and analysis. After the researcher became aware of assumptions potentially impacting data analysis, an effort was made by this researcher to remain open and reflexive to participants' stories during data collection and analysis. Clarifying the researcher's bias can also assist readers in understanding perspectives and influences brought to the study (Creswell, 2013).

Triangulation. Triangulation involves utilizing multiple data sources to provide additional insight and assist in confirmation of interview data (Creswell, 2013). This study analyzed both interviews and clinical documents brought by nursing faculty to gain a better understanding of processes utilized when facilitating and evaluating student learning in the clinical environment.

Member check. Member checking allows participants the opportunity to review preliminary data analysis findings and ensure interpretations were representative of participant experiences (Creswell, 2013). This researcher provided all participants an opportunity to review final interview transcripts and initial coding to ensure the researcher's interpretation of the data was reflective of participant experiences. Also, participants taking part in a second interview were able to review associated transcripts. This information was emailed to each participant with the researcher requesting feedback within a two-week timeframe. Only one participant discovered a minor word revision in the initial coding segment of the

transcript during an initial interview. No other participants noted any needed changes, errors, or revisions of final transcripts or initial coding conducted by the researcher.

Audit trail. Throughout the study, the researcher communicated with the dissertation committee and doctoral chair regarding revisions to interview question prompts based on initial coding. An audit trail was completed by the researcher's doctoral chair (see Appendix K) to ensure the decision-making process and rationale of constructed categories was sound (Lincoln & Guba, 1985). This assisted in ensuring analysis decisions were truly grounded in the data collected from participants (Lincoln & Guba, 1985).

Memo-writing. An additional validation measure involved the researcher's documentation of the decision-making process and rationale through writing and diagramming memos during the data collection and analysis procedures. These memos assisted in determining relationships among categories which led to decisions regarding the developed theory, ensuring analysis decisions were truly grounded in the collected data (Charmaz, 2006, 2014).

Rich, thick description. Finally, rich, thick descriptions from participants' stories are provided when discussing findings which detail connections and relationships developed among determined categories and subcategories (Creswell, 2013). The researcher anticipated that, with these measures in place, data analysis and the developed theory would more accurately represent participants' experiences.

Ethical Considerations

Multiple ethical considerations were addressed to ensure participants and data obtained were protected throughout data collection and analysis procedures. Specific steps regarding IRB approval requirements, informed consent, and confidentiality procedures taking place during data collection and analysis are described (Creswell, 2013).

IRB approval. Initial IRB approval was obtained from the researcher's educational institution (see Appendix B). After IRB approval was granted, any necessary IRB consent from other institutions utilized for participant recruitment was obtained. The need for additional approval varied among the institutions. Two institutions accepted the IRB approval of the researcher's educational program, one required its own additional IRB approval, and the other three institutions granted IRB approval after

reviewing the IRB acceptance documents provided by the initial institution. This study was classified as expedited for all IRB approvals as the anticipated risk was minimal and no vulnerable populations were included in the study.

Informed consent. For nursing faculty expressing interest in participating, informed consent (see Appendix E) was obtained from each participant prior to data collection. The researcher ensured participants were informed and aware of the purpose of the study prior to beginning data collection. Each participant was also given *The Rights of Research Participants* form (see Appendix F) from the researcher's educational institution. No other forms from other institutions were required to provide for participants. It was verbally stressed and included in the informed consent document that participation in the study could stop at any time with assurance that no negative ramifications would occur to the participant or affiliated nursing education programs (Creswell, 2013).

Confidentiality procedures. To ensure anonymity and protection of participants and the data collected, all demographic data forms were placed in a locked drawer in the researcher's residence that only the researcher had access to at all times. After interview completion, all forms were de-identified. Participants were given a pseudonym which was placed on the demographic forms. These forms will be kept for a period of three years after study completion. After this time frame, all forms will be destroyed. In addition, any email correspondence with participants was permanently deleted from the researcher's email account after any questions or concerns were addressed to ensure anonymity was maintained.

Semi-structured interviews were audio recorded on two devices with each participant. One device included a standard tape recorder. All recordings on this device were kept in a locked drawer, again at the researcher's residence, that only the researcher had access to at all times. The other device included a digital recording device. All recordings from this device were uploaded onto a computer file that was password protected. Only the researcher had access to these recordings and knowledge of the password. The recorded interviews were not shared with any other individual, including other participants. After transcription, interview recordings were permanently deleted or erased and pseudonyms assigned ensuring all participants remained anonymous. Also, any other potential identifying information including

names of healthcare facilities and educational institutions were deleted in the transcriptions as this information was unnecessary for data analysis and ensured participant anonymity. All transcripts, when printed, were stored in a locked drawer at the researcher's residence that only the researcher had access to and will be kept for a period of three years after study completion. After this time, any printed transcriptions will be destroyed. Transcripts were also saved on the researcher's computer in a password-protected file that only the researcher had access to during the study. Three years after study completion, all transcript files will also be permanently deleted.

As stated, participants were asked to bring an example document of student clinical paperwork that nursing faculty had evaluated as part of the clinical learning experience. Nursing faculty were instructed to remove all identifying student information prior to the interview for protection of nursing students. These documents were not kept by the researcher and returned to faculty members after interviews were completed.

Summary

This chapter described the research design choice and rationale for this study. The constructivist grounded theory methodology served to address the research questions and purpose. This chapter also described sampling procedures, data collection methods, and analysis techniques. The role of the researcher and potential assumptions and biases brought to the study were explained in case these did influence results, although data validation measures assisted in ensuring participant data was represented as accurately as possible. Finally, ethical considerations were described, as ensuring the safety and confidentiality of participants and data was paramount. The next chapter discusses the research findings and describes the construction of a grounded theory explaining the process Midwestern BSN faculty utilize when facilitating learning in the acute care setting while using the TCM of instruction.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

Providing clinical instruction remains an essential component of nursing education when preparing students to become professional nurses. Understanding the process faculty utilize when facilitating learning in the clinical setting can assist healthcare organizations, nursing education programs, and faculty themselves in best preparing students for the nursing role. With advances in healthcare, a continuing nursing shortage, and nursing programs still relying on older clinical models, gaining an appreciation for this process through the eyes of faculty members is crucial to continue improving clinical education and ensure students enter the nursing field ready for practice.

Through listening to the experiences of nursing faculty members, this study sought to better understand the facilitation of learning process participants utilized in the acute care setting when integrating the TCM of instruction. By incorporating the data collection and analysis procedures outlined in chapter three, the researcher strove to represent participants' experiences by constructing a grounded theory describing this process. This chapter discusses the results of the research questions and reviews the constructed theory of interest representing this process.

Research Questions

To better understand the process faculty utilize when facilitating learning in the clinical setting, this study sought to answer the following central research question initially presented in chapter one:

What process do nursing faculty at Midwestern BSN programs utilize when facilitating student learning using the traditional clinical model in the acute care setting?

Also of interest were the following subquestions inherent to this process:

1) How do Midwestern BSN faculty facilitate student learning in the acute care setting when utilizing the traditional clinical model?
2) How does the traditional clinical model of instruction influence Midwestern BSN program faculty when facilitating student learning in an acute care setting?
3) How does the acute care setting influence Midwestern BSN faculty when facilitating student learning?

4) What other factors assist or inhibit Midwestern BSN faculty when facilitating student learning in the acute care setting?
5) How do Midwestern BSN faculty determine when effective facilitation of student learning has occurred after providing instruction in the acute care setting?

After data collection and analysis was completed, a significant amount of rich information was gathered from 14 participant interviews, serving as a solid foundation for construction of the grounded theory. The findings of each subquestion and the central research question of interest are supported by participants' own stories regarding their experiences when facilitating learning in the acute care setting and are summarized in this chapter.

Findings

Charmaz's (2014) method of data analysis was utilized to determine answers to the research questions of interest, resulting in the development of multiple categories and subcategories. When describing the findings of each research subquestion, categories that emerged are discussed in addition to their defining *properties*, or characteristics. When categories included subcategories, those subcategories became the defining properties of the associated category. In these cases, each subcategory possessed its own defining properties which are also described. Any variations in responses, or *dimensions*, are also included when discussing the findings, in accordance with Charmaz's method (2014). The central research question is reviewed first followed by a discussion of the research subquestion findings. The chapter concludes with an explanation of the constructed grounded theory.

Central research question. The results of this study led to the construction of the Flott Facilitation of Clinical Learning in Nursing Theory. This theory assists in understanding and describing the process Midwestern BSN faculty utilize when facilitating learning in the acute care setting, while highlighting factors of the TCM, acute care environment, and other elements impacting this process. Four main components to this theory emerged based on participant responses. The first component involved the need for faculty to *determine strategies to facilitate learning* which were chosen based upon the clinical outcome faculty were evaluating for while providing clinical instruction. After *determining*

strategies, the next component involved undergoing the entire *facilitation of learning process.* In addition, *influencing processes* that impacted faculty's ability to facilitate learning were identified, a third component of the developed grounded theory. Finally, the component of *performing the faculty role* emerged. This final component reflected faculty's ability to effectively facilitate and evaluate student learning, which often influenced participants' satisfaction with the faculty role. Multiple figures are depicted throughout this chapter which reference these different components of the theory. A key is provided in Table 6 that illustrates the figures depicted and which component of the theory the figure corresponds with to clarify findings discussed throughout this chapter.

Table 6

Key for Theory Figure Depictions

Figure Depiction	Associated Component of Theory
	Determining Strategies to Facilitate Learning
	Facilitation of Learning Process
	Influencing Processes
	Performing Faculty Role

Results of the research subquestions include descriptions of the multiple categories and subcategories developed to form this theory, and, at the end of the chapter, the developed grounded theory is discussed, illustrating how all components described in the research subquestions come together to form the theory of interest.

Subquestion 1. The first subquestion sought to investigate ways in which faculty facilitated student learning in the acute care environment. From this question, four theoretical categories emerged, including *determining strategies to facilitate learning, facilitating learning, adjusting strategies,* and *addressing gaps*. In addition, one subcategory, *building relationships with students,* was found to be an influencing factor for participants when facilitating learning in the clinical setting.

Determining strategies to facilitate learning. When facilitating learning in the acute care setting, faculty described utilizing different strategies depending on the desired outcome of student learning. *Determining strategies to facilitate learning* ensured the teaching technique matched the goal faculty desired students to accomplish while in the clinical setting. The defining subcategories, or *properties*, of this category incorporated three different focus areas of instruction, including *facilitating higher level thinking, facilitating skills/tasks,* and *facilitating professional behaviors.* All three areas were facilitated and evaluated throughout students' acute care experiences and are discussed below.

Facilitating higher level thinking. Faculty described this type of thinking by using different terms and phrases, including "thinking like a nurse", "clinical judgment", and "critical thinking". Even though participants utilized different terms, the goal when developing higher level thinking was described similarly by all participants. Higher level thinking went beyond basic recall of information, requiring students to sift through patient data, determine which data were significant, and make conclusions about patient needs while implementing and evaluating appropriate nursing interventions. This description is similar to Elder and Paul's (2010) explanation of critical thinking, a term utilized by faculty participants to describe higher level thinking.

The defining properties of this subcategory consisted of common strategies faculty utilized when *facilitating higher level thinking*. These strategies included the use of *questioning techniques,* specifically,

Socratic questioning. This type of questioning involved faculty asking students multiple in-depth questions about a topic that required application, analysis, and synthesis of patient information, similar to integration of higher-order levels of Bloom's taxonomy (Hsu, 2007; Paul & Elder, 2006; Yang, Newby, & Bill, 2010). One participant, Rebecca, described using this type of questioning when *facilitating higher level thinking*:

> I do a lot of critical thinking questions, so kind of going in and talking with them, 'What's going on with your patient? Why do you think they're doing this? Can you tell me about that?' Just critical thinking and making them think, 'Why? Why is this going on?'

Another participant, Sharon, also pushed students to dig deeper when fostering higher level thinking by utilizing Socratic *questioning techniques*: "And just kind of asking that untherapeutic, 'Why? Tell me more, tell me more. What's the pathophysiology behind this? Why are you doing this? Explain this.' And it's just constant questioning…".

Another strategy to enhance higher level thinking included *promoting reflection*, requiring students to reflect on their clinical experiences and "make connections" regarding patient needs and decisions made during the clinical day. Catherine discussed utilizing this technique:

> I am a big reflection person. I think a lot of transformative learning happens when you have to think about what you did and state it out loud, and make those connections yourself. So I think reflection is huge…and when I can help them make meaning out of that, or realize it's not that bad, or that was really awesome, that's better.

Other faculty, including Melissa, also discussed *promoting reflection* to facilitate higher level thinking:

> …so definitely we can see that, you know, 'Oh yeah…they put the epidural in and then her blood pressure tanked. Then after her blood pressure tanked, the baby's heart rate tanked.' And so then, you know, then they reflect that they did it. And then you say, 'Yes, there you go, you saw an action and then all your interventions that you did…'

Faculty also *assigned clinical documents* to assist in *facilitating higher level thinking*. Different terms were used to describe these documents, including "databases", "concept maps", and "care plans". Despite the various names, the overarching goal was to assist students in "making connections" among patient data and further develop higher level thinking. Rebecca discussed how using clinical documents assisted in *facilitating higher level thinking* with her students:

> I just think that, like, the paperwork they have to do in clinical really keeps them engaged…so you can kind of understand if they realize, if this patient got this medication, why does she get it? What are the nursing implications for it? And so forth. I think that makes them think critically, too.

Lois also described the importance of *assigning clinical documents* to *facilitate higher level thinking*, which involved determining possible complications based on patient data:

> Yeah, the care plan is the biggest part of that… I want them to make those connections, like, here's my goal for the patient, and here's my interventions, which will support how I'm going to reach that goal. I want it to be, you know, my patient's white count was 0.7, so what am I worried about with him?

A final strategy used to enhance higher level thinking involved *peer-to-peer learning.* Multiple participants described having students learn from each other to enhance the development of these higher level thought processes. Phyllis combined *peer-to-peer learning* when *assigning clinical documents,* encouraging students to learn from each other:

> And then we also try to do three different care plans or concept maps and we…so we collect from everybody and then we say, 'Okay, let's go talk about it.' I don't make them do them by themselves, because I figure they're going to learn better as a group.

Mary also combined *peer-to-peer learning* when integrating *questioning techniques* to assist in developing higher level thinking:

> …basically, I give them a list of questions and then we'll start with one person and I'll say, 'Okay, you get to pick one question on this list to answer'…so they answer that and then the next

> person will get to pick one…so it's kind of like students teaching students, and I kind of chime in, you know, if they're wrong or try to lead them back to the, you know, the right path.

Facilitating higher level thinking involved assisting students in making their own connections regarding patient care and determining needed interventions after analyzing patient data. This required students to anticipate potential complications, determine a plan of action, and provide appropriate interventions supported by rationale. Faculty utilized the strategies of *questioning techniques, promoting reflection, assigning clinical documents* and *peer-to-peer learning* to assist students in developing higher level thought processes required to provide safe patient care.

Facilitating skills/tasks. The second focus area included *facilitating skill/task* completion, which involved teaching students skills/tasks they would be expected to perform competently when entering the nursing profession. All participants integrated similar strategies when a skill/task was taught. These strategies made up the defining properties of this subcategory with the first involving *providing practice,* allowing students opportunities to practice skills/tasks in a safe environment, such as a skills laboratory. Phyllis described providing students these practice opportunities:

> Basically during our orientation period we take a 4 hour skills lab and we run, we give them opportunities to work with IV's [intravenous catheters], starting IV's, we've brought in pumps, so we can get them a little more experience in doing the pumps.

Emma also described *providing practice* for students to facilitate skill/task completion:

> We do [an] entire morning, or a half-day, of skills day with them. We have videos for them to watch. We have scenarios for them to work through in the skills lab independently and they're to come to skills lab and perform them in pairs or groups of three.

After *providing practice,* when opportunities arose to perform skills/tasks on a patient in the acute care setting, faculty listened to students *verbalizing the procedure*, allowing faculty to confirm students understood how to complete the skill/task appropriately. Lois described using this strategy: "…so when the nurse tells us, like, 'Hey, do you want to go pull, whatever?' The student and I, like, I pull them aside and I have them talk me through how they're doing it."

Tiffany also used this strategy, which she described by stating: "…I'm going to say to them, 'Okay, let's step in the back here and I'm your patient and I want you to walk me through what you're going to do.'"

When listening to students *verbalize the procedure*, faculty would interject with *questioning techniques* to ensure student understanding of the skill/task needing completion. These questions differed somewhat from the Socratic questioning utilized with development of higher level thinking, as these focused more on basic recall of information about the skill/task to be completed. Mary described utilizing these *questioning techniques* when administering medications with students:

> … we do administer medications in the afternoon, and they all have to tell me, you know, what drug they're giving, give me the class of drug, therapeutic action, you know, side effects that's going to happen while they're taking care of that patient…

Tiffany also ensured students understood the rationale for necessary skill/task steps by integrating *questioning techniques*:

> And then you know the whole, 'Why?' Because, you know, I want to get them thinking about, why you are doing these things? Not just that it's a task. That we have to do ABCD, but why are we doing it, why is it important?

Another strategy when *facilitating skill/task* completion involved the use of *peer-to-peer learning*, which Emma alluded to in her excerpt describing *providing practice* opportunities for students. Emma also described how she utilized *peer-to-peer learning* when in the acute care setting while *facilitating skill/task* completion:

> I tend to use a lot of, um, have students teach each other. So, maybe one student has a patient with, um, hemodialysis, with an AV fistula, and they are able to tell me everything you need to do to assess that AV fistula, I've seen them do it… I'll say, 'Okay, take each of your peers in there…and teach them everything you told me about this.'

Finally, similar to *facilitating higher level thinking*, faculty *promoted reflection* after a skill/task was completed, assisting students in learning from their experience and incorporating key learnings into

future practice. Melissa described *promoting reflection* with students after completing a skill/task: "…then when we're all done with the charting, I'll talk to them by themselves… I usually will try to talk to them and say, or I've been trying to say, 'How do you think that went?'"

Sue also combined the strategies of *peer-to-peer learning* and *promoting reflection,* encouraging students to reflect and share their experience with others:

> And then after they do one [skill] we reflect on what went well, what didn't go well, immediately after that. And as we come through post conference we share that with the group…so then, that student gets to say, 'Wow, that was a lot harder than what I thought' or, you know, 'I felt really awkward, I didn't know when to put on my gloves once I got in there', and so that really helps the rest of the students learn when we do that reflection.

All participants utilized a similar process when *facilitating skill/task* completion in the clinical setting. These strategies involved *providing practice, verbalizing the procedure,* utilizing *questioning techniques,* encouraging *peer-to-peer learning,* and *promoting reflection,* assisting students in learning from their experiences and improving for future practice.

Facilitating professional behaviors. The final focus area involved *facilitating professional behaviors,* which was divided into two areas including *interpersonal skills* and *management of care. Interpersonal skills* involved qualities needed to effectively work with other healthcare staff, patients, and families. This included utilizing professional communication techniques and displaying leadership qualities necessary to function effectively in a team. *Management of care* involved responsibilities needed to effectively manage patient situations. This included delegating patient needs, incorporating time management principles, and prioritizing patient cares appropriately. The same strategies were utilized to develop both areas, which included *role modeling, promoting reflection,* and *increasing responsibilities*.

Participants understood that students were novices, and due to their lack of experience, faculty often utilized *role modeling* to demonstrate necessary professional behaviors while working with patients and healthcare staff. Emma used this strategy when assisting students in *managing care* by *role modeling* how to prioritize patient needs, similar to the process she utilized when prioritizing student needs:

> …because that is another strategy I use, actually, to facilitate their learning is, I'll try to do a think aloud, and say, 'Okay, you need this, but Student A needs this and Student B needs this. So I'm going to do a little prioritizing here', and I try to think aloud for them and show them my thought process for how to prioritize.

Phyllis also used *role modeling* to display the importance of teamwork, fostering necessary *interpersonal skills* required of the professional nurse:

> I mean, there's been times where me and a couple of students have stayed late because we're doing a last-minute C-section, so you know, we're helping them out, getting rooms transferred and doing those things for them. So, you know, I try to model a lot to the students.

Promoting reflection was also utilized when *facilitating professional behaviors*. Faculty wanted students to reflect on their own performance and determine ways in which behaviors could be improved for future practice. Melissa described *promoting reflection* when students observed less-than-optimal *interpersonal skills* displayed by healthcare staff while in the acute care setting:

> …you know, nurses are humans and so sometimes the staff will talk… and so I'll say, you know, so somebody will bring it up and I'll say, 'Okay, how, how should we handle it? Or if you're the nurse and that's going on, how would you handle it?'

Mandy described *promoting reflection* with students regarding *management of care behaviors*, wanting students to reflect on how best to time manage multiple patient needs when in the acute care setting:

> As a student, I want you to be able to see what those challenges are, and with two patients, okay, how do I balance this?... So, this is where you're trying to build on that, okay, this is a past experience, how can I handle it? How can I use that going forward to assist me in these new challenges?

Finally, *increasing responsibilities* was integrated to *facilitate professional behaviors*. Faculty

would push students out of their comfort zones by providing experiences to promote growth as a professional. Mary described giving students the opportunity to be a resource for others as a way to develop leadership and *interpersonal skills*:

> One thing I do is I always assign one student as a team lead…and I just always let the students know that, if I'm unavailable, you can't find me or you need something, this is your team lead and so go to your team lead and you guys try to, you know, problem solve or whatever, and then if you can't work it out, then you come find me and then we'll work it out.

Regarding *management of care,* faculty would continually increase the number of patients students would care for to gain better experience with time management, prioritization, and delegation skills, as Sue described:

> So pretty much they are responsible for one patient their first two weeks then we bump them up as they are appropriate to two [patients] and our goal is to have them, by their senior semester, up to three patients in the acute care setting.

Students needed to display effective *interpersonal skills* when working with patients and healthcare staff while effectively *managing care* for multiple patients. The strategies of *role modeling, promoting reflection,* and *increasing responsibilities* assisted faculty in developing these essential behaviors required of professional nurses.

When *determining strategies to facilitate learning,* participants chose strategies based on three different focus areas of instruction. These strategies assisted students in developing *higher level thinking,* performing *skills/tasks,* and incorporating *professional behaviors* required to provide safe patient care. Figure 3 illustrates the category of *determining strategies to facilitate learning* along with the associated subcategories and defining properties.

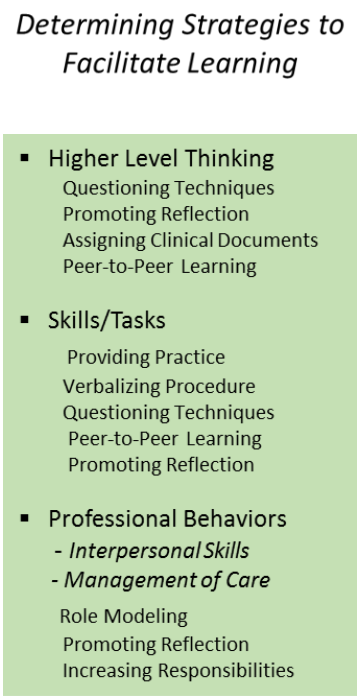

Figure 3. Determining Strategies to Facilitate Learning Category

Facilitating learning. *Facilitating learning* was the second category that emerged in response to this subquestion. After *determining strategies to facilitate learning*, faculty actively engaged in *facilitating learning*, as illustrated in participants' prior excerpts. While actively *facilitating learning*, it was noted that three guiding principles were integrated by faculty when facilitating all focus areas of instruction. These principles became the properties of this category and included *assessing foundational knowledge*, *building on foundational knowledge* and *integrating theory with practice*. These properties assisted faculty in ensuring students were progressing and learning at an appropriate pace throughout acute care clinical experiences.

When *facilitating learning*, faculty first *assessed the foundational knowledge* level of students, which included determining prior knowledge and clinical experiences students had acquired prior to arriving at the acute care setting. This allowed faculty to set realistic expectations regarding the rate at which students could grow and progress during subsequent clinical experiences. Mandy discussed the importance of *assessing foundational knowledge* to avoid overwhelming students when *facilitating learning*:

> And just…making sure that your expectations meet the level that they're at. It's kind of like, you expect them to just jump in and start assessing this two-month-old when one, they don't have children, they're nineteen years old, they've never stepped foot in a hospital. Maybe for week one we can buddy them up and just get familiar with the area.

Melissa also described the importance of knowing the curriculum requirements of the program which assisted her in understanding the knowledge and experiences students should be held accountable for when starting clinical rotations:

> I've been on the curriculum committee here several years, and so that's been very nice … so when they [students] say, 'You know, nobody ever showed me how to do this' I say, 'Oh no, I know they did last semester.'

Assessing and understanding the knowledge and experiences students brought with them when coming into the clinical setting was key for faculty to *facilitate learning* effectively, no matter the focus area of instruction.

After *assessing for foundational knowledge* and setting expectations accordingly, faculty described continuing to *build on foundational knowledge* which often correlated with the students' level, or year of education, in the nursing program. Jennifer described leveling the complexity of her questions based on students' foundational knowledge to continue building higher level thinking:

> If you are a sophomore, I might say, 'Oh, look, your patient's potassium level is 4.8. Is that normal, is that not normal?' Okay, so there's knowledge level…At the, at the senior level, I might be saying, 'Oh, your patient's potassium level was 4.4. At what point would you be worried about seeing changes in the patient's cardiac monitor, and what would happen if, all of a sudden you had tall, peaked T waves?'... and so more analysis type questions.

Building on foundational knowledge was integrated throughout all focus areas of instruction. Faculty gradually integrated more complex material and concepts into the clinical setting throughout the program, as Sue described when facilitating skills/tasks:

> So we gradually work them into that, as far as, they will start out right away passing medications, um… work them into doing their IM [intramuscular] and subq [subcutaneous] injections… still do their PO's[oral medications] and subq's [subcutaneous injections] and then ending with their IV [intravenous] administration of their medications.

Developing an understanding of students' baseline knowledge allowed faculty to continue building and developing students into professional nurses. This involved *building on foundational knowledge* at an appropriate rate while students progressed throughout the nursing program.

In addition to *building on foundational knowledge*, participants worked at *integrating theory with practice* during clinical experiences. This involved highlighting content or concepts of focus in the classroom setting and assisting students in connecting those theory areas to patient situations. Jennifer described the importance of this principle when *facilitating learning*:

> I try really hard, and I expect my faculty to try really hard, to bring in whatever classroom content we're working on, even if that's not really their patient. Like, in the coronary care unit we might be talking about renal labs or G.I. stuff, or whatever. Try really hard to bring that in…

Sharon also described the importance of linking classroom topics into the clinical setting to better assist students in "making connections":

> …they have a very hard time with that inference, with how do I actually apply what I'm learning in the classroom to my patient in the clinical setting and how do I bring this back into the classroom so that it all relates? So we work a lot on that.

This thread was, again, seen throughout all focus areas of instruction. Lois described providing theoretical concepts of communication in the classroom first, an important professional behavior, in order for students to *integrate theory with practice* when caring for patients in the acute care setting:

> We do, so the first lecture I do in the classroom is a communication, we talk about communication …all of that is done before we're in the clinical setting so they have heard that whole piece…Usually once they get in there, at first they're always really nervous, but then they kind of warm up to their patients…

There were different *dimensions*, or variations, in faculty responses regarding the ability to implement this principle. Some participants described frustration when clinical experiences did not align with classroom concepts or content as Phyllis described:

> In a perfect world, there would be some way to give them the lecture before we ever went in, but you can't do that, not in OB [obstetrics]. I struggled with that when I did the theory, trying to make sure they had what they needed could apply to the clinical… a lot of times if they're in labor and delivery they haven't hardly been exposed to that in theory.

Integrating theory with practice was important for faculty to assist students in "making connections" while in the clinical setting. When theory and clinical experiences did not align, faculty had difficulty in assisting students with facilitating these connections.

Regardless of the focus area of instruction, three guiding principles were utilized when *facilitating learning* in the acute care setting. These included *assessing foundational knowledge, building on foundational knowledge* and *integrating theory with practice.* Figure 4 illustrates this theoretical category and its' defining properties.

Figure 4. Facilitating Learning Category

Adjusting strategies. *Adjusting strategies* was the next category that emerged in response to this subquestion, which occurred if students were struggling to provide an appropriate response after faculty initially *facilitated learning.* When *adjusting strategies*, faculty utilized three techniques, which became the properties of this category, including *providing a frame of reference*, *going another direction*, and *seeking out resources.*

Participants understood that students were novices and often needed help in developing *a frame of reference* when struggling with integrating and applying knowledge in the clinical setting. Catherine *provided a frame of reference* by connecting patient situations to personal events for students with no prior acute care clinical experience:

> I think fundamental level students…you use a lot more simple things and you connect it to things they already know, like, if they have ever had a really bad migraine… you know, you can connect that to different neurological symptoms and different types of headaches or things like that.

Others utilized expectations and assignments from prior foundational courses when *providing a frame of reference*, as Melissa described:

> So when a student seems really stuck on something, I'll say, 'Hey, remember way back to nursing care one, those four questions, so now, how are you going to know?' So I think that helps to bring back to that as well.

A final way faculty *provided a frame of reference* involved role modeling. In addition to integrating this strategy when *facilitating professional behaviors,* participants also utilized role modeling to assist students struggling with handling certain patient situations, as Rose described:

> Sometimes I think modeling works, too, going in and if they're nervous about going in and talking to the patient…I just worked with a sophomore student this semester who, he wouldn't do the bath. And finally it was, I think it was all a matter of how he was saying it to the patient… so I was able to go in and be like, 'You know, we've got some wipes here, some things, how would you like to get cleaned up?'

Providing a frame of reference allowed students to reference an expert or go back to a more foundational level in order to continue progressing. It was participants' hope that *providing a frame of reference* would spark a connection for students, better assisting them in "putting the pieces together".

Another way faculty *adjusted strategies* involved *going another direction,* which was especially helpful when faculty used *questioning techniques*. Emma described *going another direction* when finding students struggling to answer initial questions:

> If the student isn't putting the pieces together totally…then I might say something, like, 'Well, I would link the diabetes to the renal failure. Can you tell me why that would be?' So then, I'll try to make the connection for them and see if they can provide me the rationale.

Mandy also utilized this strategy when noticing students were struggling to formulate responses:

> So I pull and I try and at some point I'm like, 'Okay, this is the answer. Now let's go through this together. Why am I telling you this? Why is this right?' And I try to get them to maybe connect another dot and bring it full circle.

Going another direction involved integrating different questioning techniques to better facilitate student learning while still encouraging students to develop their own correct responses and "make connections."

A final adjustment strategy centered on students *seeking out resources* when struggling to determine appropriate actions or responses. Participants were aware that some students needed time to process questions and information, and participants allowed students this time while encouraging them to validate information through the use of resources, as Rose stated:

> And so you can kind of get that sense as you're standing there saying, 'Tell me a little more about', and they're doing the, 'Uh, uh, uh'. Sometimes I'll tell them, 'I'm going to let you look this up, I'm going to let you think about this, I'm going to check on somebody else and I can come back.' And a lot of times, by that point, they are able to pull it together…

Multiple faculty described encouraging students to ask peers for assistance when *seeking out resources*, which Jennifer integrated when noting students were struggling:

> I do that a lot with reading EKGs [electrocardiograms] because they have to do it, too, when they're in the acute care, the cardiac unit, they have to do strips twice a shift, and if you're just not getting it, I'll say, 'Okay, well go talk to so-and-so, she did a really good job this morning, she can help you out'.

Finally, participants pushed students to determine resources to reference on their own when

looking for feedback or responses, which was often integrated when students approached graduation, as Catherine discussed:

> When I'm working with the seniors, that's a big push for them, to do that by themselves. It's more real to them for me to say, 'I'm not going to be here in three months, so what would you do?' And make them do it themselves and they're a lot more receptive.

When noticing students were struggling with any focus areas of instruction, faculty learned to quickly *adjust strategies*, trying different approaches to better facilitate student learning. The most common methods faculty utilized involved *providing a frame of reference*, *going another direction*, and *seeking out resources.* By *adjusting strategies,* participants addressed different learning styles while still encouraging students to develop their own solutions or connections. Figure 5 visually depicts the *adjusting strategies* category.

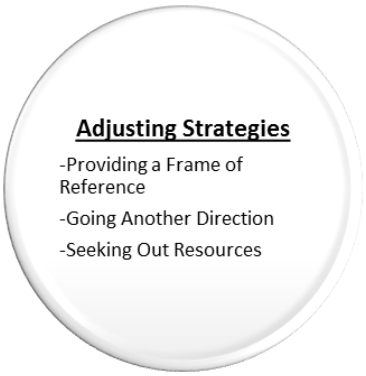

Figure 5. Adjusting Strategies Category

Addressing gaps. The final category that emerged for this subquestion involved *addressing gaps.* Faculty were continuously assessing for gaps in students' knowledge or application of knowledge when facilitating learning, both in the clinical setting and while reviewing clinical document assignments. If, after *adjusting strategies,* individuals or groups of students were still struggling with focus areas of instruction, faculty would address these gaps utilizing multiple methods. These methods became the defining properties of this category and involved *noticing trends*, followed by different solutions to *addressing gaps,* including *individualizing feedback, debriefing*, *offering remediation, developing new methods,* and *stepping in for patient safety.*

Faculty would often *notice trends* regarding gaps in knowledge when facilitating student learning which assisted participants in *addressing gaps* on an individual basis and at a group level. There was variation among all participants regarding gaps that were noticed, but gaps were found in all focus areas of instruction including higher level thinking, skill/task completion, and professional behaviors.

Rose provided an example of noted gaps with integration of higher level thinking when evaluating for students' development of appropriate nursing diagnoses: "Because they sometimes get confused, even with us at the junior level, what is the diagnosis? And that's really nursing, that's what you are actively doing…".

Mary described *noticing trends* in gaps regarding professional behaviors when facilitating learning in the clinical setting: "Because that's a, that's a real big thing that we still struggle with at all levels… we tell them how to professionally look, but sometimes acting and the communication part is they, they struggle with."

Even though gaps differed among participants' experiences, all faculty described *noticing trends* regarding gaps in student knowledge, skills/tasks, and professional behaviors, and worked to address those gaps utilizing multiple methods. One strategy implemented when *addressing gaps* was providing *individualized feedback* and developing solutions for individual students struggling with content or concepts. Participants provided feedback in both written and verbal forms to address these gaps. An example of providing verbal feedback was described by Tiffany: "I try to have a one-to-one discussion while I'm going over clinical paperwork. I try to do it individually so that if there is something that they've completed wrong, I can address it individually".

Rebecca described *individualizing feedback* in a written format on students' clinical document assignments: "But usually I'll write them a little note about their clinical day… I can go and highlight what I found, and if I have any feedback, like revisions or anything, I'd put it down here. "

Individualizing feedback allowed faculty to facilitate learning on an individual level when noticing gaps in focus areas of instruction. This feedback provided students' insight regarding areas to improve upon for future clinical experiences.

When addressing gaps in a group setting, *debriefing* was often conducted during post-conference sessions where faculty could address concerns and facilitate learning with all students. Melissa described utilizing this technique when noticing students struggling with integrating ethical concepts into clinical practice:

> So a lot of our post-conference does focus on…it just happens that it works out really well to speak about ethics and, and what our responsibility is, and how social services…gets involved and what is our responsibility, and what can we say and what can't we say.

Some faculty utilized *debriefing* to assist students in learning from situations that they may not have had prior exposure to in the clinical setting, as Jennifer described: "And then somebody will code… and when that happens, that's when I might do a real post-conference and pull students together and say, 'Okay, let's talk about what just happened.'

Debriefing allowed faculty to address concerns and bridge gaps with entire groups of students when noticing the majority of students were struggling with certain concept or content areas.

Another method utilized to address gaps involved *offering remediation* opportunities. This was most commonly utilized when students were struggling with skill/task performance in the clinical setting, and was usually offered on an individual basis. Phyllis described the ability to individualize student learning needs when noting gaps by *offering remediation* to students:

> …one of the nurses came up and said, 'I don't think she knows how to count baby's heartbeat. She said that the baby's heart rate was only 70.' And I said, 'Okay.' So I went and talked with the student and then we came back to the simulation lab a different day, got the newborn so she could work on hearing how fast it was…

Mary also described *offering remediation* when students were struggling with performing skills/tasks in the clinical setting:

> We do a newborn assessment check out and a postpartum assessment check out here on campus. They do it again at the site on real people…and then if they get a referral on a real person, then

> they get a week before the next clinical to get that referral done and then they have to re-check out again.

Offering remediation allowed students the chance to enhance skill/task performance through individualized instruction by being provided additional practice opportunities to strengthen performance.

An additional strategy when *noticing trends* in gaps over time involved *developing new methods*, where faculty adjusted teaching strategies to *address gaps* for future students. Emma described incorporating new clinical documents to bridge gaps in knowledge she had noticed over the span of a few semesters while instructing the same level of student in the clinical setting:

> …I think, after teaching at this level for several semesters, I could see where they needed to, maybe, just grow in certain areas… so this is just designed to take them up the next step with many of the things they were doing in the course below us. So, as an example, at my level when they come into our course, they typically still ignore the IV [intravenous] solution and rate and all that in their head-to-toe assessment, and this is just prompting them to include that when they do their head-to-toe [assessment].

Tiffany also described evaluating resources for student learning and making changes when necessary to *address gaps*: "We also have implemented using a new pocket guidebook for clinical and so this is really good with nursing diagnoses because they were really struggling with that."

Faculty investigated ways in which they could improve teaching after *noticing trends* regarding gaps in student knowledge, continuously improving facilitation of learning and working to improve student understanding of clinical concepts.

The final method utilized when *addressing gaps* involved *stepping in for patient safety*, where faculty would take over care if patient safety was a concern when a gap was noted. Faculty wanted to allow students as many opportunities as possible to formulate responses and perform care on their own, but faculty would intervene when no other option was available and patient safety needed to be maintained, as Melissa described:

> …during a Foley [catheter] or something, I'll just say, 'Oh, let's see, we need to change your gloves', or something and then I usually go ahead and put on sterile gloves when the student does, too. That way, in case something happens, I'll have to step in as well.

Rose also discussed encouraging students to form their own patient care decisions while understanding the need to step in if necessary:

> So allowing them to make some of those decisions, too, and not being like, 'Why didn't you do it?' Now, granted, I would jump in if it wasn't safe, but if it was a fair decision and they had rationale behind it then, yeah.

When *addressing gaps,* faculty first *noticed trends* in focus areas that either individual or groups of students were found to be struggling. When implementing strategies, faculty made sure to *individualize feedback*, integrate *debriefing* strategies, *offer remediation*, or *develop new methods* while understanding the need to *step in for patient safety* if necessary. Figure 6 visually depicts this category and its' defining properties.

Figure 6. Addressing Gaps Category

Four separate categories emerged describing how faculty facilitated learning in the acute care setting. First, faculty *determined strategies to facilitate learning* after deciding whether higher level thinking, skills/tasks, or professional behaviors were the focus of instruction. Then, faculty incorporated three guiding principles while actively *facilitating learning* in the acute care setting, no matter the focus area of instruction. These principles included *assessing foundational knowledge, building on foundational knowledge,* and *integrating theory with practice.* Next, if after *facilitating learning* students were noted to

be struggling when providing responses or performing skills/tasks appropriately, faculty would then *adjust strategies* to better assist students in developing the correct response. Finally, if after *adjusting strategies* students were still noted to be struggling, faculty would *address gaps* at the individual or group level by incorporating strategies to continue assisting students in improving for future clinical experiences.

Building relationships with students. In addition to the four categories describing faculty's process when facilitating learning, one subcategory was identified as influential for faculty when teaching students in the clinical setting. This subcategory, entitled *building relationships with students*, was part of the overarching category of *negotiating multiple relationships*. Of utmost importance to faculty was *building relationships with students,* which involved getting to know students and their learning needs. Building these relationships improved when faculty ensured they were *being approachable to enhance learning*, a defining property of this subcategory. This approachability assisted in fostering relationships with students that promoted learning and growth, as Sharon described: "And I think fostering a relationship where students feel respect for you, but they're not so scared of you, that you have a healthy relationship with them, and they aren't afraid to give you a wrong answer."

Rose also mentioned the importance of being approachable when facilitating learning: "…so I think it's the approach, too, you want to be approachable and want to have people come and ask. For students to not be afraid…And then they get comfortable with us…"

In addition to exhibiting approachability, instructing students in both the clinical and classroom setting also enhanced *building relationships with students.* Lois described this experience as she initially started as an adjunct instructor. Since becoming a full-time faculty member and working in both settings, she noticed an ability to *build relationships with students* quickly:

> It helps now that I'm in the classroom setting. I know the students before we get to the clinical site, too. Where before I would just kind of show up and whoever was in my group, was in my group. And some were great and some were not great and it took a little bit for me to get to know

> them and for them also to get to know me, whereas, now we're already kind of comfortable with each other and that part's ready to go.

After *being approachable to enhance learning* and getting to know students, faculty were better able to *individualize student learning needs,* a second property of this subcategory. Jennifer described her ability to better *individualize learning needs* after *building relationships with students* over consecutive semesters:

> And I think I have a huge advantage because I do have the same cohort of students, freshman, sophomore, senior. So I can level the way I approach them, and I know from day one what the senior's good at, what she's not good at, or what he's needing help with, and that really helps, too, because I feel like I'm more tailored than somebody who's never had the student before.

There were variations noted in participant responses, as not all faculty were able to develop and build these relationships, as Emma described, which led to an inability to address *individual student learning needs*:

> So, sometimes it feels so rushed that I don't get a great amount of time to really get to know the students if I don't already know them and if I haven't already had them in clinical. And then, I feel like we just dive right in and I don't get a chance to really figure out who they are, what their learning needs are…

In addition to the multiple ways faculty facilitated learning, participants' needed to *build relationships with students* to best *individualize student learning needs.* These relationships were improved when faculty focused on *being approachable to enhance learning,* allowing for positive learning experiences. Figure 7 displays the overarching category of *negotiating multiple relationships* along with the subcategory of *building relationships with students* and its' defining properties.

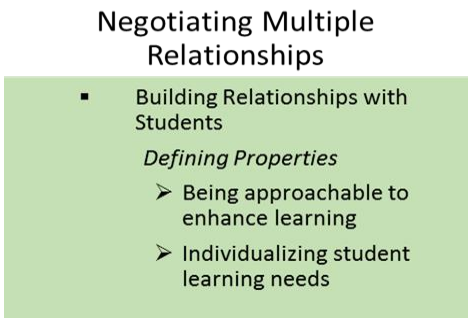

Figure 7. Building Relationships with Students Subcategory

Subquestion 2. The second subquestion addressed how the TCM impacted faculty's ability to facilitate learning in the clinical setting. As stated in chapter one, the TCM is the most common model of clinical instruction utilized in this country and typically involves one faculty member facilitating clinical learning for a group of students in one to two acute care units. From participant responses, two subcategories and one overarching category emerged, including *instructing large clinical groups*, *performing the faculty role,* and *building relationships with students,* all of which describe the influence this model had on participants when facilitating learning in the acute care setting.

Instructing large clinical groups. This subcategory is part of the overarching category entitled *dealing with a larger system,* which addresses influencing factors that are a part of multiple systems and structures in place impacting clinical education. These factors were often due to regulations, standards, or requirements put in place by nursing education programs or outside agencies. *Instructing large clinical groups* was the most frequently mentioned aspect of the TCM influencing faculty's ability to facilitate and evaluate learning. It should be noted that the number of students allowed in clinical groups is often regulated by the affiliated State Board of Nursing. Participants from two states were included in this study with each state setting different maximum faculty-to-student ratios allowed in the clinical setting; however, as noted when evaluating participant demographic data, the average number of students in a clinical group was equivalent regardless of the state. Despite the different ratios mandated by each State Board of Nursing, participants from both states felt the ratio was too high and impacted clinical instruction in a negative manner. Mary described her inability to *divide time with students* when

instructing large clinical groups, a property of this subcategory, negatively impacting her ability to facilitate learning with students:

> I know the faculty-to-student ratio is, you know, anywhere from 8 to 10, which I think is asinine, because you cannot give these students the attention that they need. I don't care what level you're at. To be prepared, you know, and that's one of the things that they talk about, you know, new graduate nurses not being prepared for practice…but when you have 10 students in a clinical setting, you cannot pass meds on 10 patients with 10 students making sure that they know why they're giving these meds …

Melissa, along with other participants, mentioned that some nursing programs tried to avoid implementing the maximum faculty-to-student ratio, which was appreciated:

> So, I have to say, our college, we've really taken a stand that we're going to have smaller numbers even though the State Board says we can have up to 10. We just don't feel that that's really a great learning experience.

In addition to facilitating learning, participants discussed that *instructing large clinical groups* impacted faculty's ability to *monitor student performance*, another defining property describing the ratio's impact on evaluating student learning, as Jennifer described:

> The more students you have, we joke around here, there's always some clinical student that you didn't even know was on the floor that day because you never saw them, you know… but yes, sometimes I look at those clinical evaluation forms and say, 'I don't know what to do, because I did not see anything, I didn't hear anything.' Well if I didn't hear anything bad, I guess I'll give them the three, which is the expected number, but I don't know what to say because I don't know what you did all day long.

Some participants also mentioned safety concerns due to the inability to adequately *monitor student performance*, as Sue stated:

> And if a nursing student her senior year or his senior year gets a little overconfident and clinical instructor's not available and primary nurse is busy, that's when you can get the overconfidence,

> ‘Oh, I can do that; I've done that before, I don't need to have any, you know.’ And, has it happened? I'm sure it's happened, and that's the scary part.

Emma had also experienced this, stating that the nursing staff shortage in addition to the amount of students in each clinical group led to safety concerns when facilitating clinical learning:

> Well, if they’re short-staffed, they’re going to have less time for the students. They also have less time for the patients and so sometimes I feel like, they’re resource nurse has, maybe, not given as much oversight to their patient care and they are being pulled in so many more directions.

Even though most participants discussed concerns with *monitoring student performance* while *instructing large clinical groups,* there were variations in responses regarding this impact. Leah described that, even with a larger clinical group, her ability to evaluate students was not impacted: “I think through their paperwork, through constantly checking in on them, and when they do a lot of their skills and stuff, I do think I’m able to efficiently evaluate them every day.”

A final defining property when *instructing large clinical groups* was the *availability of learning opportunities* provided to students. Rebecca described students missing out on opportunities while waiting on faculty who were assisting other students:

> They might, I've had students actually miss out on things because I’m not available. And that’s not fair for them sometimes. I think it’s hard, it’s really hard. The bigger the clinical group, the harder it is for that instructor to be with students.

With smaller groups, Catherine described that students had increased responsibilities by providing care to more patients, offering realistic learning opportunities that prepared students for practice:

> …but there was a summer where…I had 4 students and I gave them each three patients and they had never had that amount of responsibility and they loved it! It was fantastic…they got to manage care, they got to prioritize what they went and did, and they felt like they learned a lot more.

The majority of participants felt that, as the number of students in each clinical group increased,

the ability to facilitate and evaluate learning was impacted in a negative manner. This was viewed as a negative consequence of the TCM which was influenced by the State Board of Nursing regulations regarding faculty-to-student ratios. Figure 8 illustrates this subcategory and its' defining properties.

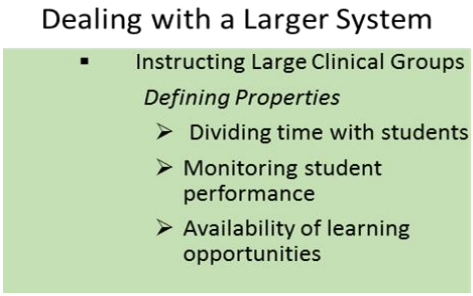

Figure 8. Instructing Large Clinical Groups Subcategory

Performing faculty role. In addition to the size of the clinical group, the TCM was also found to influence faculty's satisfaction regarding their ability to *perform the faculty role* when providing instruction in the acute care setting. Faculty often felt the pull to choose between facilitating skills/tasks and focusing on higher level thinking, which was attributed to the structure of the TCM. Faculty knew both elements needed to be facilitated, but most faculty were aware that developing higher level thinking should be the priority, as these thought processes were imperative in practicing safe nursing care versus simply understanding how to complete a skill/task. Rose described this aspect of the TCM and how it influenced facilitation of student learning:

> I wonder, I sometimes even wonder if we get too task oriented. And that's one thing I think the traditional model is, you can get caught up in is, are we too tasky? And that's where sometimes I [say], 'No, let's back off, we don't need to do that IV [intravenous] start, you can get that experience somewhere else. We need to sit down and talk about your map.' Of course, the students don't like that, they want to do all the skills. That's a big satisfier for them. But sometimes we have to pull them back and really explain to them, you know, there's, there's other things that we need you to take notice.

In addition to students, Sharon described working to change the mindset of nursing staff when trying to focus on development of higher level thinking versus completion of skills/tasks:

> And I love to tell my students, they get so angry at me when I say, 'I can teach a monkey to put in an IV [intravenous catheter], but I can't teach a monkey to think. That's what deciphers you and your role as a nurse is to be able to critically think.' So getting students to see the bigger picture is a huge part of what clinicals is now. And trying to get them pulled back and letting the nurses, let them pull back a little bit and actually learn and not just be saying, 'Hey, I need you to do this, and I need you to do this' is a huge part of it.

Three subcategories were included in the *performing faculty role* category, which described faculty's varying satisfaction with their ability to perform the role of clinical instruction. These subcategories were entitled *fulfilling faculty purpose, going through the motions*, and *disengaging from learning.* One defining property differentiating those in the *fulfilling faculty purpose* subcategory from the others was the ability to *determine the clinical teaching focus*. For those *fulfilling faculty purpose,* preparing students for practice meant prioritizing the development of higher level thinking which faculty knew would be demanded and required of students after graduation. This meant turning away skill/task opportunities to carry out this focus, as Rose described:

> And that's one thing when you're in your own facility, staff knows you and so they will come find you for everything. So I've got an IV [intravenous catheter] start, I've got an NG [nasogastric] tube… I'm kind of finding that now I sometimes have to turn those opportunities away. What's more important? To spend time and promote that critical thinking or to go do a task?

When unable to *determine the clinical teaching focus*, or carry out this focus, faculty found themselves *going through the motions.* This subcategory represented situations where faculty felt they were running from one student to the next, simply completing skills/tasks versus developing needed thought processes. Emma described this frustration by stating: "Some days I feel like all I'm doing is tasking, and those are the days, I get to the end of the day and I feel like I did a terrible job that day…"

Mary also described this aspect of *going through the motions* when facilitating learning in the acute care setting: "Well, I'm constantly… I honestly, a lot of times I feel like I'm babysitting and just making sure all the kids are where they need to be."

Even if participants didn't describe this conflicting emotion, it was evident from some responses that *determining the clinical teaching focus* meant completing skills/tasks versus developing students' higher level thinking, which Leah alluded to when describing her typical clinical day:

> …I put them in order by room number on my cheat sheet, so every hour I have whatever written down, what needs to be done, and so I'm pretty much just rounding around them constantly. So I check back in on everything and I will write on my sheet. If there's something that needs done that's not done I'll circle it and then I'll cross through it once I know it's done.

The structure of the TCM was found to support skill/task completion versus development of higher level thinking, which was often frustrating for faculty. Participants worked at *determining the clinical teaching focus,* and for those participants prioritizing facilitation of higher level thinking, faculty found themselves having to *navigate influencing processes* by changing the mindset of students, nursing staff, and at times, directors of acute care units to *fulfill their purpose* and best prepare students for practice. For those unable to determine or carry out this focus, participants were caught *going through the motions,* jumping from one skill/task to the next and checking off boxes versus developing student thought processes. These are just two properties of the *performing faculty role* category found to influence faculty satisfaction with the role of providing clinical instruction. Figure 9 depicts this entire category, subcategories, and all defining properties which determined where participants fell on the *performing faculty role* continuum. As illustrated, *fulfilling faculty purpose* was the goal of nursing faculty and is placed on the positive end of the continuum, with *going through the motions* located in the middle of this spectrum. A thicker arrow connects the four properties to the *fulfilling faculty purpose* subcategory as all properties were fully experienced in a positive manner for faculty in this part of the continuum. A thinner arrow connects the properties to the *going through the motions* subcategory as at least one property was either not experienced or experienced in a negative manner, placing faculty in the middle of the identified continuum. The other properties and the final subcategory of *disengaging from learning* will be elaborated on during discussion of the constructed theory later in this chapter.

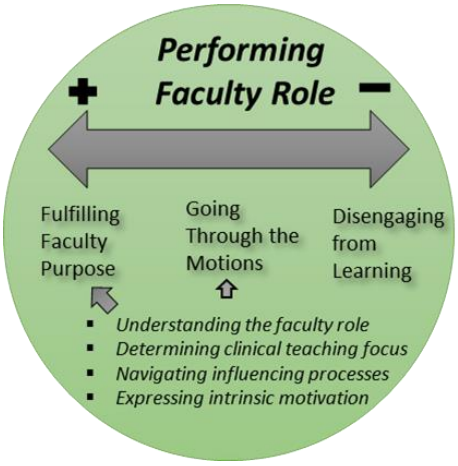

Figure 9. Performing Faculty Role Category

Building relationships with students. This subcategory, described in subquestion one, was also impacted by the TCM of instruction. It was noted that a positive aspect of the TCM included faculty's ability to get to know students, directly influencing the facilitation of learning process. The specific property of *individualizing student learning needs* was enhanced when participants utilized the TCM. Faculty could partially control student learning experiences with this model, allowing for needed progression and student growth. Phyllis described the positive impact the TCM had on her ability to *build relationships with students* by stating: "But, I love it, I love the traditional [model], because I like having that time with the students, getting to know them and seeing that light bulb go off."

Rose discussed that getting to know each student allowed her to make patient assignments based on *individual student learning needs*, which could be enhanced with the TCM: "… if somebody needed more of a challenge, than I make sure, or if they need more IV antibiotics, or they need to focus more on safety, you know, again you find those experiences for them."

Along with *individualizing student learning needs* came the advantage of knowing the learning experiences students were offered, ensuring students grew from those experiences, as Melissa stated:

> I think the advantages to that is that I know exactly what's going on with the patient, so I know what students should have gotten out of it…they'll say, 'Yeah, I didn't get to do anything today', if their patient didn't happen to labor. And I'm like, 'Yes, but you did get to see decels, or you did

get to see interventions for this', you know, those kind of things. So I do think that's definitely a strength with the traditional model, is because you, you're present.

Being able to control and tailor learning experiences for continually learning and growing throughout clinical rotations.

Based on participant experiences, there were advantages and disadvantages noted regarding the TCM of instruction. *Instructing large clinical groups* proved a challenge to most faculty when facilitating and evaluating learning as not all students could be provided individualized attention. Also, faculty described difficulty in *performing the faculty role* due to the emphasis on skill/task completion, which the TCM supported, versus developing higher level thinking. A positive aspect of the TCM included *building relationships with students*, specifically *individualizing student learning needs*. Faculty had better knowledge of student experiences and could individualize assignments with the TCM when compared to other models, assisting faculty in *building on foundational knowledge* when facilitating learning.

Subquestion 3. The third subquestion was interested with elements of the acute care environment that influenced faculty's ability to facilitate learning. Conducting clinical in an acute care setting meant interacting with multiple healthcare professionals and integrating organizational needs and policies while promoting positive learning experiences for students. Four subcategories emerged describing these influencing processes including *engaging with healthcare staff, managing unpredictability, incorporating organizational needs,* and *fostering a collaborative culture.*

Engaging with healthcare staff. *Engaging with healthcare staff* was another subcategory of the *negotiating multiple relationships* category. This subcategory specifically addressed relationships faculty developed with healthcare personnel, in particular, the nursing staff, on acute care units. These relationships were a frequently mentioned component of the acute care environment impacting the facilitation of learning process. Besides nursing staff, participants described interacting with other healthcare personnel, including nursing techs, physicians and respiratory therapists. These relationships were mainly viewed as impacting facilitation of learning in a positive manner, which Phyllis stated:

> There's some excellent physicians, I think, that love to teach… they'll actually talk to them just like they're teaching their students. Talk to them about what they're doing and why they're doing it. So, for me, that's a big enhancement.

Lois also described positive experiences and interactions with healthcare staff: "…I mean the physicians, the respiratory therapists, you know, even the non-nursing faculty will pull students in and be like, 'Hey, do you want to come see something cool?' And, so that's really neat."

Despite these interactions with other healthcare personnel, due to the close proximity of working with nursing staff, faculty felt these relationships had the largest impact when facilitating learning in the acute care setting. One property of *engaging with healthcare staff* was the need for faculty to "*establish credibility*", an in vivo code describing faculty's need to verify their competency when facilitating learning in the acute care setting. Rebecca described her experience with "*establishing credibility"* while *engaging with healthcare staff*:

> I think that when you first start, they just don't know about your background, and what you can and can't do, so I think just being able to, being in clinical and you're introducing your student to the nurse and talking with them, it just takes a little time to build that rapport, and let them know, I guess, yes, I know what I'm doing, it's okay to let me do that with the student…

Until credibility was established, nursing staff did not always interact with faculty in a positive manner and sometimes restricted learning experiences offered to students, which Phyllis experienced:

> But before I felt like I was really, I didn't get that support or that back-up from them like I felt like I got from the other units. But now, again, now…I've done clinicals over there, things changed. They'll say, 'Oh, yeah, bring them on in', whereas, for a while, it was like, 'No, the patient doesn't want students.' When, no, it's not the patient, it's the nurse that didn't want it.

Tiffany also noticed that more learning experiences were offered to students after she *"established credibility"* with the nursing staff:

> … I've had to build up that credibility with them and I think that's, you know, something, honestly, that you just have to earn their respect. And I think you're getting better learning

> experiences because they trust you, they trust that your students, you and your students, are going to be able to handle that situation, so I think it's great.

When "*establishing credibility",* it was important for faculty to maintain relationships over time, as Leah stated:

> The unit I'm on I'm very comfortable. I know the management, I know the nurses, and I think that is huge versus being constantly switched around. We try for consistency and I think that's a must have with faculty. Because if you're coming to a new unit every single semester… I mean, it's evident that you're not going to be as comfortable with it, and that facilitates learning.

Engaging with healthcare staff provides another example of how faculty had to *navigate influencing processes* and develop solutions to factors impacting the ability to effectively *perform the faculty role,* a category introduced in the previous subquestion. These solutions included faculty taking an active stance in building relationships with nursing staff and demonstrating competency in the clinical area.

"Establishing credibility" assisted in fostering the next defining property of the *engaging with healthcare staff* subcategory, which was having healthcare staff *engaging students in the learning process.* This was important, as faculty understood that, when they were busy assisting a student, the main teacher of other students became the nursing staff members. Faculty noted varying degrees of engagement with nursing staff when in the acute care setting. Mandy described this engagement level and ways in which it impacted student learning:

> Well, so depending on the floor, the staff have a lot to do with it, a lot to do with it… when they're open and inviting and receptive, it makes it a lot easier because you know when that nurse is working with the student they're talking them through things, they're not just doing it and then saying, 'Oh, did you see what I did? Do you know why I did that?' They're making them connect the dots. In other environments that are not that student friendly, then you don't know that those nurses are doing that or walking their students through that and asking them questions.

Emma also described potential safety issues when disengaged nursing staff did not interact or

listen to student concerns:

> …it gives the student a very different learning experience than when they have a nurse who is not receptive to questions, who gives abrupt responses to concerns…they feel like they're just being brushed off and then, maybe, the student thinks, 'Maybe I shouldn't be concerned about that; she doesn't seem to be concerned.'

Even though faculty described their overall relationships with the nursing staff as positive, all participants mentioned that a few members did require faculty input and action regarding *addressing behaviors,* another property of this subcategory. Faculty acknowledged positive behaviors regarding nursing staff after receiving student feedback, as Melissa stated: "And then any time the students…that they recognize their nurse that they had, that was just so great with them, I'll send that to their manager and I'll send that to the staff as well, too."

Despite these positive interactions, all participants described addressing negative behaviors that nursing staff, at times, exhibited towards students. Emma described the need to address these behaviors by directly speaking to the nursing staff member:

> …sometimes maybe staff here are not always role modeling evidence-based practice or aren't being perceived to be kind to the students. That happened a couple of weeks ago where, the staff, I had to say, 'Okay, students, you have to wait', and I have to talk to the staff person, um, to see what's going on and try to understand what we're seeing here…

Faculty also addressed negative interactions by turning these experiences into learning opportunities for students, having students reflect on how these interactions could be taken forward and influence their future interactions with students, as Catherine described: "You know, telling the students, 'Someday you'll have an opportunity to treat students better than you were treated, I hope you do that.'"

Even with occasional negative behaviors, participants were appreciative of nursing staff as the majority were engaged with student learning while addressing their additional patient care responsibilities. Mary described her appreciation of the nursing staff on the acute care unit: "So, I mean,

thank God the staff, where we're at, are awesome and they always give us feedback saying how well our students come prepared…so I think that makes a world of difference."

Faculty did display *respect for the nursing staff role,* acknowledging the additional responsibilities nursing staff had while engaging with students. Sharon described the need for nursing staff and faculty to display mutual respect to promote a positive learning environment: "So I think just learning to respect each other and what each other's role is and how you can assist them and how they can assist you in making it a positive environment for everybody."

Mandy also described showing appreciation to the nursing staff for their role when assisting students in the acute care setting:

> I'm always like, make sure you always say thank you, we always try to give them a card and treats at the very last day just to show our appreciation. And if they have feedback for us I like to try and improve on that whatever that might be.

Faculty felt the impact of *engaging with healthcare staff* when facilitating learning in the acute care environment. Participants needed to "*establish credibility"* with healthcare staff, especially nursing staff, which would often influence the type of learning experiences offered to students. After "*establishing credibility",* staff were found to better *engage students in the learning process.* Even with many positive interactions, faculty described *addressing behaviors*, especially those negatively impacting student learning, while *respecting the nursing staff role,* as students did add additional responsibilities to the nursing staff role when in the acute care setting. While *respecting the nursing staff role*, participants also needed to ensure students received positive learning experiences in the acute care environment. Figure 10 depicts this subcategory and the associated defining properties.

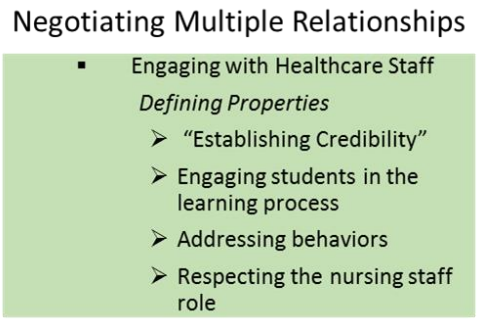

Figure 10. Engaging with Healthcare Staff Subcategory.

Managing unpredictability. *Managing unpredictability* was another subcategory of the *dealing with a larger system* category, and involved faculty's need for flexibility when teaching in the ever-changing acute care environment. This subcategory was defined by faculty's need to continuously *adjust for unexpected situations* and *incorporate flexibility* when facilitating learning during the clinical day. Faculty described multiple situations where *incorporating flexibility* was needed, including when changes in assigned patient experiences occurred unexpectedly. An example of this was when not enough patients were available for students to care for during the clinical day. During these situations, faculty provided alternative learning experiences; however, faculty preferred that students gain experience by providing hands-on patient care, as Rebecca described:

> … if there's really not enough patients in labor to put 9 students in a room, then they're going to have a day where they get an alternate activity and you kind of have to be creative, because sometimes it's case studies, sometimes it's doing a concept map … there have been times in the past where…I had 2 to 3 students not in rooms and that makes for a long clinical day to sit in a classroom and do an alternate assignment.

Other faculty described having to alternate originally assigned patients due to unexpected transfers, leading to faculty and student stress, as Emma stated:

> We get there in the morning and the patient that we knew was going to be there ended up deteriorating in the night and transferred. Um, so that right there is my least favorite way to start

> the day, probably, scrambling, because it creates stress for the student, and, um, so that requires adjustment and it puts me behind for getting to everybody.

In addition to patient transfers, faculty also discussed *incorporating flexibility* based on nursing staff availability. Some participants dealt with the nursing shortage directly when facilitating learning and wanted to assist staff in providing the safest care possible, as Catherine brought up:

> Sometimes the nursing staff is short, so I want to accommodate the floor as well, and we'll adjust which students have patients or where they're located so that they can be as most helpful as they can to the unit.

Faculty also displayed flexibility throughout the clinical day when *adjusting for unexpected situations* related to patient circumstances, as Rose described:

> I remember there was one day that I thought was going to be an easy day, and it was a nightmare on the floor. And not only, I think, the students just had more needs, there were a lot of different things going on, a patient coded, and it happened to be a patient that was with a student… so you know, I think every day it's… you anticipate one thing but it's always something different.

Ensuring student needs were met during these stressful situations was paramount as Lois described when *adjusting for unexpected situations:*

> Other things, we had a patient code the other day which was… so, we do an orientation before we get on the floor so they kind of know what they're supposed to do but it's still, like… I had three girls who were crying… so we cut our day short that day, because, like, they can't, they were just done.

Despite these adjustments, faculty appreciated the varied patient experiences that the acute care environment offered for student learning. This led to better preparation for practice, which Rose described:

> I think, too, working in a facility, we see everything…we see a lot of cardiac stuff, med-surg stuff over here, but on the other side… you know, you get people that are homeless, who don't have

insurance… that allows them, again, to get that holistic view of the patient. So I think just being on a med-surg floor promotes a lot of learning…

Leah also felt this way by stating: "I think having a variety of types of patients is important to facilitate learning..."

Due to the unpredictable nature of the acute care setting, faculty understood that *managing unpredictability* and *incorporating flexibility* were essential qualities when facilitating learning in this type of environment. No matter the situation, faculty were focused on how these unexpected circumstances impacted students' learning experiences, ensuring their needs were met when these situations arose. Figure 11 summarizes this subcategory and its' defining properties.

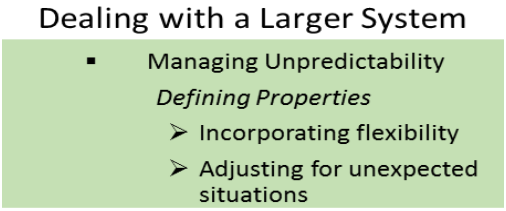

Figure 11. Managing Unpredictability Subcategory

Incorporating organizational needs. Conducting clinical in the acute care setting meant faculty needed to *incorporate organizational needs* when providing clinical instruction, which was another element of the *dealing with a larger system* category. The properties of this subcategory included *abiding by organizational policies* and *integrating needs of new graduates*.

Faculty described being impacted by organizational policies and procedures when facilitating clinical learning. Lois described that, due to certain policies, students were restricted regarding the skills/tasks they could perform in the acute care environment:

So [name of institution] is a little different in that, they don't let students do a lot of invasive procedures. Um, we can do things… we can put NG's down, we can remove things, so we can pull IV's, I had a student who got to pull a PICC [peripherally inserted central catheter] line the other day…

She went on to describe her understanding with the decision while being conflicted with wanting

students to participate in those learning opportunities:

> I do wish they would let students do more hands-on…when I worked there, before I had students, I didn't let anybody touch my patients. So, I get it, but at the same time, I'm like, you know, but they can put in a cath [catheter], they've been checked off on it.

Catherine also described this same conflict at the healthcare facility where she provided instruction:

> I mean, the organization has a lot to do with what skills we're allowed to do and how much we're allowed to participate in, you know, central line dressing changes are not allowed for nursing students anymore, PICC line dressing changes.

In addition to restricting completion of skills/tasks, Jennifer added that some organizational policies impacted the amount of time faculty had available when facilitating student learning:

> …they have these new medication rules. For instance, some med that's every four hours, if you give it more than 30 minutes late, you have to fill out a variance report… so, you can't hardly even manage that. And as sophomores, I want to do their meds with them.

While faculty understood and respected outlined organizational policies, there were instances where this did interfere with facilitating learning in the acute care environment.

The other defining property of this subcategory included *integrating needs of new graduates*. Faculty wanted to ensure nursing students were prepared to successfully function in the acute care environment after graduation. To address these needs, some nursing programs communicated with local healthcare facilities to determine necessary qualities and skills new graduates would need upon entering practice. Emma discussed these organizational needs and their impact on her focus when facilitating learning:

> …our nursing advisory council, you know, employers and things that are on our advisory board, they tell us that, consistently, each semester we meet with them, we can teach them the skills and all of that, but the thinking behind that, the prioritization, what things can be delegated to other

people, those pieces, the collaboration, teamwork, those are what we need them to come to us with when they graduate from your program.

Leah also described receiving similar input from local healthcare facilities regarding new graduate needs, which included development of *professional behaviors*:

I think that they're [students] beginning to be able to really manage their time and able to prioritize what they're doing, because those seem to be the two things that we constantly hear, that new graduate nurses cannot do.

Organizational needs and policies were found to be a component of the acute care environment influencing faculty's ability to facilitate clinical learning. For some, *abiding by organizational policies* negatively impacted the student learning experience; however, faculty often understood the rationale for these organizational decisions. Also, *integrating needs of new graduates* was important when facilitating learning to prepare students for working in this same environment as professional nurses. Figure 12 visually depicts this subcategory and the associated defining properties.

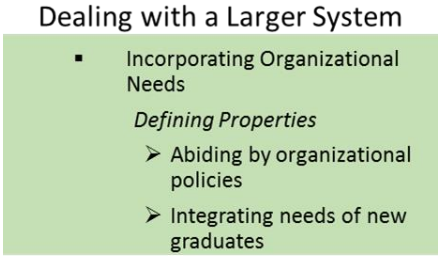

Figure 12. Incorporating Organizational Needs Subcategory

Fostering a collaborative culture. The final element of the acute care environment impacting facilitation of learning involved *fostering a collaborative culture*, another component of the category entitled *negotiating multiple relationships. Fostering a collaborative culture* described faculty's role in developing an organizational culture that fostered student learning. Most faculty experienced a positive learning culture when instructing students in the acute care setting, finding both students and the organization benefitting from these relationships. This assisted in *establishing working relationships*, the defining property of this subcategory. A culture that fostered learning often meant positive learning

experiences for students while organizations could actively recruit students to work as new nurse graduates.

Many faculty facilitated learning in organizations that had established connections with nursing education programs. This often meant when staff were hired that employees came in with an understanding that engaging in student learning was an expectation, much as Sue described: "…I mean, it's a learning facility. The nurses know when they get hired there that the expectation is that it's a learning environment and that they will, at some point, be with a nursing student, that's an expectation."

Mandy also described this expectation at the healthcare organization where she facilitated learning:

> …they feel that the college does a great job of educating and they're always happy to hire [name of nursing program] grads. And a lot of [name of nursing program] students are working at the hospital while they're going to school in various capacities, and it's a teaching hospital.

In addition to the positive environment, Mandy also brought up the advantage for healthcare organizations to recruit students as new nurse graduates which Lois had also experienced:

> They have a great culture for fostering learning, they really want students to come work when they're done. They hire new grads, so they try to make it a really friendly open place for students so they want to go there when they're done.

If new nurse graduates were hired into these same healthcare organizations after graduation, faculty noticed the positive engagement these nurses had with students, as they understood the importance of a positive learning environment, continuing the cycle of a culture valuing student learning, which Rebecca appreciated: "…most of the nurses who work…where I do clinical are truly [name of educational institution] grads. So they're very open to having students, very willing to let them learn and to be part of it."

When a positive culture valuing student learning was established, other benefits were observed. Rose discussed that one healthcare facility actively reviewed and integrated nursing student research projects to enhance patient care:

> Even our students last year, we took them to a convention, and you know, they used to do color coded uniforms. But they actually found this [badges] was more effective. It's our students that got these, so everybody in the hospital now has like, RN, or whatever they are. And so it's fun because our students will do research projects and then our administrators want to hear about it and they've actually implemented change...

Participants wanted to be a positive link between nursing programs and healthcare organizations, working together to positively impact future nurses and provide a supportive culture that fostered student learning. Figure 13 illustrates the *fostering a collaborative culture* subcategory and its' defining property.

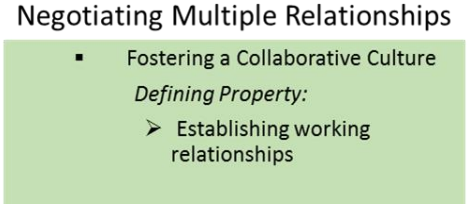

Figure 13. Fostering a Collaborative Culture Subcategory

Faculty were influenced by multiple facets of the acute care environment when facilitating learning. These elements included *engaging with healthcare staff, managing unpredictability, incorporating organizational needs,* and *fostering a collaborative culture*. All of these factors were negotiated while participants facilitated learning to promote positive clinical experiences and best prepare students for organizational expectations upon graduation.

Subquestion 4. The fourth subquestion addressed other factors impacting faculty's ability to facilitate student learning outside of those presented by the acute care setting and TCM. Other factors influencing this process included *growing as a facilitator of learning,* along with three subcategories, entitled *working with adjunct faculty, juggling workload requirements,* and *lacking clinical sites.*

Growing as a facilitator of learning. One category that emerged as an influencing process was participants' *growth as a facilitator of learning*. All participants felt they had grown in their ability to facilitate learning since first beginning to teach in the acute care setting. This category was defined by the

subcategories of *drawing from experience and education, seeking out development opportunities, learning to step back,* and *making learning meaningful.*

Drawing from experience and education. The first subcategory involved faculty *drawing from their own experience and education* when preparing for the clinical faculty role. Faculty came from a wide range of backgrounds regarding their level of preparation when entering the nursing education field, with many feeling the effects of *navigating a learning curve*, the defining property of this subcategory. Jennifer described her large learning curve as she had no preparation for the role:

> I had absolutely no orientation, had absolutely nothing. They were short clinical staff and ran around to the units and asked for any Master's prepared nurses, and asked, 'Do you want to teach?' Sure, okay! I'll do that! That'll be something fun to do. That was it.

She went on to point out improvements regarding orientation programs now in place to assist faculty in adjusting to the role: "It's a whole different system now, we have faculty orientation, and we have all kinds of things set up to help people be successful."

Other participants received formal preparation, with many receiving Master's degrees specializing in nursing education; however, many faculty described that classroom instruction was the focus and their educational experiences did not adequately prepare them for clinical teaching. Catherine, who had this experience, described that she drew from her experience as a staff nurse when first providing clinical instruction:

> I have all these students in their nice pressed uniforms sitting in front of me and I felt like, I don't know what we're going to do today! But I know how to be a nurse, so I can show you that, and I know this starts, this is the beginning of the day, you have patient assignments. Tell me what you want to do and I'm just going to make sure, like, to get you to do as much nursing stuff as possible. That is my literal goal.

Mandy also had this experience, drawing from her familiarity with being a preceptor for nursing students and orienting new nurse graduates when starting to teach in the clinical setting:

> And so here I am, I'm up on this floor with 8 very brand new, green nursing students and I'm like, 'Well, what are we going to learn guys? Let's do this together!' You know, and then I precepted and oriented in my own unit, so I just kind of was like, okay, now I have 8 preceptors, or 8 orientees.

Others did have both formal classroom and clinical preparation for the faculty role, such as Melissa, who drew from both her educational preparation and orientation provided by the nursing program, which was appreciated:

> I got my Master's… and they have a Master's with an education focus, which was good…they had us do like a practicum, or like clinical. I was mentored by somebody…for a semester so I got to sit in on her classes and watch her through clinical as well, too… I felt very lucky that way. And then when I started here, too, I did the same thing. Um, they had me follow, they didn't just say, 'Here you go.'

No matter the orientation or preparation, all faculty felt they had grown in their ability to facilitate learning when compared to first beginning clinical teaching. *Drawing from experience and education* provided faculty a frame of reference when first starting out in this new role.

Seeking out development opportunities. In order to grow, and continue to grow, in their role, participants started *seeking out development opportunities.* This allowed participants to *continually improve in the role*, the defining property of this subcategory. Some participants described learning from peers to strengthen their teaching techniques, as Mary stated: "I mean, by me just seeing how other people do things and how, you know, bopping in on other people's classes and things, I mean, I'm still learning, still learning."

Phyllis described participating in faculty development opportunities to improve as a faculty member: "And so, you know, just finding new ways to reach the student. A lot of faculty development that we have has been very beneficial, so I mean, I've just really improved from all the resources that I've had."

To become better facilitators of learning, participants understood the importance of *seeking out development opportunities* to continue growing and providing better learning experiences for students. Again, this described ways in which faculty *navigated influencing processes* to best *perform the faculty role* and provide effective clinical instruction.

Learning to step back. Regarding ways in which faculty improved as facilitators of learning in the clinical setting, *learning to step back* was a subcategory that emerged describing part of this growth process. This subcategory was defined by the property of *allowing students to struggle.* Faculty had to let go of always supplying the answers when questioning students to ensure they developed their own necessary problem solving skills and higher level thinking prior to entering the nursing profession. Mandy described her growth in this area:

> I think that from day one I used to be like, 'So you do this because of this because of this.' And now I'm like, 'I don't know, why do you do that?'… so I have really, and I don't know if it's just clinical or me being in the classroom have helped me, I used to be just a teller and now I'm way better at being an asker.

Mary also described similar improvements in this area when facilitating clinical learning:

> But I remember, I became more of a facilitator of learning versus me always telling them the answer. I started, I've learned how to question them and, you know, kind of go around it to try to get them to tell me the answer versus me always saying, 'This is the answer.' And that was hard for me, you know, really hard for me, and it is still.

Another aspect of *allowing students to struggle* involved not taking over skill/task opportunities, as Sue stated: "Wow, I've grown. Um, I think, again, I've learned to let go more and…observe the students do the tasks instead of saying, 'No, I'm the one that has to do this.'"

Catherine also described growth in this area, discussing her philosophy in regards to the importance of *learning to step back* when facilitating learning:

> If you're super cautious and don't allow them opportunities to do things, then of course they're going to fail, they'll be too scared to do anything. But if you say, 'No, you got it, you got it', they

> will do it. They will rise up because the nurses are watching out for them and I'm watching out for them. We're not going to let them hurt anybody. But we're going to let them at least try. Because I want you to make mistakes, I want you to put stuff together wrong, I want you to fail at something while I'm there so you can learn why that was the wrong choice. Because the next time you do it, you'll do it better.

Rose also described *learning to step back* and trusting students to complete skills/tasks where competency was established, increasing student independence throughout clinical experiences:

> But that's hard to let go because how, you know, they've told me they've given this subq [subcutaneous] injection multiple times. I've got to trust, are you comfortable doing this or do you want me to be with you? And if they say, 'Okay', then I'm going to let you go in and do it… so yeah, I think that's been a big piece, because I used to feel that I had to be around for every single thing.

For faculty, *learning to step back* was not something that came easily, but was an important aspect when facilitating learning to better prepare students for practice. This involved *allowing students to struggle* and make mistakes while going through the learning process, instead of always taking over or supplying students' the answers. In this way, students were better prepared to function independently versus constantly relying on faculty members for validation and support.

Making learning meaningful. Finally, multiple participants described growing in the sense of *making learning meaningful* for students when providing clinical instruction. Faculty wanted to ensure they were *providing a purpose for all assignments*, the defining property of this subcategory. Whether it was a clinical document or caring for specific patients, participants wanted to ensure learning experiences were enhancing student growth and progression throughout the program. Catherine described her growth in this area when providing clinical instruction:

> It's a lot more purposeful. Before it was kind of haphazardly, like, you take this person and this person and this person, and now there's a lot more preparation and thought about what are those student's particular needs and what does the patient offer to help the student bridge that.

Leah also described growth in this area, as her planned post-conference sessions are considered more meaningful now than when first starting to teach in the clinical setting:

> I never really used to plan all their post-conferences and now I have a plan each week, where before, it was just like, 'Okay, what did you learn today? What did you see today?' And more just very casual. Where now it's more of a set, so they feel like they're getting something out of it and not just wasting their time.

For all participants, *growing as a facilitator of learning* was an ongoing process. This process was defined by faculty developing their own frame of reference through *drawing from experience and education* when first starting clinical teaching while continuing to improve by *seeking out development opportunities.* Specific ways faculty had grown in regards to facilitating clinical learning included *learning to step back* and *allowing students to struggle* during the learning process. Faculty also learned to *make learning meaningful*, ensuring students' learning opportunities were helping them grow throughout the program. Figure 14 depicts the category of *growing as a facilitator of learning* with the associated subcategories and defining properties.

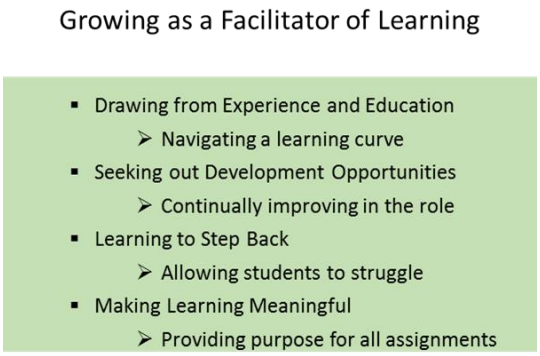

Figure 14. Growing as a Facilitator of Learning Category

Working with adjunct faculty. Another influencing factor included *working with adjunct faculty,* a subcategory encompassed in the *negotiating multiple relationships* category. While this subcategory did not directly impact participants' ability to facilitate clinical learning, it was found to impact students' learning experiences, which concerned multiple participants. This subcategory was defined by two properties including *desiring quality learning experiences* and *providing needed support*.

All participants wanted students to experience valuable and *quality learning experiences*, and adjuncts were, at times, found to not provide these experiences for multiple reasons, proving frustrating for participants. Sue had experienced this firsthand after working with adjuncts assigned to acute care units and then discovering their specialty was in a different nursing field:

> Well, as a faculty right now I have two adjuncts that are teaching for me that, both are community, and they're in a MedSurg [setting], and so it's hurting my students because they do not have that personal knowing that they can build on and share with the students. And they themselves are watching the videos for the skills, you know, and that is very frustrating for me and for my students.

Catherine had also experienced a disconnect with integration of theory to practice when students were instructed by adjunct faculty:

> I think there's a big benefit of having adjuncts because they're mostly just nurses that full-time work in the field and then they pick up teaching and they have an interest in teaching, but they don't have that appreciation for, 'Okay, well this is what we just learned in theory'…so they don't see the big picture for the students…

Jennifer also noted that extrinsic motivation, including monetary gain, could drive adjuncts to pursue clinical teaching leading to a lack of understanding and appreciation for the clinical faculty role, while also bringing up the importance of the second defining property, *providing needed support*:

> Especially when you're working with adjuncts, you know, and you've probably had the adjunct experience… I've got another full-time job and I don't really care and I want my $3,000 and that's it. Well, those are the people who really need the mentoring and you can't.

Faculty acknowledged that providing adjuncts' support was necessary to improve their facilitation of learning techniques. Other faculty shared this same sentiment as some participants, prior to working as full-time or part-time faculty, started as adjunct instructors. These participants identified the need for mentoring and support to improve their teaching practices. Mandy, who experienced this

firsthand, described her need to display initiative in improving as an adjunct faculty when first entering nursing education:

> And I feel like, they had to mind map, and I had to grade those, and I had never done that, I didn't know what that was. So I specifically came to the college and sat through the class where their instructor taught them how to mind map… so you also need to hire people that will take initiative and want to be a part of the learning, and not just, 'Oh, I could do that for a few extra bucks'.

Sharon also desired more support for adjunct faculty to assist in improving student learning experiences:

> So we will have 18 instructors between the two of us. And of those 18 instructors, probably half of them are brand new, have never taught clinical before. And we have three classes going during the week plus facilitating clinicals, and it's like you can never spend enough time with those new instructors.

Even though there was a desire to provide adjuncts more mentoring, faculty were often unable to provide this support. While not directly impacting facilitation of learning, *working with adjunct faculty* did impact participants' goal of best preparing students for the professional nurse role. Figure 15 visually depicts the subcategory of *working with adjunct faculty* and its' defining properties.

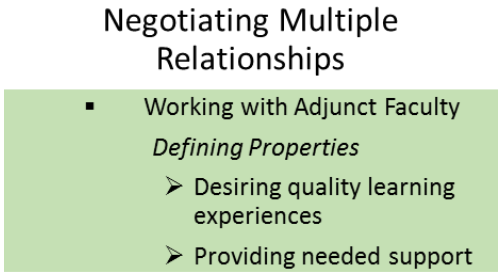

Figure 15. Working with Adjunct Faculty Subcategory

Juggling workload requirements. This subcategory assisted in explaining the difficulty faculty had in providing needed support to adjuncts. This was another component of the category entitled *dealing with a larger system* and represented the multiple responsibilities faculty had in addition to providing

clinical instruction. One property of this subcategory was *organizing classroom and clinical experiences,* which impacted the amount of support faculty could provide to others, as Rebecca confirmed:

> And, you know, we don't really, I'm course coordinator and I teach in the classroom and in clinical, so really to be there for your adjuncts and really to help them, that is very challenging. You know, I don't have enough time to look over my own paperwork, let alone my adjuncts.

Jennifer also described the frustration in not being able to follow-up with other faculty in her course due to workload requirements:

> Now I am a course coordinator, and I feel like I should be able to go around to all the different clinical sites and check on my faculty, but I'm in clinical the same time they are, so I can't, and I think that's a burden.

In addition to impacting adjunct faculty, Tiffany recognized her workload requirements impacted the ability to learn about individual student needs prior to instructing students in a clinical rotation:

> And when you have 60 students in a class, you know, trying to keep track of exactly who's who and who has what pattern, that's where, you know, reading the other clinical evaluations is helpful when you have time. But realistically do any of us have time to look back and see how these six students did last week? No.

Another property of this subcategory included *supervising multiple individuals.* When providing clinical instruction, faculty, at times, simultaneously supervised students in Master's programs and provided orientation to new faculty members. Having these extra responsibilities impacted the facilitation of learning process, as Emma stated:

> Also, sometimes I'm orienting new faculty, sometimes I am precepting Master's students, um, so it's just another layer. Oh, I'm educating you but I'm also trying to educate you at the same time. So I enjoy that challenge, I enjoy it very much, but it's another layer that takes a lot of thought.

Sharon also described orienting a new faculty member in the clinical setting and its impact on facilitating student learning:

> …so I had a brand new instructor with me this past semester, and so they had two, or they were over their limit by two, and so they put those two students in my clinical group… I had 10 students and a brand-new instructor, so essentially I had 11 students. So those days you feel like you get nothing done.

A final defining property when *juggling workload requirements* included evaluating clinical documents assigned to students. This property, entitled *assessing student work*, was viewed as a potential burden to not only students, but also faculty who were responsible for reviewing and providing feedback on these documents. Mandy described the paperwork assignments as the following: "…they have horrendous paperwork, it's ugly. And even as an instructor, I hate reading it all."

Rebecca expressed this same sentiment and discussed concerns regarding how these assignments interfered with students' clinical experiences:

> …I know why we need the clinical paperwork, but I feel like we bombard the students so much with clinical paperwork. You know, you want them to have the clinical experience and if they're spending all of their time on the computer trying to find the information they need, than how much are they really engaging in the learning experience? ... How can we help keep it so it's not overwhelming, not only for the student, but also for the instructor because we have to grade it all?

There were different dimensions, or variations, in responses regarding how faculty addressed the issue of *assessing student work*, as some participants, including Rose, could *navigate this influencing process* and better *perform the faculty role* by reviewing clinical documents with students while on the acute care unit, assisting in *juggling workload requirements*:

> …I hear some faculty, some of our newer faculty…will want to take these home and grade them. I don't know how you do that, because this is really the student's work, so that's where I'm like, you really have to find time in the clinical area to really sit down with each student individually and let them walk you through this.

Tiffany had also implemented a similar strategy, which she discussed:

> You know, I don't know, that was making more work for me to sit at home and have to go through and manually grade all this stuff when I think that they learned more sitting down one to one discussing it with me because I can't really convey everything in writing and that doesn't give them the chance to ask me any questions back.

For participants, *juggling workload requirements* was found to interfere with facilitation of student learning and with faculty's ability to provide support to other individuals, including adjuncts. For some faculty, integrating solutions to these workload necessities, including *assessing student work*, assisted in creating a more manageable workload while still providing students individualized feedback. Figure 16 illustrates this subcategory and the associated defining properties.

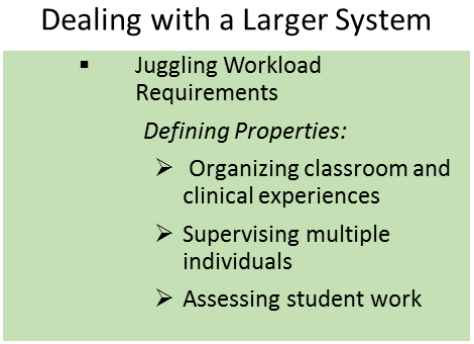

Figure 16. Juggling Workload Requirements Subcategory

Lacking clinical sites. This was the final factor found to impact the facilitation of learning process. *Lacking clinical sites* was another subcategory included in the category of *dealing with a larger system*, which was influenced by multiple factors, including *increasing student enrollment*, resulting in an influx of nursing students in the areas where faculty facilitated learning. Sue described experiencing this situation firsthand: "Um, just that in this particular area we are so saturated with nursing students. Just being able to have, um, designated units for our students is huge."

Jennifer also described the *lack of clinical sites* as impacting student learning: "And I think the lack of clinical sites is a huge issue. You can only do so much simulation, you know, and then they need to see a real person."

An *increasing amount of programs* was also found to impact the availability of clinical sites, with organizations sometimes restricting the number of students able to participate in clinical experiences, which Catherine discussed:

> …there will be floors closed that day because maybe the organization, has, I don't know, let eight nursing schools in and they don't want the floor to be too busy so they'll close one down or something like that. So we might not have as many opportunities if there's more competition, that's unfortunate…

Phyllis also discussed the *increasing number of programs* as impacting the amount of clinical sites available while also attributing some of the issue to a *changing patient census*:

> Yes, we have multiple OB services, but again, with censuses, we're having to back off on some because they don't have the census to get the experiences. So, and then you keep bringing on new programs that need clinical sites… just stop bringing on new programs.

There were multiple reasons attributed to *lacking clinical sites*, but participants found finding acute care units to provide instruction difficult, impacting the amount of patient care experiences students were exposed to while in nursing education programs. Faculty understood that reasons for *lacking clinical sites* was outside of their immediate control but wished for solutions to ensure students received the experiences necessary to prepare students for practice. Figure 17 summarizes this subcategory and the defining properties.

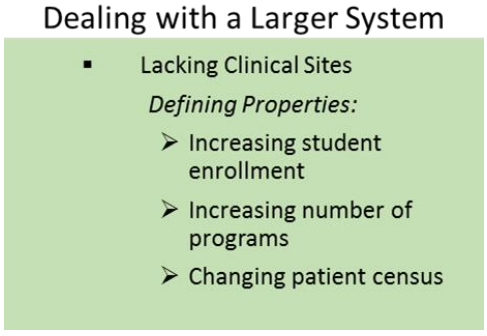

Figure 17. Lacking Clinical Sites Subcategory

In addition to influencing factors brought about by the TCM and acute care environment, other factors influencing facilitation of learning included *growing as a facilitator of learning, working with adjunct faculty, juggling workload requirements,* and *lacking clinical sites*.

Subquestion 5. The last subquestion sought to understand faculty's process when evaluating student learning in the acute care setting, determining whether effective facilitation of student learning had occurred. Three categories emerged representing the evaluation process including *evaluating responses, seeking progression,* and *determining student focus.* In addition, the subcategory of *building relationships with students* was found to be an influencing factor when evaluating student learning.

Evaluating responses. When *evaluating response*s, faculty assessed for multiple properties demonstrating effective integration and competency of higher level thinking, skills/tasks, and professional behaviors. *Evaluating responses* followed *facilitating learning* and occurred after *adjusting strategies* to gauge students' understanding regarding focus areas of instruction. Faculty evaluated for five properties including *preparing for safe care, performing safe care, "connecting the dots", becoming a professional,* and *meeting expectations.* Similar to *facilitating learning,* evaluation occurred both in the clinical setting and when reviewing clinical document assignments.

Ensuring students were *preparing to provide safe care* was always at the forefront when faculty evaluated students in the acute care setting. Evaluating for this component started when students first arrived at the acute care unit. Understanding that students were novices, most participants required completion of some sort of pre-clinical assignment before students could care for patients. Students would often review patient information, research medications and patient care needs, and start formulating a plan of care for the day. Sue discussed pre-clinical requirements for students in her clinical rotation:

> …before they can come to clinical, to demonstrate that they're ready to care for this patient, they would've had to go through the pathology of their major diagnoses, um, looked up all of their medications including route, classification, why they're taking it, patient teaching, nursing considerations, um, all that had to have been done as well as any diagnostics.

If students did not show adequate preparation, consequences occurred. Typically, students were not allowed to care for patients until faculty ensured safe patient care could be provided, as Leah described:

> …if they're not prepared I even question whether they should stay that day. We're pretty strict on that… I look at their paperwork in the morning after they've pre-labbed and just look it over to make sure they're doing it…you know, you need to make sure this is done and you're not going to take care of this patient until you've done this… so, definitely, the student has to show me they're prepared. And usually just in conversation, even if they have a paper right in front of them, you know, I can tell if they're prepared.

Preparing for safe care also involved ensuring competency when performing skills/tasks. Faculty often evaluated students on their performance through a check-out procedure prior to arriving on the acute care unit, as Jennifer described:

> …once they get into their second sophomore course they have a formal skills check out every semester where… you have to sign up for a time, and faculty sign up for a time, and you are assessed on your ability to do the skills proficiently…

Leah also discussed necessary competencies students completed prior to being allowed on the acute care units:

> …we have skills lab checks that they have to do in order to even get into clinical, so we will do like a skills day for that senior level…we've had certain packets of information that they have to complete that go along with, like, blood administration, and, you know, certain things you see at that complex level that they need to know about…so we have some things that they have to do before they go to the clinical site to prove their competency.

Ensuring students were *preparing for safe care* was essential and often evaluated before allowing students to even start providing patient care when in the clinical setting.

After ensuring students were *prepared for safe care,* faculty then evaluated students' ability to

perform safe care throughout the clinical day. As students were often provided practice opportunities for skills/tasks, it was expected students would competently perform these cares in the clinical setting. To ensure safe care was provided, faculty would directly observe students performing skills/tasks while providing necessary space, as Rebecca described:

> And then I just go in and I let them perform the skill and I watch and facilitate as much as I need to. You know, I don't feel like, if they're giving their first IM [intramuscular injection] to a new mom, they don't want to have me, like, breathing on them, but I make sure they're doing it properly.

Jennifer also described utilizing direct observation to ensure students were *performing safe care* while acknowledging students' anxiety due to their inexperience. She discussed providing support and guidance when evaluating for skills/tasks in the acute care setting:

> …typically, because they've done this ahead of time, by the time they get to clinical their issue is that they're nervous, it's not that they can't do the skill. So, usually, it's just more, 'Okay now, remember don't lean over too far because you're going to contaminate that sterile field', so it's more guidance at that point.

Faculty provided direct observation of students to validate if safe care was being performed. It was participants' expectation that students would arrive competent to *perform safe patient care*; however, faculty understood the need to give students space and provide guidance due to their inexperience when completing skills/tasks. This provided students' necessary support while ensuring safe care was provided.

Another focus of faculty when *evaluating responses* was to ensure students were *"connecting the dots"*, an in vivo code participants described as reflecting integration and development of higher level thinking. Students needed to understand how to appropriately analyze patient data they had collected to determine future nursing actions. Leah provided an example of what effectively *"connecting the dots"* looked like when evaluating student learning in the clinical setting:

> I look for whether I can tell that they're putting it all together, like, if they know why they're giving this certain med. Not that they're putting everything down, but that they know why we're

> checking this certain lab or why that lab is high, so it kind of, you know, they can tell me what, you know, those connections hopefully that they're making, the connection between the patient, the pathophysiology, and, you know, the disease process, the treatments, the meds, all of that, and the labs, and putting it all together.

Jennifer also evaluated for deeper knowledge and higher level thinking to ensure students were *"connecting the dots"* when evaluating clinical documents*:*

> But I guess the common theme throughout it is, you prove to me that you have more than superficial knowledge, I don't want you copying stuff. I want you to make it a living, working document for your patient.

Ensuring students had a strong foundational knowledge base was important, but faculty also evaluated for students' ability to connect data together, validating that students understood how to interpret patient data and make informed nursing care decisions based on analysis of that data.

Another component faculty evaluated for was students' growth in *becoming a professional*. This meant students were integrating appropriate *interpersonal skills,* including communication techniques, when interacting with healthcare staff and patients. Participants understood that, after becoming professional nurses, students would be part of a healthcare team and needed to work well with other individuals. Mandy discussed evaluating for these skills when observing students' interactions with others: "I think that's the biggest one right there, is communication, and their ability to function within the team. So how are they working with their ancillary personnel? Are they making contact with them?"

Leah also evaluated for how students interacted with members of the healthcare team: "…that they are reliable, that they have good communication. I really focus, too, on that they continue to maintain professionalism and that's demonstrated to colleagues, that sort of thing."

Students also needed to interact professionally with patients and families, as Sharon discussed: "It's how they talk to parents, the education they provide to parents and to that child, how were they around that child?"

The other component of *becoming a professional* involved students' ability to *manage care* effectively. Catherine described ensuring students were actively reflecting on managing care appropriately when evaluating for effective *management of care*: "Even if it isn't like a physical problem, they're making connections about delegation or prioritization, and I can see that in their reflection sometimes better than I can see in their care plans."

Leah also described evaluating for effective *management of care*: "…I'll check in with them and help and see how they're prioritizing their day and if they're getting the needs of the patient met…"

Evaluating for development of professional behaviors was another component faculty assessed when providing clinical instruction. As future nurses, students would be expected to communicate effectively with others while managing complex patient situations.

After evaluating for the above properties, faculty ensured students were *meeting expectations* by formally comparing students' clinical performance to outlined objectives. Multiple participants utilized clinical evaluation forms to evaluate student learning, and described consequences if expectations and outcomes were not met, as Jennifer described: "…we have an unsafe/unsatisfactory policy where they accrue points and after so many points they have a hearing and they may be dismissed from the college."

Lois also described completing formal objective evaluations assessing student performance: "I quiz them on their meds, if they don't know what they're doing I'm obviously not going to let them give meds, they're going to get an unsatisfactory."

Even with objectives in place, some faculty had difficulty in ensuring evaluations accurately reflected students' clinical performance, including Tiffany, who stated:

> I sometimes feel like it's trying to get, you know, a square peg in a round hole because, you know, you just can't put their finger on it. Yes they did the work, but they weren't necessarily really engaged and enthusiastic, you know, so they kind of met all of it minimally, you know, I can't really give them a U [unsatisfactory] yet, did they really earn that M [met objective]?

When *evaluating responses,* faculty identified five properties that guided the evaluation process

to determine whether students were effectively learning in the clinical setting. These included *preparing for safe care, performing safe care, "connecting the dots", becoming a professional,* and *meeting expectations.* Some faculty described struggling to ensure students were fairly evaluated when comparing clinical performance to outlined objectives. Figure 18 illustrates this category and the defining properties.

Figure 18. Evaluating Responses Category

Seeking progression. In addition to evaluating student learning during clinical experiences, faculty were also *seeking progression* week to week and throughout the entire rotation or semester, acknowledging that substantial changes in student performance took a longer period of time to develop. The goal was for students to integrate feedback and incorporate new learnings into future experiences, signifying that students were continually growing and preparing for the nursing role. Faculty evaluated three properties when *seeking progression*, including *"taking initiative", bringing learning forward,* and *managing complex patient situations.*

A major property faculty evaluated for when *seeking progression* was students' ability to *"take initiative"* when providing care. This in vivo code meant that participants wanted to observe students initiate actions, seeing themselves less as a student and more as an emerging professional nurse, as they progressed through the nursing program. Rose described evaluating for this property when reviewing a clinical document assignment completed by a student:

> I have to laugh, and we want them to answer this as a nurse themselves. They're the nurse, so I always laugh when I see, 'notify the nurse', or this one, actually 'notify instructor'. Okay, but you're the nurse, so what would you do, what steps would you take? How would you respond,

> would you notify the RRT [rapid response team]? Would you call the doctor? What would you need to do?

Lois also described wanting to see students *"take initiative"* which involved not being hesitant when caring for patients and letting go of the need for constant validation and support from faculty:

> I like them to not be hesitant, to go into their patient room, to have that confidence like, I know what I'm doing, I know how to work the equipment, I know how to talk to a pediatric patient and their family. To not be quite so scared and hang back and be like, '[Name of participant], will you go with me?' That sort of thing.

"Taking initiative" also meant students' were proactive in seeking out their own resources prior to approaching faculty with needs, as Jennifer stated:

> I think… seeing questions and looking for answers, you know, like, I love it when students say, 'I have to take out a chest tube and here's the policy. I printed it off, I looked it up and printed it off and I've read through it.' I'll say, 'Well, you tell me how to do it', you know.

Evaluating for *"taking initiative"* meant students were taking action without frequent prompting from nursing staff or faculty members. Students could let go of constantly relying on faculty support and began seeking out their own solutions with minimal direction.

Another property faculty evaluated for when *seeking progression*, involved students' *bringing learning forward,* or improving in future clinical experiences by integrating provided feedback, as Mandy stated: "I want to see progression, I want to see that when I gave you feedback on your previous paperwork in regard to that area that you're doing better in the next, next paperwork moving forward."

Phyllis also described evaluating for this property while reviewing clinical document assignments: "Yes, and the next week it should get better. And, you know I'll be honest, a lot of times by the third week they've got it down pat…"

In addition, Sue discussed the need for students to *bring learning forward* from prior clinical experiences to influence future clinical practice, acknowledging that this took time and experience:

> …when they can go in there and they can give me…report, for instance, on their patient, without me doing all this prompting. They have demonstrated that they are… they are thinking ahead, 'I anticipate this because I have personal knowing with working with other patients like this'; um, and again that comes with time…

Bringing learning forward was important for faculty to observe when *seeking progression* as this signified students were continually building on prior knowledge and feedback provided throughout the program.

The final property evaluated for when *seeking progression* was *managing complex patient situations.* As students progressed through a clinical rotation, the expectation was that students would begin to feel more comfortable caring for an increased number of patients or in handling more complex patient situations. Catherine described her expectations when *seeking progression* in this area by stating:

> …when they can pick up new things without anxiety, like, I'm going to give you a new patient, and they already start formulating a plan. Their management sheets look better because they know how long something is going to take or when to be concerned.

Lois evaluated for this component based on patient acuity level, gradually increasing acuity over time with the expectation that students could adjust to this responsibility appropriately:

> I don't like to give them very acute patients, at first. And then, as our quarter goes on, usually the last week, I have it so we're on the step-down ICU floor with, like, the heart kids with the trach vents. Cause they've kind of worked up to that point.

Managing complex situations looked differently depending on the level of student instructed in the clinical setting. When Sue instructed her senior level students, it was expected that they would function more independently while caring for multiple patients toward the end of the rotation:

> As a senior, I would like to have them be able to take care of three patients by the end of their clinical day, meaning that they could get that report for those three, they could time manage everything that they would need to do for those three, they would be able to discuss, um, at a

higher level, abnormal labs and diagnostics, clinical judgments, and reflect on what they did well and what they did not do well, um, as far as their interventions with that patient.

When *seeking progression,* faculty evaluated for gradual changes from week to week and throughout the rotation that demonstrated students were integrating higher level thinking and professional behaviors necessary to provide safe patient care. Faculty understood this process was gradual, but were looking for students to grow from one clinical experience to the next. This culminated in students requiring less faculty validation and guidance, with students trusting their own foundational knowledge and determining their own solutions when problem-solving. Faculty ensured students were *"taking initiative"* and *bringing learning forward* while working up to *managing complex patient situations* when evaluating for *seeking progression.* Figure 19 depicts this category and the defining properties.

Figure 19. Seeking Progression Category

Determining student focus. After *seeking progression* in student performance, faculty determined which students to focus on both during the clinical day and in upcoming clinical experiences. This emerged as the final category of the evaluation process. Regardless of the number of students in a clinical group, faculty needed to *determine student focus* when facilitating learning. Multiple properties were considered when *determining student focus*, including *identifying strengths of students*, *building from feedback, prioritizing patient needs*, and *ensuring all are evaluated.*

When *identifying strengths of students,* faculty discussed spending more time with "weaker" students versus "stronger" students when in the acute care setting. Mary differentiated these two groups by describing the following qualities:

> …the prime example is those students that, when you give them their assignment, they go off and they know to go get report from that nurse. They know to, 'I am supposed to go in here and scrub my hands first before I go and meet my patient', you know, they go to that room and introduce themselves to the patient and…my weaker students, it's like, you have to tell them each step of the process of what they need to do…

Mary went on to acknowledge that not all students progressed at the same rate during clinical rotations, and described her rationale for focusing on those considered "weaker", which was to ensure patient safety:

> If you had all the same students who were all on the same level, then you could divide your time equally, but I know it's not. I'm always more focused on those students that are weak because I'm so afraid of them being unsafe. And I want them to be able to gain strength and confidence, you know, so they can be successful.

Sharon also provided this same rationale, acknowledging that, due to the increased attention provided to struggling students, other students went through the clinical day without as much supervision:

> And unfortunately, our super, super good students kind of go out and they fly, and we touch base with them. Our middle students check in with us, but those weak students is who we have to usually spend our time with and that's so unfair to our other students.

Identifying strengths of students was important when faculty considered which students to spend time with during clinical experiences. Ensuring students were providing safe patient care was the priority for utilizing this criterion when *determining student focus*, even though this meant other students did not receive as much time as participants preferred.

Another method utilized when *determining student focus* was evaluating whether students were *building from feedback*, which tied into the *seeking progression* criteria of *bringing learning forward*. It was the expectation that students would build and improve upon provided feedback, and if that did not happen, faculty often followed up with those students first during subsequent clinical experiences. Phyllis

described utilizing this method after evaluating clinical documents and determining students were struggling: “I probably will start out with that person and making sure that they’re getting it...”

Rose also utilized this method, ensuring follow-up with students occurred if noting a student was struggling with responses during the prior clinical day:

> So sometimes you do, sometimes you see they really do need to look this up and we'll talk again tomorrow… those are usually the ones I’m bee lining it to, probably the first ones I talk to in the morning. Did we look everything up and what did you find out?

An inability of students to *bring learning forward* signaled that further intervention and facilitation of learning was needed, prompting participants to focus on those students during future clinical experiences.

An additional method faculty utilized when *determining student focus* was *prioritizing patient needs.* Though not based on student performance, faculty would often ensure they were assisting students caring for patients with more critical needs to provide necessary support and facilitate learning of complex concepts, as Lois described:

> So, actually, the last time I was on the floor, one of my students had a patient who was actively seizing, so she and I were kind of in there. Meanwhile, I had two other students who had medications due, one other student was waiting because she was told she could go pull an IV [intravenous catheter], so I did ask the floor staff, like, ‘Would you be comfortable giving medications with these two students?’… but my priority was with the one student who had a patient who was seizing.

Melissa also used this strategy when assessing for which students to assist in the clinical setting:

> I'll know by the patient, you know, whether or not it’s somebody that's close to delivering and we need to go hang this antibiotic now before the baby comes, or we’re just putting in a Foley [catheter] and they just got an epidural, we’ve got, we could wait 20 minutes on that, so yeah, it just definitely depends on patient condition.

Ensuring urgent patient needs were met was also considered when *determining student*

focus to ensure patient safety was maintained and that students providing more complex care had appropriate faculty support.

The final method when *determining student focus* involved *ensuring all are evaluated.* This was integrated to confirm that, at some point, all students were evaluated in the clinical setting to validate competency and readiness to progress. Sharon described her expectations on the minimum experiences students should be evaluated on when in the clinical setting:

> So I always tell students, I have to at least see you do an assessment, I have to at least see you give meds, you know, at the beginning of the rotation with me and at the end of your rotation with me, so I can see if they have grown.

Faculty also described keeping track of which students were evaluated to *ensure all students were evaluated*, as Leah described:

> But I do try to have some consistency so that all semester doesn't go by and I didn't give meds with somebody. So that's something, too, I always write down who I gave meds to and highlight that on my cheat sheet. Then I look at my last week's cheat sheet to make sure I'm not giving meds with that same student.

Due to the number of students faculty were responsible for in the clinical setting, participants utilized some sort of method when *determining student focus* to ensure students were providing safe patient care. Faculty wanted to spend an equal amount of time with students during the clinical day, but due to the number of students and differing rates of progression, many times this was not possible. Due to this reality, faculty looked at *identifying strengths of students, building from feedback, prioritizing patient needs,* and *ensuring all are evaluated* when *determining student focus* in the clinical setting. Figure 20 illustrates this category and its' defining properties.

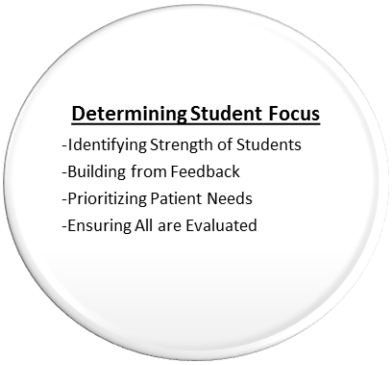

Figure 20. Determining Student Focus Category

Building relationships with students. In addition to *facilitating learning*, *building relationships with students* also influenced faculty's ability to evaluate student learning. Jennifer discussed the importance of getting to know students when determining why students were possibly struggling in the clinical setting:

> The first thing is to have a conversation and try to determine why it is they don't get what's going on. Are they just overwhelmed, are they scared, are they nervous? Maybe they just need somebody to put the pieces together for them and then the light bulb goes off and they're like, 'All right, I got it', and off they go… so it kind of starts with assessing the situation, what was the problem… maybe that patient reminds me of my grandma, and it's hard, and I kind of can't deal with it. So, it takes a lot of prodding, I think, to figure out, is it really that they're unsafe, or do they just need a little support right now?

Rose also described the need to get to know students and differentiate anxiety from those providing unsafe care when evaluating learning. This involved the property of *being approachable for student learning* as she discussed:

> Sometimes you can just tell that they just need to take a breath and tell you, there's just this, after doing it for however many years, you just know. You just need to step back and relax versus the ones that really don't know.

Building relationships with students (see Figure 7) and understanding individual student needs assisted faculty when evaluating student learning. This helped faculty determine whether students were unprepared or just needed more support to think through responses and move forward.

When evaluating student learning, faculty *evaluated responses* throughout the clinical day while *seeking progression* over subsequent clinical weeks, expecting students to continue building and growing after receiving feedback. Based on student progression, faculty *determined student focus* for subsequent clinical experiences to continue evaluating progress and ensure all students were providing safe care. Finally, *building relationships with students* assisted faculty in determining reasons for students' inability to meet expectations, allowing faculty to better facilitate learning for future clinical experiences.

Development of the theory. Founded on participant experiences, The Flott Facilitation of Clinical Learning in Nursing Theory was co-constructed by the researcher and participants to address the central research question of interest. This theory describes the process faculty utilize when facilitating student learning in the acute care setting while using the TCM of instruction. This theory incorporates all four components described throughout this chapter, which include *influencing processes* impacting facilitation of learning, *determining strategies to facilitate learning,* the *facilitation of learning process,* and the ability for faculty to effectively *perform the faculty role.* This next section describes how all categories and subcategories that emerged in the subquestions relate to form this grounded theory. A visual depiction of the theory is provided in Figure 21.

Influencing processes. After analyzing participant responses, it was determined that three theoretical categories representing influencing processes impacted faculty's ability to facilitate learning in the acute care setting. These categories included *dealing with a larger system, negotiating multiple relationships,* and *growing as a facilitator of learning.* Participants often negotiated these categories while simultaneously facilitating learning, increasing the complexity of the faculty role.

As stated in prior examples, *dealing with a larger system* represented the multiple systems and structures impacting clinical education, including governing agencies, healthcare organizations, and

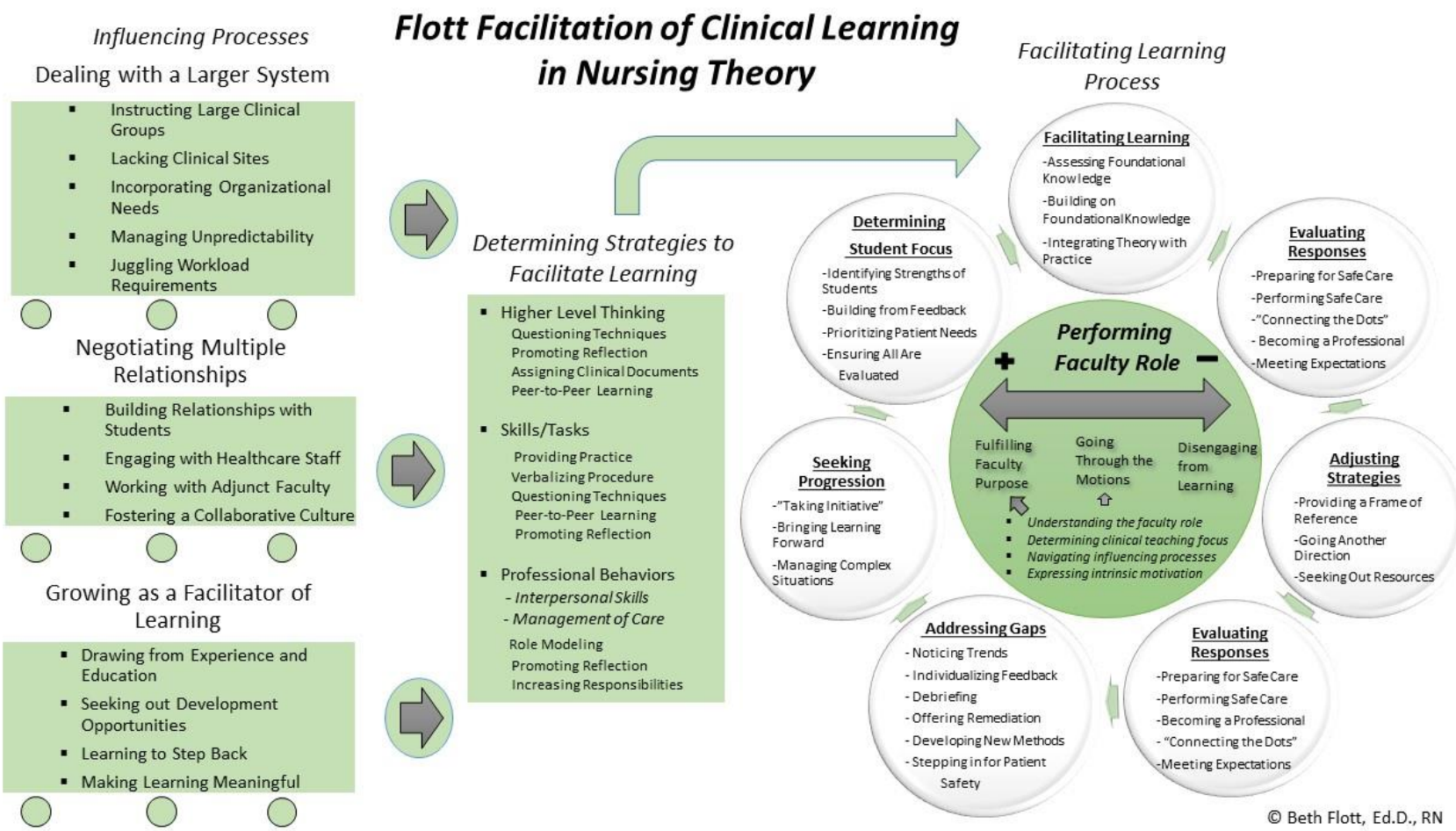

Figure 21. Flott Facilitation of Clinical Learning in Nursing Theory

nursing education programs. These influences were represented by the subcategories of *instructing large clinical groups, lacking clinical sites, incorporating organizational needs, managing unpredictability,* and *juggling workload requirements.* Due to State Board of Nursing requirements and the structure of the TCM, multiple faculty were impacted by *instructing large clinical groups* in the acute care setting. Also, due to increasing nursing programs and student enrollment, *lacking clinical sites* impacted the availability of acute care experiences faculty could provide students. Faculty also had to ensure requirements and needs from healthcare organizations were integrated into clinical instruction, represented by the subcategory of *incorporating organizational needs,* all while *managing unpredictability* and the unexpected situations arising in the acute care environment. Additionally, faculty were often *juggling workload requirements* required of nursing programs while providing clinical instruction. All of these systems and structures impacted the facilitation of learning process, especially in regards to the amount of time and experiences faculty could provide students in the acute care setting.

The next category and influencing process was *negotiating multiple relationships*, depicting the multiple individuals faculty engaged with while facilitating learning. These interactions were represented by four subcategories, including *building relationships with students, engaging with healthcare staff, working with adjunct faculty,* and *fostering a collaborative culture. Building relationships with students* was of utmost importance, as participants strove to remain approachable and get to know students to best individualize learning needs. In addition, faculty also *engaged with healthcare staff*, particularly nursing staff. Faculty valued having positive relationships with nursing staff as this often contributed to students receiving positive learning experiences while in the acute care setting. Participants also needed to frequently *work with adjunct faculty.* While participants appreciated their contributions, there were also concerns regarding adjunct faculty performance, particularly when extrinsic motivators, such as financial gain, led to the desire to teach in the clinical setting. These concerns were magnified by faculty's inability to provide appropriate mentoring and support to this group of faculty members. Finally, faculty recognized their role in *fostering a collaborative culture* by becoming a positive link between nursing programs and healthcare organizations. This culture benefitted organizations, nursing programs, and

students, often leading students to find jobs in these organizations as new nurse graduates. Faculty worked at building all of these relationships, often simultaneously, while facilitating clinical learning to promote a positive learning experience and environment for students.

The final influencing process involved participants *growing as facilitators of learning.* All faculty expressed improvement in their teaching techniques since first facilitating learning in the clinical setting. Regardless of their orientation and educational preparation, participants often drew from their education and prior experiences as nursing staff members, managers, and preceptors when starting to teach in the clinical setting. Faculty also continued to grow by learning from peers or attending formal development offerings, assisting in further improving facilitation of learning techniques. Through this growth, faculty learned to provide students the time and space necessary to develop responses while ensuring all assignments were purposeful, better preparing students for the professional nurse role.

All three categories, *dealing with a larger system*, *negotiating multiple relationships,* and *growing as a facilitator of learning*, represented processes influencing faculty's ability to facilitate learning in the acute care setting. Faculty typically dealt with multiple categories and subcategories represented by these influencing processes simultaneously when preparing students for the nursing role.

Determining strategies to facilitate learning. This first step when instructing students in the clinical setting was completed prior to facilitating learning and involved *determining strategies to facilitate learning.* These strategies differed depending on the focus area of clinical instruction. These focus areas included *higher level thinking, skills/tasks,* and *professional responsibilities.* As mentioned previously, faculty utilized different strategies to assist students in progressing through all focus areas of instruction, ensuring all strategies were purposefully assisting students in gaining competency among all of these focus areas of instruction.

Facilitation of learning process. After *determining strategies to facilitate learning,* faculty then started the *facilitation of learning process,* which involved implementing guiding principles of *facilitating learning,* including *assessing foundational knowledge* and then *building on foundational knowledge* while

integrating theory with practice to ensure students were progressing at an appropriate rate throughout clinical experiences.

Next came the need to *evaluate responses.* Faculty evaluated for multiple elements, including students' ability to *prepare for safe care, perform safe care, "connect the dots",* and evaluate students' growth in *becoming a professional.* Finally, faculty ensured students were *meeting expectations* by comparing students' performance with outlined clinical objectives, ensuring students were progressing appropriately throughout clinical experiences.

If faculty did not receive correct responses, *adjusting strategies* occurred next in the process. Participants *adjusted strategies* to account for different student learning styles while still encouraging students to develop accurate responses using their own thought processes and prior knowledge. After *adjusting strategies,* if this step was needed, faculty would again *evaluate responses* to reassess for student understanding.

If students were still noted to be struggling after *adjusting strategies* and *evaluating responses* a second time, the need to start *addressing gaps* occurred, the next step in the facilitating learning process. At times, this happened right away in the clinical setting with individual students, while other times this occurred after participants evaluated clinical documents and observed student performance over a period of time. Faculty would *notice trends* in gaps, both with individuals and entire groups of students. Different strategies were utilized to address these gaps, including *individualizing feedback, debriefing, offering remediation, developing new methods,* and *stepping in for patient safety,* ensuring students developed a better understanding of clinical concepts.

After *addressing gaps,* faculty would then *seek progression* during future clinical experiences. Faculty wanted to see students *bringing learning forward, "taking initiative",* and *managing complex patient situations.* This ensured students were gradually breaking away from constant faculty validation by looking up information on their own and performing care in a safe and competent manner.

The final step of the process involved *determining student focus.* Faculty utilized some sort of criteria, usually based on student progression, to determine which students to focus on both during the

clinical day and in future clinical experiences. Participants also described tracking and rotating which students were evaluated during clinical experiences to ensure all students were evaluated.

These steps then start over with the *facilitating learning* step and the process continued. At times, all steps would happen throughout one clinical day; however, oftentimes faculty would need to reflect upon student performance and evaluate clinical document assignments before *addressing gaps*. After *addressing gaps,* faculty would then evaluate for *seeking progression* during future experiences and *determine student focus* based on that progression.

Performing faculty role. As discussed previously, this category represented faculty's satisfaction with their ability to *perform the faculty role*. The ability to perform this role was represented by three different subcategories placed on a continuum and included *fulfilling faculty purpose, going through the motions*, and *disengaging with learning* (see Figure 21). The *fulfilling faculty purpose* subcategory was the positive outcome faculty strove to accomplish while facilitating clinical learning with students.

Four defining properties influenced faculty's satisfaction and ability to *perform the faculty role,* determining where faculty landed on this continuum. One property, already discussed, was entitled *determining clinical teaching focus*. Some participants were only able to focus on skill/task completion instead of developing students' higher level thinking abilities, which was attributed to the structure of the TCM. As described earlier through participant excerpts, faculty focused on skill/task completion were simply *going through the motions* by completing one skill/task after another versus those *fulfilling faculty purpose* who could develop thought processes required of students to provide safe patient care.

Another property already discussed that also determined where faculty fell on this continuum involved *navigating influencing processes.* It was obvious from excerpts provided throughout this chapter that the influencing process categories often dictated whether faculty felt they were *fulfilling faculty purpose* or falling into another subcategory. As it was impossible to eliminate all influencing processes presented, faculty's ability to navigate these processes often differentiated those in the *fulfilling faculty purpose* subcategory from others along the continuum. Those *fulfilling faculty purpose* included

participants who had developed solutions to influencing processes, including integrating better ways to manage workload requirements and developing positive relationships with healthcare staff.

An additional property differentiating where faculty fell on this continuum involved *understanding the faculty role.* Those *fulfilling faculty purpose* had determined their priority was to remain focused on student learning and clarified the faculty role and responsibilities with others, as Emma stated:

> … that was one of the challenges I had with this staff member last week. And one reason I had to pull her aside was she was expecting me to do, so, what I perceived to be, her role. It had nothing to do with facilitating learning for my students, um, but, you know, if supplies weren't on the unit I, she would say, um, 'Can you take care of that?... Or she was just expecting me to [do that]. So I had to say, 'I, I have six students and, um, I can't take on some of that staff role.'

Sharon also described the need to communicate to healthcare staff that the focus of her role was on student learning:

> …you're there for your students and I try to really instill that in those nurses on the floor and the director. I don't have 8 patients, I have 8 students. And my job are those 8 students, those nurses still have to care for those 8 patients. So really setting that tone, and just, you know, being a good instructor, and doing your job and doing it well is a huge thing.

Participants in the *fulfilling faculty purpose* subcategory also had an *understanding of the faculty role* regarding their need to prepare students as future professional nurses, receiving satisfaction in assisting students with reaching this goal, as Rebecca stated:

> I'll get a lot of, they do a reflection at the end of their database, a lot of, 'I felt like a real nurse today', you know? And that's what you want…I felt like a real nurse today, and that's my ultimate goal.

Faculty falling in other subcategories appeared to struggle with an *understanding of the faculty role.* Sue described working with faculty who did not have a focus on facilitating student learning as those faculty often viewed nursing staff as the primary teacher of students:

> Well, I think that there is a different mindset with clinical instructors. Some clinical instructors I, I have seen and worked with, that feel like they're more of the organizer and that it's the unit nurse that is responsible for the teaching of the student. And I am just the opposite… all clinical instructors need to understand their role and responsibility. That it's not that unit nurse's responsibility to be teaching our students, it's our responsibility.

Mandy also described the importance of faculty understanding their role as the primary facilitator of learning:

> Because the staff, as willing as they want to be and as willing as they will be, they cannot be the sole person responsible for the teaching of the students and that shouldn't be their job. So we need them to help support that because if you're going to have a student go in with you, I want you to be talking through those things with them. But that's not, that's additionally to your job, that's not your job.

This lack of understanding regarding the role was a property leading faculty to either *go through the motions* or *disengage from learning*, letting nursing staff to take over the facilitation of learning process.

The final property included *expressing intrinsic motivation.* Those in the *fulfilling faculty purpose* subcategory described an intrinsic passion and desire to perform the role well while integrating high standards when evaluating student performance. Sharon described a passion for the role by stating: "Now that I'm here I can't ever imagine leaving education or doing anything else."

Tiffany described her high standards when providing clinical instruction, expressing her intrinsic motivation to prepare future nurses that would uphold these same high standards:

> I have very, very high values… I just, you know, always said that, you know, my beliefs and my values are, are pretty much intrinsic and I, I don't want to compromise them. So I just, I guess for me integrity's a big thing and I expect that of my students, too.

The properties of *understanding the faculty role, determining clinical teaching focus, navigating influencing processes,* and *expressing intrinsic motivation* were found to differentiate faculty in the

fulfilling faculty purpose subcategory from those in other subcategories along the continuum. This is visually depicted in the diagram with an arrow connecting the four properties to this positive subcategory outcome. A thinner arrow connects these same properties to the *going through the motions* subcategory as not all properties were experienced by faculty in this particular subcategory, leading to some dissatisfaction with the role. It is important to note that faculty could fluctuate among these subcategories from one clinical experience to the next, particularly because of effects from *navigating influencing processes,* as these influencing processes could change frequently throughout clinical experiences.

Participants in this study described falling into either the *fulfilling faculty purpose* or *going through the motions* subcategories. Those *going through the motions* were either impacted negatively by influencing processes or had difficulty in prioritizing higher level thinking as the clinical teaching focus. While participants did not describe being in the final subcategory, *disengaging from learning*, some faculty received feedback from healthcare staff regarding their experiences with faculty in this category. These faculty were described as having minimal interaction with students, becoming more of a passive observer in the acute care clinical setting. Sue described hearing this feedback from nursing staff: "Because the nurses would tell me, 'Oh, instructor so-and-so, she just sits there and, you know, the students have to come to her and she never gets up', and they don't like that because they can't trust them."

Tiffany had also received this feedback from nursing staff: "According to what the staff has told me, some of the other faculty members from other programs are not really on the floor with the students. They're, you know, stopping in just to check over the charting…"

It appeared as if those *disengaging from learning*, at a minimum, either lacked *intrinsic motivation* or an *understanding of the faculty role*. This behavior went on to negatively influence other relationships, including those with the nursing staff. Ensuring faculty had an *understanding of the faculty role, determined a clinical teaching focus, navigated influencing processes,* and *expressed intrinsic motivation* led to faculty feeling satisfied in their performance of the faculty role allowing participants to best prepare students for practice as professional nurses. This lack of engagement is visually depicted in

the diagram with no arrow connecting the four properties to the *disengaging from learning* subcategory as multiple properties were missing from faculty described as being in this *performing the faculty role* subcategory.

Validation of the theory. As stated previously, three participants underwent a second interview to provide the researcher feedback on the proposed theory. All participants provided positive feedback, with only two areas requiring modifications. The first was adding the *juggling workload requirements* to the *dealing with a larger system* category. Feedback was received that this addition was necessary to represent the additional responsibilities required of nursing programs and the influence on facilitating clinical learning. After finding that participant data supported this suggestion, the researcher added this subcategory. The other modification involved adjusting the title to the *performing faculty role* category. The original title for this category was *fulfilling faculty purpose,* which was noted as confusing to all three participants, as not all faculty members were necessarily able to *fulfill faculty purpose.* This title was adjusted to represent the most positive subcategory while the category's title was changed to *performing faculty role*.

Summary

In summary, the grounded theory methodology assisted in answering the research questions of interest. Based on participant experiences, the process faculty utilize when facilitating clinical learning in the acute care setting while using the TCM of instruction was clarified. This involved determining strategies to actively facilitate learning, understanding influencing factors presented by the TCM and acute care environment along with additional factors impacting this process, and recognizing ways in which faculty evaluate student learning when providing clinical instruction. After answering these subquestions of interest, the resultant grounded theory was developed. The Flott Facilitation of Clinical Learning in Nursing Theory points out influencing processes interfering with faculty's ability to facilitate learning, describes the process faculty utilize when facilitating learning, and discusses faculty's satisfaction and fulfillment when performing the faculty role effectively, which was impacted by the ability to properly prepare the next generation of students for nursing practice.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

This study sought to better understand the process nursing faculty utilize when facilitating clinical learning in the acute care setting while using the TCM of instruction. By applying the data collection and analysis procedures outlined by Charmaz (2014), and in accordance with the grounded theory methodology, the research questions of interest were addressed by listening to nursing faculty that utilized this process firsthand. Thus, the Flott Facilitation of Clinical Learning in Nursing Theory was developed, assisting in clarifying this process and addressing a noticeable gap identified in the literature. This theory can assist healthcare organizations, nursing education programs, and faculty in improving the clinical preparation of nursing students while ensuring faculty can best facilitate learning in this setting. This chapter includes a detailed discussion of the findings by comparing results of this study with prior literature. In addition, implications for practice and future research are described.

Discussion of the Findings

A discussion of the central research question of interest and each related subquestion is provided. Findings from this study are compared to prior research related to each subquestion, with similarities, differences, and new findings described. Prior research related to the areas of nursing education literature reviewed previously and depicted in Figure 1 are also compared to findings from this study. Similar to the previous chapter, the research subquestion findings are examined first followed by the central research question of interest.

Subquestion 1. To review, the first subquestion was interested in how faculty facilitated learning in the acute care setting. After evaluating participant responses, it was determined that multiple methods to facilitate learning were utilized depending on the specific clinical area faculty were addressing. These strategies assisted in developing *higher level thinking, skills/tasks,* and *professional behaviors*. These same areas highlighted by faculty appear to correlate with the cognitive, psychomotor, and affective learning domains developed by Bloom (Anderson & Krathwohl, 2000). For development of higher level thinking, faculty utilized the methods of *questioning techniques, promoting reflection, assigning clinical documents,* and *peer-to-peer learning.* This aligned with prior literature, which highlighted that these

same strategies have been utilized by faculty when developing critical thinking skills, a term multiple participants used that was synonymous with higher level thinking (Hobus, 2008; Kaddoura, Van Dyke, Cheng, & Shea-Foisy, 2016; Twibell, Ryan & Hermiz, 2005). In addition to prior research, some teaching strategies introduced by the Cognitive Apprenticeship Model correlated with the strategy of *questioning techniques* identified in this study (Brown, Collins, & Dugoid, 1989). As described in chapter two, the Cognitive Apprenticeship model is a branch of Social Constructivism that described potential teaching strategies faculty may utilize when providing clinical instruction (Brown, Collins, & Dugoid, 1989; Vygotsky, 1978). The concepts of articulation and exploration explained in this model correlate with the strategy of Socratic *questioning techniques* identified by participants from this study. After utilizing *questioning techniques*, faculty would ensure students had an accurate understanding of potential patient complications and could determine appropriate nursing interventions if complications occurred. Faculty would then continue pushing students by asking increasingly difficult questions, further enhancing the development of higher level thinking and correlating with the concepts described by the Cognitive Apprenticeship Model (Brown, Collins, & Dugoid, 1989).

Even though all strategies to facilitate higher-level thinking discovered in this study were brought out in the literature, these prior studies either only investigated the effectiveness of one specific strategy (Van Dyke, Cheng, & Shea-Foisy, 2016) or only determined that faculty utilize a few of the strategies that emerged during this study (Hobus, 2008; Twibell, Ryan, & Hermiz, 2005). This study confirmed that faculty utilize all of these previously identified techniques to facilitate higher level thinking when actively providing clinical instruction to students in acute care settings.

In addition to higher level thinking, faculty instructed students on skill/task competency and facilitated the development of professional behaviors. As these concepts emerged during data analysis, the researcher returned to the literature, investigating and comparing findings from this study with prior research examining these topics. This study determined that faculty applied the strategies of *providing practice, verbalizing procedures, questioning techniques, peer-to-peer learning,* and *promoting reflection* when facilitating skill/task competencies. Some of these strategies correlated with the literature, as

research confirmed faculty *provide practice* for skill/task opportunities before students arrive to acute care settings (Nickle, 2007; Salyers, 2007; Taylor & Care, 1999; Williams & West, 2012). In addition, the literature stated that faculty utilize *questioning techniques* to ensure student understanding of how to properly perform skills/tasks (Gonzal & Newby, 2013; Woolley & Jarvis, 2007) while also supporting the use of *peer-to-peer learning* (Godson, Wilson, & Goodson, 2007; Roberts, Vignato, Moore, & Madden, 2009; Yates, Cunningham, Moyle, & Martin, 1997), encouraging students to learn from each other while completing skills/tasks; however, these studies only examined strategies utilized when teaching skill/task completion in a skills laboratory setting.

A few studies reviewed did investigate strategies utilized while faculty actively provided clinical instruction, confirming that *verbalizing procedures* prior to entering the room and *promoting reflection* afterward occurred during skill/task completion in the acute care setting (Houghton, Casey, Shaw, & Murphy, 2012; Williams & West, 2012). In addition to prior research, the strategy of *providing practice* correlates with the concept of sequencing introduced by the Cognitive Apprenticeship Model, as faculty ensured student understanding of basic skill/task concepts in a controlled environment prior to completing them on actual patients (Brown, Collins, & Dugoid, 1989).

While some studies investigated facilitation of skill/task performance when faculty actively taught in the acute care setting, this study provided a more comprehensive picture of this process. No prior study was found investigating this process from the beginning of instruction provided in the skills laboratory to the acute care clinical setting where skills/tasks were completed on patients. This study addressed this gap, clarifying the entire process faculty used when facilitating skill/task performance. First, faculty anticipated that students would bring knowledge forward after *providing practice* opportunities from the skills laboratory into the acute care setting. Then, faculty confirmed students' understanding of the skill/task needing completion prior to entering the patients' room, and finally, faculty had students reflect on their performance, including teaching peers about key learnings, to assist in improving skill/task performance in the future. The three components that encompass the process when facilitating skill/task performance are graphically displayed in Figure 22.

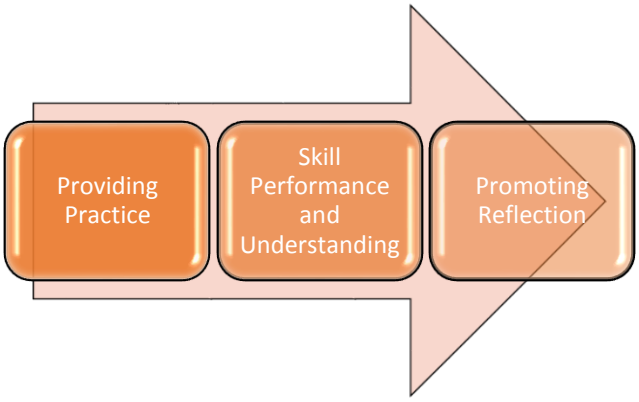

Figure 22. Components of Facilitating Skill/Task Performance

The final category involved facilitation of professional behaviors, including interpersonal skills and behaviors needed to effectively manage patient care. Participants from this study utilized *role modeling*, *promoting reflection*, and *increasing responsibilities* to facilitate these behaviors deemed necessary for nursing practice. Prior research investigating facilitation of interpersonal skills discovered that faculty have utilized peer-to-peer learning (Cooper, Martin, Fisher, Marks, & Harrington, 2013; Lee, Mast, Humbert, Bagnardi, & Richards, 2013), role play opportunities (Kesten, 2011), *reflection* (Yoo & Chae, 2013), analysis of student-patient interactions (Jones, 2007), and simulation scenarios (Kesten, 2011; Yoo & Chae, 2011) to enhance student communication techniques; however, these studies all occurred outside acute care facilities with instruction provided either in a classroom, simulation laboratory, or skills laboratory setting. While *promoting reflection* was confirmed in prior research to assist in the development of interpersonal skills, this study clarified how faculty utilize all three of these teaching strategies when facilitating the development of these behaviors while actively instructing students in the acute care setting.

Regarding management of care behaviors, prior research determined that faculty utilize case studies (Powell, 2011), provide journaling opportunities to *promote reflection* (Enenbach, 2016; Powell, 2011), integrate simulation scenarios (Kaplan & Ura, 2010; Nowell, 2016), incorporate *role modeling* videos (Coram, 2016; Franklin & Gubrud-Howe, 2014), and allow students to actively delegate responsibilities to other healthcare personnel (Conger, 1999; Lekan, Corizzini, Gilliss, & Bailey, 2011) to

better develop these behaviors. This study confirmed that participants *promote reflection* and incorporate *role modeling* when facilitating management of care behaviors, including prioritization and delegation; however, comparable to research investigating facilitation of interpersonal skills, most of these studies occurred in settings outside acute care facilities, including classrooms and simulation laboratories. A few studies did utilize reflection assignments to promote management of care behaviors during some part of acute care clinical experiences, including pre- and post-clinical activities (Enenbach, 2016; Conger, 1999; Ganxer & Zauderer, 2013; Lasater & Nielsen, 2009a; Powell, 2011), aligning with participants' utilization of *promoting reflection* identified in this study.

In regards to *role modeling*, researchers have determined this strategy is important from students' perspectives in enhancing clinical learning while building student confidence when in the clinical setting (Donaldson & Carter, 2005; Felstead, 2013; Levett-Jones & Lathlean, 2009; Newton, Jolly, Ockerby, & Cross, 2010). Students also view faculty as important role models in demonstrating concepts, such as caring, when providing patient care in acute care facilities (Nelms, Jones & Gray, 1993; Wiseman, 1994). In regards to faculty utilizing *role modeling* as a facilitation of learning strategy, one study investigated role modeling characteristics medical school faculty integrated to promote student learning (Althouse, Stritter, & Steiner, 1999). The characteristics deemed most beneficial to display from the faculty perspective included demonstrating a passion for teaching and exhibiting good interaction and communication skills with patients In regards to nursing education, faculty have utilized *role modeling* as a strategy in simulation laboratories to enhance clinical judgment and facilitate professional behaviors, including prioritization skills, during simulation scenarios (Coram, 2016; Franklin & Gubrud-Howe, 2014). This was accomplished by using videos depicting experienced registered nurses *role modeling* care to standardized patients prior to students participating in scenarios.

In addition to prior research investigating *role modeling* from the nursing faculty perspective, the use of this strategy is also supported by the Cognitive Apprenticeship Model (Brown, Collins, & Dugoid, 1989; Vygotsky, 1978). This model describes the teaching method of modelling which is used to provide a frame of reference for novices when learning new skills or activities (Brown, Collins, & Dugoid, 1989).

Included in this teaching method is the need for faculty to verbalize thought processes and actions to assist students in making necessary connections, supporting participants' use of *role modeling* discovered in this study. While prior research studies confirmed the use of *role modeling* during simulation, no prior studies were found identifying ways in which faculty utilized this strategy while actively facilitating learning in acute care settings.

Finally, the strategy of *increasing responsibilities* is also supported by the Cognitive Apprenticeship Model through the concept of sequencing, which involves providing novices increasingly complex tasks and situations as foundational concepts are integrated into practice (Brown, Collins, & Dugoid, 1989). This was participants' goal when *increasing responsibilities* and further developing interpersonal skills and management of care behaviors while instructing students in the clinical setting. Even though little research has investigated how faculty develop professional behaviors by *increasing responsibilities* in the acute care setting, prior studies confirm this strategy has been integrated when facilitating these behaviors in other clinical settings. As an example, some researchers provided the opportunity to develop management of care behaviors by having students care for multiple simulated patients. This was only incorporated with students close to graduation who were better prepared and equipped for the *increasing responsibilities* needed to care for multiple patients (Chunta & Edwards, 2013; Kaplan & Ura, 2010; Nowell, 2016). Even though some facilitation of learning strategies were alluded to in prior research, this study provided a more inclusive picture regarding the multiple strategies faculty utilize when actively developing professional behaviors while instructing students in the acute care setting.

An important strategy to acknowledge was that of *promoting reflection* as this was utilized by participants throughout all areas of clinical instruction. Ensuring students could learn from clinical performances and experiences while integrating key learning pieces into future practice was an essential activity faculty facilitated throughout the acute care experience. Prior research, along with the Cognitive Apprenticeship Model, also supports this strategy, which assists in the development of deeper level thinking while encouraging students to continually learn from past experiences. Furthermore, this strategy

also enhances the student learning process by decreasing student stress and increasing confidence while in the clinical setting (Brown, Collins, & Dugoid, 1989; Letizia & Jennrich, 1998; Enenbach, 2016; McMillan-Coddington, 2013; Megel, Nelson, Black, Vogel, & Uphoff, 2013).

In addition to *determining strategies to facilitate learning,* this study also gained insight regarding guiding principles faculty integrated when *facilitating learning* which were applied throughout all clinical areas of focus. These principles included *assessing foundational knowledge, building on foundational knowledge,* and *integrating theory with practice.* While no literature was found investigating principles guiding faculty when actively providing clinical instruction, prior research exploring clinical learning does allude to integration of these principles. For example, multiple studies discussed the importance of *assessing foundational knowledge* by either having students complete pre-tests on research areas of interest (Kesten, 2011; Lekan, Corazzini, Gilliss, & Bailey 2011; Yoo & Chae, 2011) or by providing students information regarding concepts or content prior to providing clinical instruction (Kesten, 2011; Lee et al., 2016; Lekan, Corazzini, Gilliss, & Bailey, 2011).

Similarly, multiple studies implied that teaching strategies were meant to *build on foundational knowledge.* These included studies incorporating multiple-patient simulations which were integrated into senior level courses. This intervention was only appropriate for students prepared to care for more than one patient based on foundational clinical experiences (Kaplan & Ura, 2010; Nowell, 2016). Other studies concerned with skill/task performance also found faculty *building on foundational knowledge* throughout the program, starting with simple skills/tasks and then integrating those considered more complex (Coffman, 2012; Woolley & Jarvis, 2007).

In addition, other studies described faculty intentionally assigning patient experiences to assist in *applying theory to practice*, ensuring students could complete recently learned skills/tasks when in the clinical setting (Williams & West, 2012). Patient assignments were also intentionally made to assist students in connecting recently learned leadership and delegation skills to patient care activities (Lexan, Corazzini, Gilliss, & Bailey, 2011). Again, none of these studies were exclusively focused on principles

faculty utilized when actively facilitating learning but do support and demonstrate the use of these principles while preparing students for practice.

Aligning with these findings, the theory of Social Constructivism, discussed in chapter two, also supports these guiding principles, particularly that of *building on foundational knowledge.* Emma described utilizing this principle during clinical instruction as providing "building blocks" for student learning, helping students to continue building on foundational levels of knowledge, which this theory supports (Hafler, 2011; Vygotsky, 1978). The related model of Cognitive Apprenticeship also spoke to this principle when describing the concepts of scaffolding and sequencing by promoting faculty to *build on foundational knowledge* and gradually increase the complexity of concepts taught after providing students a solid foundation (Brown, Collins, & Dugoid, 1989). In addition, the concept of domain content from this same model refers to learning foundational knowledge in the classroom with faculty assisting students in *applying theory to practice* after entering the clinical setting (Brown, Collins, & Dugoid, 1989). Finally, the Situated Cognition model within the context of workplace learning aligns with the concept of *applying theory to practice,* describing the importance of providing novices opportunities to learn in the actual workplace environment in order to best prepare them for the demands of professional practice (Hafler, 2001).

As discussed, the principles guiding faculty when *facilitating learning* align with theoretical perspectives and prior research; however, this study presents distinct examples from nursing faculty utilizing these principles when actively instructing students in the acute care setting which was not identified in prior studies. Participants wanted to ensure students developed at an appropriate rate and used these principles to best facilitate student growth and progression when providing clinical instruction.

Along with determining specific strategies utilized when facilitating learning, this study uncovered ways in which faculty *adjusted strategies* while in the acute care setting. Faculty *adjusted strategies* by *providing a frame of reference, going another direction,* and *seeking out resources* when students struggled to develop accurate responses to questions or situations. Only one other study was found describing the need for faculty to adjust teaching strategies, but these adjustments were attributed to

the acute care environment, not student performance. In addition, the study did not describe the specific strategies faculty utilized when adjusting clinical instruction (Hossein, Fatemeh, Fatemeh, Katri, & Tahareh, 2010).

Regarding theoretical perspectives, the Cognitive Apprenticeship Model does highlight the use of *role modeling* to provide novices a frame of reference, as discussed previously (Brown, Collins, & Dugoid, 1989). This study supports this finding while also discovering that faculty utilized other techniques to *provide a frame of reference* for students in addition to role modeling. Also, the concepts of heuristic knowledge content and control content from the Cognitive Apprenticeship model encourages students to *seek out resources* on their own and utilize experts to assist in problem-solving strategies; however, this model does not describe the use of these strategies in the context of adjusting facilitation of learning based on student responses. Instead, this model simply describes these concepts as potential strategies for faculty to utilize when providing instruction (Brown, Collins, & Dugoid, 1989). When promoting students to *seek out resources,* faculty described the importance of enhancing student learning by allowing students' more time, if needed, to process and formulate responses. This finding also aligns with the Cognitive Apprenticeship Model, which describes that different students need differing levels of support depending on individual progress (Brown, Collins, & Dugoid, 1989). For faculty participating in this study, determining that level of support was important to best individualize student learning.

Clarifying that faculty *adjust strategies* throughout the clinical day provided a missing link regarding the overall facilitation of learning process as this component was not discussed or investigated in prior studies. This finding also reinforces that facilitation of learning does not stop when students are unsure of a response. Faculty continue *adjusting strategies* and pushing students to make connections on their own, further fostering the development of higher level thinking and problem solving abilities. This focus on learning versus treating missed responses with punitive actions was reinforced by multiple participants, as it was their desire for student growth to occur in the clinical setting. Discovering the category of *adjusting strategies* also demonstrates that facilitation of learning is a continual process occurring throughout the clinical day. Prior research has primarily focused on investigating one teaching

strategy or one component of learning and then determining if improvement in specified clinical outcomes occurs after implementing a specific teaching strategy instead of viewing this process in its' entirety. This study clarifies that faculty need to *adjust strategies* quickly and often during the clinical day while ensuring adjustments address individual student learning needs.

In addition to *adjusting strategies*, participants had to determine when to step in and actively *address gaps* in student knowledge. This involved utilizing the techniques of *noticing trends, individualizing feedback, debriefing, offering remediation, developing new methods,* and *stepping in for patient safety.* Prior literature has highlighted the use of *debriefing* primarily in the context of simulation, which involves discussing key learnings and clarifying questions about a scenario with an entire group of students, similar to what participants did during post-conferences as described in this, and prior, research studies (Breymeier, 2012; McMillan-Coddington, 2013; Jaeger, 2012; Jefferies, 2005; Letizia & Jennrich, 1998; Megel, Nelson, Black, Vogel, & Uphoff, 2013); however, this study determined that, at times, faculty specifically utilized post-conferences to *address gaps* in student knowledge when deficiencies as a group were observed. While multiple studies have pointed out gaps in the preparation of students as they transition to the new nurse graduate role (Athlin, Larsson, & Soderhamn, 2012; Burns & Poster, 2008; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013), no prior studies were found investigating the entire process faculty utilize when *addressing gaps* while actively facilitating learning in the clinical setting. Prior studies have investigated specific teaching interventions meant to improve certain areas where gaps have been noted, such as critical thinking development (Hobus, 2008; Kaddoura, Van Dyke, & Shea-Foisy, 2016; Moran, 2000; Twibell, Ryan, & Hermiz, 2005); however, this study provided examples of how faculty *notice trends* regarding gaps in performance while actively providing clinical instruction. Also, this study determined ways in which faculty addressed these gaps, both immediately while students were providing patient care, such as when *stepping in for patient safety*, and afterwards when evaluating the provision of patient care and clinical document assignments, determining when to *develop new methods* after noticing consistent gaps in student performance over time.

Finally, this subquestion determined that, to best facilitate learning, faculty needed to *build relationships with students.* This study highlighted the importance for faculty in getting to know students and their individual needs while remaining approachable to foster a positive relationship. This supports prior research investigating this important relationship; however, prior research has only focused on the student perspective regarding this relationship, finding that students valued faculty that were approachable and fostered a positive learning environment (Cook, 2005; Shahsavari, Yekta, Houser, & Ghiyasvandian, 2013; Yaghoubinia, Heydari, & Roudsari, 2014). This study confirms that positive relationships enhance both groups, assisting faculty in best facilitating learning in the acute care setting.

In summary, this subquestion uncovered specific ways in which faculty utilized strategies when actively facilitating learning in the acute care setting. Also, this study discovered that participants continually assess and evaluate student learning, *adjusting strategies* when students struggle with formulating accurate responses. Faculty strive to *assess* and *build on foundational knowledge*, integrate appropriate teaching strategies based on the desired clinical outcome, and *address gaps* to continue fostering student learning. These findings provide a more comprehensive picture of the entire process faculty utilize when actively providing instruction, demonstrating that facilitation of learning is not a static activity, but a continual one, in which faculty integrate individual learning needs to assist in student growth and progression.

Subquestion 2. The second subquestion addressed how the TCM influenced faculty's ability to facilitate learning. This study found that faculty were impacted both positively and negatively by this model through the subcategories of *building relationships with students* and *instructing large clinical groups.* In addition, these factors often impacted faculty's satisfaction and ability to *perform the faculty role* effectively while providing clinical instruction.

This study aligned with prior research confirming that faculty were negatively impacted when *instructing large clinical groups* in the acute care setting (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010; Langan, 2003; Teel, Smith, & Thomas, 2008). When asked if anything could be changed to improve clinical instruction, Jennifer affirmed several participants' sentiments by stating,

"The size, the ratio. I would say that all of the downfalls could be improved by just decreasing the number of students you have." Prior research confirms faculty have consistently felt faculty-to-student ratios are too high (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010; Langan, 2003; Teel, Smith, & Thomas, 2008); however, this study addressed a noted gap in the literature by determining specific examples of how this ratio impacts facilitation of learning, as participants highlighted safety concerns when responsible for such large groups of students (Teel, Smith, & Thomas, 2008). These concerns included worrying about students completing skills/tasks without nursing staff or faculty guidance which was impacted by both the high ratio and the nursing shortage. In addition, proper evaluation of student learning was often compromised due to the decreased availability of faculty to assist and evaluate all students in the clinical setting. Finally, due to decreased faculty availability, this high ratio also led to students missing out on potential learning opportunities.

In regards to *performing the faculty role,* multiple participants found the TCM promoted skill/task completion versus higher level thinking development, comparable with other studies finding that faculty spent most of their time completing tasks with students versus fostering metacognitive thinking skills (Ironside & McNelis, 2010; Ironside, McNelis, & Ebright, 2014; Teel, Smith, & Thomas, 2008; Tiwari, 2005). This meant faculty were just *going through the motions,* or jumping from one task to another with students, instead of developing necessary higher-level thinking skills, which was the ideal clinical focus for participants to best *fulfill faculty purpose*. Additional studies also found both faculty and students wishing more time could be spent with each other during the clinical day when the TCM was utilized (Breymeier, 2012; Webster, 2006). What this study adds is the impact this model has on faculty's ability to effectively perform the role of clinical instruction. It was evident that the ratio and promotion of skill/task completion greatly impacted faculty's ability to facilitate and evaluate student learning. Unless faculty *determined a clinical teaching focus* that centered on higher level thinking development and worked to *navigate influencing processes,* faculty often felt dissatisfied with their performance when providing clinical instruction. This study also identified ways in which faculty worked through challenges to better *fulfill faculty purpose.* Some participants described turning down skill/task opportunities

provided by nursing staff to focus on development of students' higher-level thinking which led to better facilitation and evaluation of student learning.

The final factor, *building relationships with students,* was identified as a positive aspect of the TCM, fulfilling another gap identified in the literature. No prior research was found investigating positive aspects of this model from faculty perspectives. Faculty wanted to get to know students, promote positive relationships, and tailor learning experiences, which the TCM allowed. The TCM provided the opportunity to align experiences and assignments based on individual student learning needs. This allowed faculty to partially control student learning experiences and ensure student growth occurred throughout clinical rotations.

Determining influencing factors brought about by the TCM assisted in addressing multiple research gaps, including identifying specific safety concerns brought about by the faculty-to-student ratio, determining positive aspects of the TCM from faculty perspectives, and discovering that these influencing factors directly impact faculty's ability to effectively perform the role of clinical instruction. Finally, this study identified strategies participants had developed to overcome these presented challenges. Overall, this study provided a more inclusive look at both challenging and positive aspects of the TCM from the faculty perspective.

Subquestion 3. The third subquestion investigated ways in which the acute care environment impacted the facilitation of learning process. Definite similarities were noted between the study findings and Lewin's Behavioral-Environment Theory, previously described in chapter two (1936/2015). This theory explains that individuals are influenced by the surrounding environment when performing professional and personal roles (Lewin, 1936/2015). This study revealed faculty were impacted by multiple elements of the acute care environment, including *engaging with healthcare staff, managing unpredictability, incorporating organizational needs,* and *fostering a collaborative culture.* Lewin (1936/2015) identified that individuals are impacted by relationships and the developed culture of the surrounding environment which aligns with participant experiences from this study. In addition to Lewin (1936/2015), the interactions with healthcare staff impacting participants' ability to facilitate learning

aligned with concepts identified by the Need-Press Model, previously described in chapter two (Murray, 1939/2008). This model identified specific environmental "presses" could either assist or inhibit individuals from accomplishing objectives or "needs." The process faculty underwent to develop positive relationships, particularly with nursing staff, relate to the identified "presses" of *Ambition* and *Information,* as faculty worked to overcome obstacles presented by the environment to ensure student learning occurred (Murray, 1939/2008). Faculty would actively develop positive relationships with nursing staff to promote an environment that fostered student learning, overcoming challenges presented by the environment to best perform the faculty role.

Regarding prior research, one article was found gaining insight on how this same environment impacted faculty (Young et al., 2014) but data collection was limited to discerning what was liked and disliked about the acute care setting. It was discovered that faculty desired more collaborative relationships with nursing staff, similar to this study; however, no discussion regarding how these relationships impacted facilitation of learning was provided. All other research studies pertaining to the acute care environment were focused on ways in which this environment impacted student learning. Findings from this study had some similarities with a prior concept analysis completed regarding the clinical learning environment (Flott & Linden, 2016), confirming that faculty were impacted by some of the same elements as students when in this setting (see Table 1). Elements impacting both groups included relationships and interactions with healthcare staff, particularly nursing staff, aligning with the psychosocial and interaction factors impacting student learning (Bloomfield & Subramanium, 2008; Chuan & Burnett, 2012; Dunn & Burnett, 1995; Flott & Linden, 2016; Levett-Jones & Lathlean, 2009; Sand-Jecklin, 2009). This study determined that participants went through a definite process when developing relationships with nursing staff in the acute care setting. Trust and *"establishing credibility"* took time but was essential to promote nursing staff engagement with student learning, aligning with prior research findings (Langan, 2003); however, because this process took time, student learning experiences were sometimes impacted in a negative manner until credibility was established. In addition, faculty were often impacted when students were treated in a negative manner by nursing staff in the acute care

environment. This meant faculty had to shift the focus away from facilitating learning and, instead, work to promote positive relationships. These findings compared to other research identifying that students often encounter negative behaviors with nursing staff while in the clinical setting, adversely affecting the learning experience (Babenko-Mould & Laschinger, 2014; O'Mara, McDonald, Gillespie, Brown, & Miles, 2014).

Other research studies investigating faculty relationships with healthcare staff in the clinical setting have focused on faculty role strain. Prior research has determined that communication and relationships among faculty, nursing staff, and administrators could contribute to faculty role strain; however, these prior studies did not detail specifically how communication and role strain impacted the facilitation of learning process (NLN, 2008; Piscopo, 1994; Young et al., 2014). This study highlighted ways in which these relationships impact the facilitation of clinical learning and discovered strategies participants utilized when *navigating these influencing processes*, including confronting staff and administrators when negative behaviors were displayed, working to develop positive relationships with nursing staff, and turning negative interactions into student learning opportunities. Finally, this study identified that it was important for faculty to show respect for those in the nursing staff role, as students did add to this workload, while clarifying that the faculty role meant focusing on student learning versus assisting nursing staff in completing cares.

Another environmental aspect impacting this process included the *fostering a collaborative culture* of the acute care setting. This also aligns with prior research focusing on student learning experiences (see Table 1), including the concept analysis completed on the clinical learning environment (Bisholt et al.,2013; Chan, 2002; Dunn & Burnett, 1995; Dunn & Hansford, 1997; Flott & Linden, 2016; Hosoda, 2006; Levett-Jones & Lathlean, 2009; Newton, Jolly, Ockerby, & Cross, 2010; Palmer et al., 2005). Participants found that relationships established between nursing programs and healthcare institutions benefitted faculty as participants could facilitate learning in a setting that valued students and nursing education. This also benefitted the associated healthcare organizations with facilities actively recruiting these same students to fill vacant nursing positions after graduation. The impact of this

environment and culture aligns with the Ascent to Competence framework developed by Levett-Jones and Lathlean (2009) which states that students need to feel physically and psychologically safe for effective learning to occur. This study determined that, for faculty to best facilitate learning, positive relationships, trust, and a collaborative culture is necessary for faculty to best perform their role, supporting prior studies investigating student clinical experiences (Henderson, Briggs, Schoonbeek, & Paterson, 2011). Participants also felt having clinical assignments at the same acute care setting over time assisted in maintaining these positive relationships, which prior research confirmed (Piscopo, 1994).

While some elements impacting faculty aligned with student experiences, this study discovered other environmental aspects specifically impacting faculty when performing their role. This included faculty's need to *manage unpredictability*, as patient conditions and changes in census would often warrant unexpected adjustments. As stated earlier, one prior study discussed the need for faculty to adjust teaching strategies due to the acute care environment as changes in situations occurred rapidly, correlating with these study findings (Hossein, Fatemeh, Fatemeh, Katri, & Tahareh, 2010). Finally, the element of *incorporating organizational needs* highlighted faculty's desire to ensure students were properly prepared for the demands presented by acute care settings while simultaneously ensuring organizational policies were followed. Participants were aware of literature highlighting the unpreparedness of new nurse graduates (Athlin, Larsson, & Soderhamn, 2012; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013). Some participants also received this feedback directly from healthcare administrators, as several nursing programs actively communicated with local healthcare agencies to determine behaviors and skills new nurse graduates would need upon entering practice. Faculty wanted to integrate this feedback when providing clinical instruction to better prepare students for the new nurse graduate role.

In summary, determining aspects of the acute care environment impacting faculty's ability to facilitate learning addressed a noted gap in the literature highlighted by other researchers (Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007). Even though some findings compared to elements impacting students' learning experiences, other elements of the environment specifically impacting faculty were discovered, as no prior studies have examined the influence of this environment from the

faculty perspective. This study determined elements directly impacting the facilitation of learning process which were often negotiated simultaneously while faculty facilitated student learning.

Subquestion 4. This question investigated factors outside the acute care environment and TCM that influenced the facilitation of learning process. It was revealed that *growing as a facilitator of learning, working with adjunct faculty, juggling workload requirements,* and *lacking clinical sites* were additional factors influencing this process.

When compared to prior research, this study confirmed similar findings regarding the category of *growing as a facilitator of learning*. Prior studies have focused on the transition of faculty moving from a clinical nurse role to that of nursing educator, noting the difficulties with this transition when limited education and orientation was provided (Cangelosi, Crocker, & Sorrell, 2009; Gazza & Shellanbarger, 2005; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013; Schoening, 2013; Suplee, Gardner, & Jerome-D'Emilia, 2014). This study confirmed these findings, as all participants felt unprepared when initially providing clinical instruction. Faculty discussed experiencing growth and an enhanced ability to provide effective clinical instruction after experience was gained even when formal nursing educational preparation and orientation was received prior to entering this new role. Participants also emphasized the importance of taking initiative in *seeking out development opportunities* to become a better nursing educator, which aligns with the Situated Cognition Model in regards to workplace learning (Hansman, 2001). As discussed in chapter two, this model described that, until someone is immersed in the environment in which they will be working, it is difficult to fully prepare for a new role (Hansman, 2001). Faculty confirmed this same experience when entering the field of nursing education and first providing clinical instruction.

This study also discovered particular areas in which faculty had improved after providing clinical instruction over time. Specifically, faculty *learned to step back* and *allow students to struggle* through the learning process without always immediately providing answers. Prior research has also confirmed that stepping back can be difficult when transitioning to the faculty role and beginning to instruct students (Schoening, 2013). This type of teaching strategy also correlates with the pedagogy of coaching often

associated with nursing education and highlighted in the Cognitive Apprenticeship Model (Benner, Sutphen, Leonard, & Day, 2010; Collins, Brown, & Holum, 1991). Even though prior studies have identified coaching as important to implement when instructing nursing students (Dickson, Walker, & Bourgeois, 2006), this study confirmed that facilitating learning in this manner did not come naturally and was difficult to incorporate when first providing clinical instruction. Faculty learned over time that this approach was best to enhance the development of students' higher level thinking and problem-solving skills. In addition to the pedagogy of coaching, *learning to step back* also connects to the teaching methods of scaffolding and fading introduced by the Cognitive Apprenticeship Model and reinforced by the Gradual Release framework (Brown, Collins, & Dugoid, 1989; Fisher & Frey, 2014). Faculty learned to individualize the amount of support provided to students while understanding this support should diminish over time as they transitioned to the new nurse graduate role (Brown, Collins, & Dugoid, 1989; Fisher & Frey, 2014). Furthermore, faculty grew in *making learning meaningful*, connecting to the guiding principles of *building on foundational knowledge* and *applying theory to practice* when determining clinical assignments. Faculty learned through experience the importance of individualizing student learning needs and worked to ensure clinical document assignments, patient care activities, and group discussions promoted growth and progression of student learning. Initially, these activities were described as "haphazard" and lacked focus; however, with experience and further development, faculty recognized that every assignment should assist students in transitioning to the independent professional nurse role. While prior research had highlighted the difficulty when faculty first transitioned to the role of nursing educator, this study specifically confirmed aspects of this transition impacting facilitation of clinical learning.

Working with adjunct faculty was another factor identified in this study as impacting the facilitation of learning process. Concerns regarding this factor correlate with previous literature focused on adjunct instructor experiences, finding that adjunct faculty also have difficulty transitioning to the nursing education field partly due to feeling a lack of integration with the associated university and receiving little communication from full-time faculty (Gazza & Shellenbarger, 2010; Volk, Homan,

Tepner, Chichester, & Scales, 2013). While prior research investigated this concern from the adjunct faculty perspective, no prior research was found addressing full-time or part-time faculty concerns regarding relationships with adjunct instructors. Participants confirmed that a lack of communication and mentoring provided to adjunct faculty was upsetting, leading to concerns about the quality of learning experiences provided to students. A deficiency of intrinsic motivation and lack of understanding regarding the importance of the faculty role were described as possibly impacting adjunct faculty performance. While adjunct performance did not directly influence faculty when actively facilitating learning, apprehensions regarding student learning outcomes did stem from concerns with this specific faculty group.

The subcategory of *juggling workload requirements* also aligned with prior research investigating role strain among faculty members (Gazza, 2009; Oermann, 1998). What this study adds is that these workload requirements also impact the facilitation of learning process in the clinical setting. Also identified in this study were solutions participants implemented when presented with these workload challenges. These solutions included faculty reviewing paperwork with students while actively facilitating learning instead of grading multiple documents outside the clinical setting. In addition to impacting facilitation of learning, other research has highlighted that role strain, which is influenced by the multiple responsibilities faculty often juggle, could contribute to worsening an already present nursing faculty shortage and should be investigated to improve retention and alleviate this current trend (Roughton, 2013).

Finally, participants felt the impact of *lacking clinical sites* when providing instruction in acute care, noting difficulty in accessing sites that could provide quality student learning experiences. This finding supports recent nursing education trends felt throughout this country and others, confirming that these trends not only impact student learning, but also faculty's ability to facilitate learning (AACN, 2010; Ironside & McNelis, 2010; MacFarlane, 2007; McNelis, Fonacier, McDonald, & Ironside, 2011).

This subquestion confirmed many prior research findings but did so in a different context. Faculty were able to specifically describe how all factors impacted the facilitation of clinical learning process and

student learning experiences. As concerns grow regarding the inadequate preparation of nursing students, knowledge of these influencing factors may assist in finding solutions to these challenges and alleviating the noted preparedness gap of new nurse graduates. Also, these findings identify appropriate resources and support needed by faculty to best perform the role of clinical instruction. Ensuring faculty are provided this necessary support could enhance nursing faculty retention.

Subquestion 5. The final subquestion was interested in how faculty evaluated clinical learning, ensuring students were effectively progressing during acute care experiences. In regards to *evaluating responses*, faculty assessed for five subcategories, including *preparing for safe care, performing safe care, "connecting the dots", becoming a professional,* and *meeting expectations.*

Prior research aligned with participants' expectations that students should be *prepared for safe care* at the start of each clinical day (Webster, 2006). Participants often assigned pre-clinical documents for nursing students to complete, understanding students were novices and needed time to process and review information to provide safe care, even though these assignments contributed to increased faculty workload (Webster, 2006). Participants ensured assignments were completed at the beginning of the clinical day and consequences occurred if this did not happen, with some faculty even sending students home. In regards to evaluating skill/task completion, similar findings from this study were also mentioned in prior literature. Faculty ensured students were *performing safe care* by directly observing students complete skills/tasks prior to arriving at the clinical setting and when providing direct patient care (Hengameh et al., 2015; Houghton, Casey, Shaw, & Murphy, 2012; Williams & West, 2012).

When evaluating for the development of higher level thinking, the in vivo code of *"connecting the dots"* was brought up my multiple participants. Faculty evaluated for students' ability to pick out pertinent data and analyze this data to determine and anticipate necessary nursing interventions. The ability to *"connect the dots"* was evaluated while students provided patient care and in clinical document assignments. When compared to prior literature, other studies found faculty utilized similar terms when evaluating for integration of higher level thinking, including "putting it all together", which involved students demonstrating appropriate reflection techniques while applying knowledge to new situations and

anticipating patient needs (Twibell, Ryan, & Hermiz, 2005, p. 71). In addition, other studies described evaluating these same elements by utilizing clinical documents, including concept maps (Kaddoura, VanDyke, Cheng, & Shea-Foisy, 2016), supported by findings from this study. This study confirmed prior research findings regarding elements evaluated for when assessing the development of higher level thinking and skill/task competency, but again, provides a more comprehensive view of this process, describing ways in which faculty evaluate for these elements while actively facilitating learning in the acute care settings.

In regards to *becoming a professional*, participants evaluated for students' ability to exhibit appropriate leadership and communication skills while providing patient care and working with healthcare staff. Faculty did not state specific criteria that ensured integration of these behaviors; rather faculty simply desired students to display these behaviors appropriately when caring for patients and interacting with the healthcare team. When compared to prior research, studies examining the evaluation of interpersonal skills were mainly concerned with the effectiveness of specific teaching interventions meant to improve these behaviors. This was done by distributing satisfaction surveys and determining whether students and faculty thought the intervention was effective (Cooper, et al., 2013; Jones, 2007). Other studies developed formal scales evaluating for improvements in these behaviors (Kesten, 2011; Lee, et al., 2016; Yoo & Chae, 2011). These tools measured specific items related to teaching strategies under investigation, including students' ability to communicate pertinent assessment changes and provide appropriate recommendations for patient care during simulated scenarios. Again, none of these prior studies researched evaluation methods utilized in the acute care setting, as all were evaluated either in classrooms, simulation laboratories, or skills laboratories.

Similarly, prior research concerned with evaluating management of care behaviors either utilized standardized tools and examinations (Conger, 1999; Nowell, 2016; Lekan, Corazzini, Gilliss, & Bailey, 2011; Powell, 2011) or gained student feedback regarding effectiveness and satisfaction with a specific teaching intervention (Conger, 1999; Jones, 2007; Kaplan & Ura, 2010; Nowell, 2016). Only two studies were interested in student development of these behaviors when providing care in the acute care setting

(Conger, 1999; Powell, 2011), but again, both evaluated for the effectiveness of specific interventions meant to develop these behaviors. As prior research has only been interested in determining the effectiveness of specific teaching strategies when evaluating for professional behaviors, this study better clarified the entire process faculty utilize and integrate when evaluating professional behaviors while facilitating clinical learning. With research identifying some of these behaviors as lacking in new nurse graduates (Athlin, Larsson, & Soderhamn, 2012; Burns & Poster, 2008; Del Bueno, 2005; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013), this study confirmed that evaluating for these same behaviors is important to ensure students are prepared for the professional nurse role.

Finally, when *evaluating responses*, faculty confirmed that students were *meeting expectations*, ensuring outlined criteria in clinical and course evaluation forms were met before student progression occurred. Prior research has also determined that faculty find clinical evaluation forms important to provide objective feedback concerning student clinical performances (Mahara, 1998; Rafiee, Moattari, Niknakht, Kojuri, & Mousavinasab, 2014). Participants appreciated the guidance provided by these forms while also struggling, at times, with evaluating specific elements of student performance, which was also supported by prior research (Karayurt, Mert, & Beser, 2008; Lofmark & Thorell-Ekstrand, 2000; Mahara, 1998; Rafiee et al., 2014). Although precise criteria included on evaluation forms was not obtained from participants in this study, evaluation criteria on clinical evaluations investigated in prior research differed from one study to the next; however, all forms addressed specific knowledge, skills, and behaviors expected from student performance (Karayurt, Mert, & Beser, 2008; Lofmark & Thorell-Ekstrand, 2000; Mahara, 1998; Rafiee et al., 2014). This study confirmed the need for objective clinical evaluation tools which were necessary for participants to provide formal and objective feedback regarding acute care clinical experiences.

Another aspect of evaluation discovered from this study was that of *seeking progression.* Participants described not only evaluating students statically during one clinical experience, but also evaluating for improvements from one experience to the next, ensuring students were integrating faculty feedback and incorporating more complex skills/tasks and theoretical concepts into subsequent clinical

experiences. This was manifested by students' *"taking initiative", bringing learning forward,* and *managing complex situations.* These findings align with the Cognitive Apprenticeship Model (Brown, Collins, & Dugoid, 1989) and Gradual Release framework (Fisher & Frey, 2014), which describe the importance of ensuring students require less faculty support over time. Participants expected the amount of support required by students to decrease as they progressed throughout the program. Other literature described this same concept of fading when evaluating for student learning in the simulation laboratory, aligning with findings from this study (Parker & Myrick, 2012). Again, no other literature was found investigating how faculty actively evaluated for this increasing independence while in the acute care setting, providing another missing link regarding the facilitation of learning process. It is important to note that, depending on the level of student, participants had differing expectations regarding the amount of progression expected during clinical experiences. Faculty teaching students close to graduating evaluated for students' ability to provide care to multiple patients with minimal guidance which differed from faculty teaching introductory students.

In addition, after *seeking progression*, faculty *determined student focus,* which meant determining which students were not progressing appropriately during clinical experiences. Faculty *identified strengths of students,* determined if students were *building from feedback,* and *prioritized patient needs* while *ensuring all were evaluated* at some point during the rotation. Faculty would often use notes and documents to remember important clinical events and ensure all students were evaluated at some point during the rotation. This practice of documenting student activities in the acute care setting was supported by prior research (Hall, Daly, & Madigan, 2010); however, no research was found describing ways in which faculty *determined student focus* while actively facilitating learning in the acute care setting. This part of the facilitating learning process does align with the Cognitive Apprenticeship Model, which describes that students learn at different rates and faculty focus is often adjusted depending upon the amount of support students need (Brown, Collins, & Dugoid, 1989). This study determined that ensuring students were providing safe care was the main priority for faculty, and, if this was not observed, participants would spend more time with those students of concern, understanding that other students

would not receive equivalent amounts of time from faculty. Regarding evaluation practices of faculty, this study provided a more comprehensive image of the multiple areas of instruction faculty evaluate, not only during the clinical day, but throughout entire clinical rotations.

Finally, the subcategory of *building relationships with students* again emerged as an influencing factor for faculty when evaluating student learning. Getting to know students allowed faculty to better determine whether students were not meeting outlined objectives or just needed support due to increased anxiety levels. Similar to *facilitating learning*, prior studies confirmed that students were impacted by relationships with faculty (Cook, 2005; Shahsavari, Yekta, Houser, & Ghiyasvandian, 2013; Yaghoubinia, Heydari, & Roudsari, 2014). This study confirmed that *building relationships with students* not only impacted the ability of faculty to *facilitate learning*, but also evaluate student learning as well.

Central research question. This study was ultimately interested in understanding the process faculty utilize when facilitating student learning in the acute care setting, including determining factors influencing this process. The results of this study led to the development of a substantive level theory (Creswell, 2013), providing a better picture and framework regarding elements faculty negotiate while providing clinical instruction in this setting. A substantive level theory relates to a "specific problem or population of people", which applies to this study, as the focus was on nursing faculty providing clinical instruction in acute care settings (Creswell, 2013, p. 89). The Flott Facilitation of Clinical Learning in Nursing Theory (see Figure 21) demonstrates that faculty facilitate learning in a continuous cycle while simultaneously negotiating multiple influencing processes. When first investigating the literature, two overarching theoretical frameworks, Social Constructivism and the Behavioral-Environment Theory, described concepts possibly explaining elements of this process. While comparing the findings of this grounded theory study to these theoretical frameworks, similarities were noted and described throughout this chapter (Brown, Collins, & Dugoid, 1989; Hansman, 2001; Lewin, 1936/2015; Murray, 1939/2008; Vygotsky, 1978). The links between the developed grounded theory and these two influencing frameworks is graphically depicted in Figure 23.

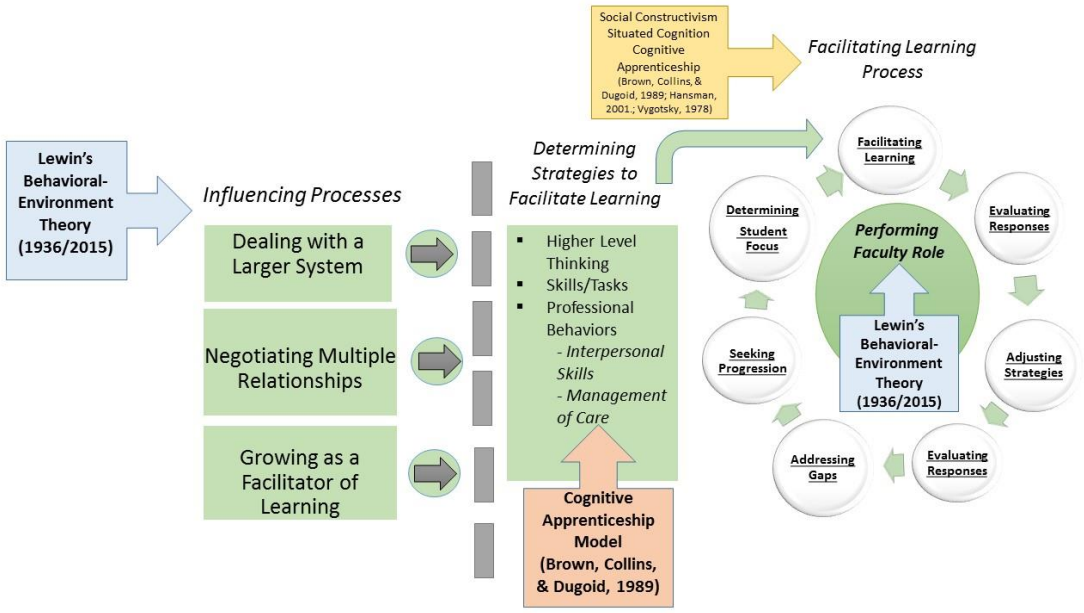

Figure 23. Theoretical Influences of the Flott Facilitation of Clinical Learning in Nursing Theory

These frameworks provided a starting point for investigating ways in which faculty facilitated learning and how the surrounding environment may impact this process; however, there was a definite gap identified in the literature regarding how environmental components and other factors influence the facilitation of learning process. This disconnect between the two original influencing frameworks is illustrated by the gray dashed line in Figure 23. Lewin's Behavioral-Environment Theory (1936/2015) was supported by this study, as faculty were influenced by the acute care environment when facilitating clinical learning. These environmental influences, along with others, impacted the ability for faculty to effectively facilitate clinical learning with nursing students. Also aligning with this theory was that these influencing environmental components could lead to the inability for faculty to accomplish their goal, which was *performing the faculty role* effectively while providing clinical instruction; however, this theory did not address the facilitation of learning process or how these elements specifically impacted the provision of clinical instruction.

The framework of Social Constructivism (Vygotsky, 1978), along with the associated models of Situated Cognition (Hansman, 2001) and Cognitive Apprenticeship (Brown, Collins, & Dugoid, 1989), identified elements that connected with the facilitation of learning process identified throughout this

study. These included correlations with specific teaching strategies faculty utilized when facilitating learning. In addition, other concepts, including the need to *build upon foundational knowledge* and understanding that students need differing levels of support depending on individual learning needs were supported by this theory and associated models; however, what was lacking were identification of potential factors influencing this process from the faculty perspective. Also, these models were not specific to the facilitation of clinical learning process. Again, even though these theoretical influences had elements that corresponded to the developed grounded theory of interest, a gap was evident regarding ways in which the influencing processes impacted facilitation of clinical learning from the faculty perspective. This study assisted in closing this gap, providing a full picture of this process with the subsequent development of a grounded theory representing faculty experiences.

The other substantial gap addressed by this central research question was determining that, when *performing the faculty role*, a link exists between faculty's ability to facilitate learning effectively and experiencing satisfaction with performing the role of clinical instruction. Prior research has linked role strain experienced from clinical teaching to overall job satisfaction of faculty (Gazza, 2009; Oermann, 1998; Roughton, 2013), but did not identify that faculty unable to effectively provide clinical instruction often felt dissatisfied with their performance of the role. The ability for faculty to *understand the faculty role* and clarify this role to healthcare staff, *determine a clinical teaching focus* highlighting student development of professional behaviors and higher level thinking, *navigate influencing processes*, and *express intrinsic motivation* determined whether faculty would *fulfill their purpose, go through the motions*, or *disengage from learning*, potentially impacting student learning experiences and nursing faculty retention. Prior research was not found linking an *understanding of the faculty role* or an ability to *express intrinsic motivation* to *performing the faculty role* effectively which this study identified. Some prior descriptive survey studies have investigated how faculty *navigate influencing processes* and the importance of *determining a clinical teaching focus* when providing clinical instruction in the acute care setting (Ironside & McNelis, 2010; McFarlane et al., 2007). Faculty have identified that barriers when providing clinical instruction include difficulty in fostering higher level thinking skills. Strategies to

overcome this barrier involved incorporating more simulation scenarios and case studies into the curriculum, developing positive relationships with healthcare staff, and prioritizing the utilization of questioning techniques (Ironside & McNelis, 2010; McFarlane et al., 2007). Even though prior research has touched upon these barriers, this study provided a more complete picture of a continuum faculty experience regarding *performing the faculty role* when facilitating learning in the acute care environment.

The Flott Facilitation of Clinical Learning in Nursing Theory (see Figure 21) illustrates a representative picture of the facilitation of learning process, providing a framework that nursing education programs, acute care facilities, and faculty can utilize to inform future improvements regarding the delivery of clinical instruction. As noted in the literature review, prior studies addressed certain aspects of this process, but none had closed the loop on how these entities and areas interact. This study has provided a starting point to assess for ways in which nursing education programs, faculty, and healthcare facilities can improve the acute care clinical instruction of nursing students by better understanding this process, and factors influencing this process, from the faculty perspective.

Significance of the Findings

This study was significant as no other study has investigated the facilitation of learning process and factors influencing this process from the faculty perspective. Due to current trends in healthcare and nursing education, along with concerns regarding student preparation for practice, this study was timely in gaining faculty viewpoints regarding the state of clinical instruction and potential areas for improvement. Significant findings are discussed next, and include the importance of understanding this process, influencing factors impacting this process, and connections between facilitating learning and faculty satisfaction with the clinical teaching role. These findings carry implications potentially impacting the preparation of nursing students and nursing faculty retention.

The first significant finding was bringing to light the entire process faculty utilize when facilitating clinical learning. This study identified this process as continual, occurring in a cyclical manner, and not a static activity that is completed throughout a single clinical experience. When evaluating prior studies investigating student learning, researchers often sought to understand one aspect

of clinical teaching while evaluating the effectiveness of one specific intervention. This study provides a comprehensive picture regarding this entire process, influencing factors affecting this process, and the many outcomes faculty evaluate when providing clinical instruction, all of which faculty negotiate simultaneously throughout the clinical day. Some elements of this process, including the categories of *adjusting strategies, addressing gaps, seeking progression,* and *determining student focus* were steps not identified in prior literature. Knowledge of these steps in the process assists in better understanding the facilitation of learning experience from the perspective of nursing faculty.

Another significant finding included understanding the influencing factors impacting the facilitation of learning process. This study illuminated ways in which these factors can and do interrupt faculty workflow, leading to difficulties with appropriately facilitating and evaluating student learning. These concerns provide insight into possible reasons for nursing student unpreparedness when entering the workforce. Multiple participants admitted having difficulty with properly evaluating students due to a high faculty-to-student ratio, finding themselves running from one task to the next versus developing and evaluating students' higher level thinking abilities. In addition, faculty described safety concerns due to being responsible for a large number of students. Having a better understanding of these influencing factors can provide guidance for nursing education programs when attempting to improve clinical education and working to reduce the preparedness gap noted in new nurse graduates.

Another significant finding was determining that, from faculty perspectives, the preparation of students involves an entire system impacting facilitation of clinical learning. This system involves nursing education program administrators which often determine faculty workload and orientation to the role, regulatory agencies such as State Boards of Nursing that set faculty-to-student ratios, and healthcare facilities, where acute care instruction occurs. Other descriptive studies have identified similar concerns regarding aspects of this system impacting faculty (Ironside & McNelis, 2010; Macfarlane, 2007; Teel, Smith, & Thomas, 2008), but none utilizing a qualitative, grounded theory methodology that provides specific examples of ways in which elements from this system impact facilitation of learning, and potentially, preparedness of students for practice. With no prior research found justifying the faculty-to-

student ratios implemented by State Boards of Nursing and a faculty shortage leaving nursing programs few options when desiring to decrease this ratio, participants often felt overwhelmed and frustrated when facilitating clinical learning. In addition to concerns regarding the ratio, participants also felt the strain of other national trends identified in the literature, including the addition of more programs and students to offset the nursing shortage which has led to a lack of quality clinical sites available for student learning (AACN, 2010; Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010; Tanner, 2006). This study supports integrating faculty concerns to either update the current model of clinical instruction or work to develop new models alleviating these trends, providing faculty a more ideal environment when facilitating learning in the acute care setting.

In addition to influencing factors, this study also identified a significant disconnect regarding the focus of clinical teaching. Some participants described being a part of programs that developed relationships with surrounding healthcare agencies. Administrators from these agencies often communicated that new graduate nurses should enter practice with sufficient higher level thinking skills and effective management of care behaviors, coinciding with findings from the literature (Athlin, Larsson, & Soderhamn, 2012; Benner, Sutphen, Leonard, & Day, 2010; Burns & Poster, 2008; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013).; however, when faculty actively facilitated learning in these same settings, nursing staff and students were often focused on completion of skills/tasks. In response to this disconnect, some faculty developed their own solutions to overcome this challenge when *determining a clinical teaching focus* emphasizing higher level thinking, including turning down skill/task opportunities offered by nursing staff. While these solutions worked for some faculty, no long-term solutions to this issue were discussed by participants. This study brought to light the disconnect regarding the actual focus of clinical instruction when faculty were in the acute care setting versus expectations and needs verbalized as necessary by administrators when students entered practice, leaving faculty feeling conflicted when striving to perform their role effectively. These concerns also carry with them implications for nursing faculty retention and preparedness of new nurse graduates.

Another significant finding was the importance of relationships while facilitating student learning. Faculty not only needed to build relationships with students, but also healthcare staff, administrators, and adjunct faculty. Faculty were the hub connecting these individuals together while working to provide positive and quality learning experiences for students. Of interest was faculty's need to establish themselves as credible nurses to nursing staff while maintaining their professional focus on student learning. In addition, faculty dealt with nursing staff unwilling to engage with students during clinical experiences which negatively impacted student learning. Furthermore, faculty discussed concerns regarding adjunct performance partially due to a lack of mentoring and guidance that participants were unable to provide. Finally, relationships between entire nursing programs and healthcare organizations had to be fostered which participants identified as essential for student learning experiences. As multiple individuals, not just faculty, take part in the preparation of nursing students, providing effective communication, clarifying the faculty role, and developing trust with others were essential actions faculty integrated to provide positive learning experiences for students. Of most importance was faculty's ability to build relationships with students which was enhanced when faculty taught the same students in the classroom setting and could evaluate students consistently over multiple clinical rotations.

An additional significant finding was the need for faculty to consistently focus on student learning. Faculty wanted to ensure students were prepared for their future role by exposing them to varied learning opportunities while confirming students learned from errors and negative interactions that occurred in the acute care setting. Faculty wanted to build relationships with students, individualize learning needs, tailor patient experiences and clinical assignments to ensure growth, and maintain an approachable demeanor, encouraging students to seek faculty input when concerns arose. Faculty had established expectations and negative consequences occurred if these were not met; however, incorrect responses or finding students struggling during clinical experiences was not met with punitive actions, but rather, adjustment of learning strategies, providing students the necessary time to determine their own solutions. There was also a consistent understanding that students were novices and needed support to learn and grow by instituting realistic expectations when in the acute care setting.

Finally, of significance to note, were implications related to nursing faculty retention, some of which have been discussed. Participants often described frustration when unable to effectively facilitate and evaluate learning. Faculty often felt no long-term solutions to these clinical challenges would occur, leading to the development of their own solutions when *navigating influencing processes* and striving to best prepare students for practice. Another factor adding to this challenge was participants' overall feeling of unpreparedness when entering the faculty role, even if orientation and education was provided. All of these findings have implications related to nursing faculty retention which, ultimately, impacts whether nursing students are adequately prepared for the professional nurse role.

Multiple significant findings were uncovered during this grounded theory study, including the discovery of factors potentially impacting new nurse graduate preparedness for practice, nursing faculty retention, and insight that some changes are needed to the TCM of instruction. The Flott Facilitation of Clinical Learning in Nursing Theory (see Figure 21) illuminated this process, highlighting needs of faculty to best prepare students for practice in the acute care setting. Based on these findings, recommendations for practice and research are described next and should be considered to better assist faculty in performing the role of clinical instruction.

Recommendations to Enhance the Nursing Faculty Role in Acute Care Clinical Education

Multiple recommendations for practice were determined based on study findings. These recommendations include those concerning all parties involved with the education of nursing students, those impacting nursing education program administrators, and recommendations for faculty providing direct clinical instruction to students.

Recommendations involving the larger system impacting clinical education. Many implications for practice will require communication and collaboration to occur among all entities involved in the preparation of nursing students. These implications will require regulatory agencies, healthcare facilities, nursing education program administrators, and faculty, to come together and discuss needed changes to the TCM of instruction. These implications include investigating solutions to

influencing factors brought about by this system, enhancing relationships among all parties involved in nursing education, and establishing common goals regarding the focus of clinical instruction.

Developing solutions for influencing processes of the larger system. This study identified multiple influencing factors which were part of the overall system impacting nursing education. Addressing these factors will require the collaboration of all parties to evaluate and address faculty concerns regarding the impact these factors have on faculty's ability to provide effective clinical instruction.

Out of all identified factors, the most influential one discussed by participants involved the faculty-to-student ratio. Concerns regarding student and patient safety due to this ratio warrant further discussion, including the possibility of decreasing this ratio. Safety concerns brought up by participants were compounded when acute care units experienced nursing staff shortages, another trend impacting the nursing education system. This is not the first study identifying this concern, further emphasizing the importance for all entities to investigate and discuss the faculty-to-student ratio considering safety concerns brought about by faculty participants in this study (Benner, Sutphen, Leonard, & Day, 2010; Ironside & McNelis, 2010; Langan, 2003; Teel, Smith, & Thomas, 2008). If faculty are unable to fully evaluate student performance due to this ratio, students may graduate without adequate evaluation of their clinical performance, leading to even more safety concerns as these students potentially enter practice prematurely. Ensuring all entities come together and work towards developing a safer faculty-to-student ratio is imperative. This concern should also be kept in mind as nursing programs introduce new clinical models. Investigating this ratio before and after implementing new models is important to ensure these ratios promote patient safety and allow faculty adequate time to safely facilitate and evaluate clinical learning.

Other concerns brought about by this system, including a lack of clinical sites, will also require all entities to work together and communicate specific needs of each nursing program. Aligning with prior research, creative clinical solutions should be developed ensuring students from all programs are receiving quality learning experiences (McFarlane, 2007; McNelis, Fonacier, McDonald, & Ironside,

2011). Also, it is imperative to listen and include faculty perspectives prior to developing and implementing new clinical models to ensure challenges experienced with the TCM are not repeated. This will also assist faculty by providing them the best clinical model possible to best facilitate student learning.

Building relationships that value nursing education. Another influencing factor involving this larger system includes the multiple relationships faculty must develop during the facilitation of learning process. Based on study findings, faculty, nursing program administrators, and healthcare facilities should implement solutions to develop and promote positive relationships among all individuals involved in the clinical instruction of nursing students. Practice implications include fostering relationships prior to faculty providing clinical instruction. This could occur through faculty visiting acute care settings at nursing staff meetings prior to faculty arriving with students. In addition, ensuring faculty are oriented to the acute care unit and introduced to staff prior to starting clinical instruction can assist in establishing credibility early on, improving the facilitation of learning process. *"Establishing credibility"* early could enhance the facilitation of learning process and ensure students are provided adequate learning opportunities in the acute care setting.

Also, ensuring healthcare staff are aware of their impact on nursing student education is vital. Discussion regarding eliminating negative behaviors displayed towards students should also occur prior to starting clinical instruction on acute care units. Jennifer described her approach when students were exposed to these negative behaviors while actively facilitating learning, highlighting to nursing staff the importance of their role in promoting and valuing student learning:

> I've had to confront several nurses. My favorite thing to say is, 'You know, I'm not sure you're aware of how important you are to the students, and when you snap at them, they don't think that maybe you're having a bad day, they think you're mad at them and maybe you don't like them.'

Similar to Jennifer, all participants described observing or addressing negative interactions between students and nursing staff. Other faculty also brought up safety concerns when nursing staff were disengaged with student learning, highlighting that negative patient outcomes could occur if student

concerns were not addressed or acknowledged. Communicating to nursing staff the importance of their role in nursing education prior to students arriving could assist in decreasing these negative interactions. This could be communicated through meetings with nursing staff, manuals describing nursing program curricula and learning objectives, or through development of a website that includes educational resources for nursing staff to access. It is imperative that all registered nurses understand the important role they play in nursing student education and that promoting positive learning experiences is an expectation of the profession. The American Nurses Association explicitly states these expectations in a standards of practice document, describing that registered nurses should, "contribute to a work environment conducive to the education of healthcare professionals" (American Nurses Association, 2010, p. 56). Promoting positive learning experiences for nursing students must be displayed at the organizational level to ensure this mindset is observed among all healthcare staff. Building positive relationships that value nursing education can positively impact student learning. This could also influence the nursing shortage in a positive way, encouraging students to remain in a profession that values all levels of nurses, including novice students (Babenko-Mould & Lasching, 2014). To foster these positive relationships, academic partnerships have occurred between nursing programs and healthcare facilities when reviewing literature concerned with the DEU and newer models of clinical instruction (Campbell & Filer, 2008; Hegge et al., 2010; Mulready-Shick et al., 2013; Nishioka, Coe, Hanita, & Moscato, 2014a; Nishioka, Coe, Hanita, & Moscato, 2014b; Ryan, Shabo, & Tatum, 2011, Teel, McIntyre, Murray, & Rock, 2011); however, no literature was found describing these partnerships when the TCM of instruction was utilized. Placing an emphasis towards the development of building these relationships can assist faculty in best preparing students for practice. This would allow faculty to focus on their role of facilitating learning versus putting energy towards fostering relationships and addressing negative behaviors. A final implication for practice involves providing faculty consistent clinical location assignments which assists participants in maintaining positive relationships over time and aligns with prior research recommendations (Piscopo, 1994).

Establishing a clinical teaching focus. With changes in healthcare comes a need to address the provision of clinical instruction as mentioned by multiple national nursing leaders and organizations (AACN, 2002; Ironside & McNelis, 2010; McNelis, Fonacier, McDonald, & Ironside, 2011; NLN, 2005). Nurses today practice more autonomy while providing care to higher acuity patients, and with this autonomy comes the need to reprioritize the clinical focus faculty employ when providing clinical instruction (Benner, Sutphen, Leonard, & Day, 2010). Multiple researchers are finding students entering the profession with a lack of necessary higher-level thinking skills and management of care behaviors. In response to these findings, nursing programs and healthcare facilities need to work together in clarifying the goals of clinical instruction, emphasizing the importance of facilitating development of these thinking skills and behaviors versus completion of skills/tasks (Athlin, Larsson, & Soderhamn, 2012; Benner, Sutphen, Leonard, & Day, 2010; Burns & Poster, 2008; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013). In regards to implications for practice, faculty described a definite disconnect regarding a preparedness gap noted by healthcare administrators and the literature as opposed to a push in performing skill/task completion when in the acute care setting. Sharon described this struggle when her nursing program decided to emphasize higher level thinking development, experiencing resistance from multiple individuals in acute care facilities:

> You know, in the BSN we're looking at the whole picture and…there was a huge transition from that, when we go back to the hospital because, directors didn't like it, managers didn't like it, nurses didn't like it, because they want them so focused, they want them when they graduate to be on the floor and be able to run. Well that's fine, but they have to be able to think…so it's important for us to make sure they have that critical thinking. So we've done a lot of one-on-one's with directors, emails go out from us as course coordinators before the semester starts saying, this is what we are focusing on…some floors take that better than other floors…

Nursing program administrators, faculty, and healthcare staff need to come together and discuss the necessity for this change of focus which can assist in reducing the preparedness gap. All healthcare professionals need to understand and support this focus to best prepare students for the nursing role. This

focus also needs emphasized to students early on in nursing programs by having faculty explain the importance in developing traits necessary for nursing practice. Establishing and communicating this change in focus can support faculty in developing these behaviors and higher level thinking while providing clinical instruction.

Recommendations for nursing program administrators. In addition to practice implications identified for the entire system, other implications apply toward nursing program administrators. These include ensuring faculty receive proper support to adequately provide clinical instruction along with other implications impacting nursing faculty retention.

Providing education and orientation to the role. Aligning with prior literature, this study found participants experiencing some sort of learning curve when transitioning from the clinical nurse role to that of nursing educator (Cangelosi, Crocker, & Sorrell, 2009; Gazza & Shellanbarger, 2005; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013; Schoening, 2013; Suplee, Gardner, & Jerome-D'Emilia, 2014). Nursing program administrators could utilize this grounded theory to better prepare new faculty when first starting to facilitate clinical learning. This theory could offer new faculty a better picture of the facilitation of learning process while highlighting challenges that could be encountered when instructing students in this setting. By providing further orientation and better preparing faculty when transitioning to the field of nursing education, faculty satisfaction and retention could be impacted in a positive manner. In addition to supporting this transition, nursing program administrators should ensure faculty are provided educational opportunities that can assist them in further improving facilitation of learning skills. These opportunities should focus on areas faculty specifically identified as difficult to perform when entering the role, including *making assignments meaningful* and allowing students to struggle, understanding this is a necessary part of the student learning process.

Evaluating workload requirements of nursing faculty. Based on study findings, nursing program administrators should also try to evaluate workload requirements of faculty. Multiple participants identified that additional workload requirements were difficult to juggle and negatively impacted the preparation of adjunct faculty. Implications for practice include encouraging administrators to identify

solutions to workload requirements, including allowing faculty to have differing clinical shifts than adjuncts. This would provide full- and part-time faculty more time to support and mentor adjunct faculty. Also, having nursing programs evaluate the amount of clinical document assignments required for grading is vital to ensure a balance is achieved between effectively assessing student learning while providing a manageable workload.

This study identified that the ability for faculty to provide effective clinical instruction impacted satisfaction with the nursing faculty role. Ensuring nursing program administrators actively develop solutions to influencing processes by improving the preparation of new faculty and ensuring faculty development opportunities improve facilitation of clinical learning could improve retention of faculty, benefitting student learning as well.

Recommendations for nursing faculty. Finally, recommendations for practice concerning faculty are provided. These recommendations center on faculty successfully *fulfilling their purpose* as a clinical instructor along with entering the role better prepared to provide clinical instruction. Implications for practice include playing an active part in developing solutions to influencing factors, ensuring individual student learning needs are addressed in the clinical setting, utilizing this theory to clarify educational and knowledge gaps regarding clinical instruction, and ensuring all faculty understand their role as one focusing on the preparation of students for practice.

Ensuring preparedness and growth for faculty role. Participants from this study described the need to take initiative and seek out educational opportunities to improve facilitation of clinical learning skills. Implications for practice include promoting all faculty to actively seek out opportunities that will assist them in better providing clinical instruction. As mentioned, faculty can also utilize this theory as a resource when first starting the clinical teaching role. This would allow new faculty to gain a better understanding of the facilitation of learning process, anticipate challenging factors that may arise when in the clinical setting, and gain insight regarding how best to provide instruction. In addition, faculty can also gain information from this theory regarding facilitation of learning strategies to utilize in the acute care setting, when to adjust those strategies, and how to evaluate student learning while providing clinical

instruction. Finally, by utilizing this theory, faculty can provide insight regarding potential changes needed to enhance the facilitation of learning process. Now that this theory is available to provide awareness regarding this process, faculty can determine potential changes necessary to best prepare students for practice. By integrating these implications early, faculty can be better informed and prepared to perform the role of clinical instruction effectively, benefitting both faculty and students.

Developing solutions to influencing factors. It was evident that all participants were impacted by similar influencing factors yet many felt resigned that nothing could be done to change these factors to improve the clinical instruction of students. Some faculty developed their own solutions to these challenges, such as reviewing clinical documents with students during the clinical day, but this was not the norm. This study highlights the need for faculty to bring these concerns forward and assist in creating change for the entire system. In addition to bringing concerns forward, faculty should also develop and share solutions with administrators and faculty colleagues to overcome these challenges. Coming together as faculty, sharing concerns, and developing long-term solutions to issues encountered in the clinical setting should become a common occurrence in all nursing programs. Having faculty share strategies can also assist new faculty when preparing to handle these challenging aspects of the role. Solutions that address maintaining a clinical teaching focus on developing higher level thinking, fostering positive relationships with nursing staff, and individualizing student learning needs should include faculty input based on findings from this study.

Prioritizing a focus on student learning. Participants also highlighted the importance of maintaining a focus on student learning. Implications for practice include ensuring students are exposed to a positive clinical environment and have sufficient learning opportunities to enhance their growth. Students should also feel comfortable in approaching faculty when questions arise while performing patient care. Providing clinical instruction meant keeping students accountable, but ultimately, faculty worked to create an optimal environment for learning while spending time with each student and ensuring progression occurred during clinical experiences.

Other implications for practice include integrating individual learning needs when providing clinical instruction. Ensuring faculty build relationships with students, role model professional behaviors, and address individual learning needs were points brought up by multiple participants in this study. It was evident that focusing on student learning by building positive relationships was important for faculty to best prepare students for practice and should be a focus for all faculty performing clinical instruction.

Understanding and clarifying the faculty role. Another implication evident among participants was understanding the purpose of the faculty role. Faculty needed to implement and demonstrate a focus on student learning when providing clinical instruction. It was important for participants to maintain positive relationships with nursing staff while simultaneously communicating that the faculty role was to focus on student learning. Avoiding the tendency to help nursing staff by completing skills/tasks while simultaneously respecting and appreciating the nursing staff role was difficult at times, but essential to ensure faculty could effectively perform their role. *Determining a clinical teaching focus* and *understanding the faculty role* while communicating this focus is essential for all faculty to best prepare students for practice.

Faculty able to *fulfill faculty purpose* also described intrinsic motivating factors that assisted in their continued growth. When a lack of understanding regarding this role was encountered, such as with adjunct faculty motivated by external factors, participants identified the negative impact this had on student learning and preparation for practice. This also led to negative relationships with healthcare staff, with these relationships often needing to be rebuilt when new faculty arrived to provide clinical instruction. Confirming all faculty understand the importance of providing clinical instruction effectively is vital to ensure students have quality learning experiences preparing them for the nursing role.

Recommendations for Future Research

Many implications for future research were identified based on findings from this study. This developed theory was groundbreaking in the sense that no prior study has fully investigated the process faculty employ when providing clinical instruction in the acute care setting. This study determined that this process was similar for all participants, including factors impacting this process. While this study has

assisted in closing a noticeable gap in the literature, further research is necessary to continue understanding and developing interventions to improve this process, providing faculty the best possible support and environment needed to prepare students for practice.

Testing and validating the theory. First, this constructed theory needs to be investigated with other populations of nursing faculty, including male faculty and those outside the Midwest region. Replication of this study with other populations can assist in testing and validating this theory. In addition, this process needs investigation with faculty providing clinical instruction in other settings, including long-term care facilities and community health, to discern similarities and differences of this process and influencing factors when clinical learning occurs in these different areas.

Similar to other settings, this theory should also be replicated in the acute care environment when other clinical models are utilized, including the DEU model. Determining ways in which this process is similar and different depending on the clinical model of instruction, along with identifying other influencing factors impacting this process, can better illustrate where improvements in clinical instruction are needed. Finally, this theory should be tested in other prelicensure nursing education programs, including associate degree programs. With further research testing and validating this theory, additional clarity to this process and improvements to clinical instruction can occur, providing faculty the best model possible to prepare students for practice.

Investigating the facilitation of learning process. Future research should also investigate whether the process identified in this study is optimal for faculty to facilitate learning. As no prior research has sought to understand this process, future studies should examine ways in which this process can be refined or improved to best prepare students for practice. Gaining insight from faculty, nursing program administrators, and healthcare facilities regarding this process could provide insight regarding improvements to employ and test for future studies. Any changes made should include faculty perspectives while also evaluating student outcomes to determine the effectiveness of these changes. Furthermore, this theory discovered elements of the facilitation of learning process not previously identified in prior research. These categories need further investigation and include the categories of

adjusting strategies, addressing gaps, seeking progression, and *determining student focus.* Researching each component to determine ways in which faculty make determinations regarding strategies to employ for each of these categories is needed.

In addition to the overall process, future research should investigate strategies utilized when actively facilitating learning in the acute care setting. Research should focus on aligning strategies with student outcomes to determine the most effective strategies for student learning when facilitating all areas of clinical instruction. Also, limited research was found investigating how faculty actively facilitate professional behaviors, including delegation and prioritization skills, which are important elements for new graduates to develop prior to entering the healthcare field. Further investigation regarding how these behaviors are developed and evaluated by faculty when actively providing clinical instruction is needed.

Furthermore, future research should focus on specific ways in which faculty build relationships with students, as getting to know students and tailoring clinical experiences to address individual needs was an important element identified by faculty when providing clinical instruction. Investigating new clinical models and determining ways in which faculty establish and build these same relationships will be important, as faculty are not always able to tailor patient clinical experiences with other models of instruction.

Finally, further investigation into the evaluation process faculty utilize are needed. Determining specific criteria faculty evaluate when providing clinical instruction and ensuring outcomes align with healthcare facility requirements of entry-level nurses is necessary to reduce the preparedness gap identified in the literature. This would also assist faculty in better preparing students for practice.

Investigating influencing processes. In addition to the facilitation of learning process, further research should investigate strategies that can combat influencing factors. Some recommendations for these strategies were mentioned in the implications for practice section, including building relationships between faculty and nursing staff prior to starting clinical instruction, communicating established goals to promote the development of behaviors and higher level thinking, and integrating this theory when providing education and orientation to new faculty members. Any intervention meant to decrease these

challenges should be investigated to determine the effectiveness from faculty, student, and healthcare facility perspectives. Gaining feedback and evaluating these interventions can assist in providing faculty the best environment possible to prepare students for practice.

In addition, further research investigating safety concerns are necessary to ensure students are provided adequate supervision and evaluation while in the clinical setting. This will involve researching different faculty-to-student ratios and gaining faculty and healthcare facility feedback regarding the impact differing ratios have on student learning and the preparedness of new graduate nurses.

Enhancing satisfaction with the nursing faculty role. This study uncovered a link between nursing faculty's ability to provide effective clinical instruction and satisfaction with *performing the faculty role*. Further investigation into this link is necessary, including determining personal characteristics of faculty in all identified *performing faculty role* categories and researching strategies faculty implement to successfully *navigate influencing processes*. Investigating these areas could assist in developing better education and orientation for those transitioning to the nursing faculty role and uncover additional solutions to influencing processes identified in this study. In addition, determining whether faculty satisfaction with performing clinical instruction impacts student satisfaction with the clinical experience and achievement of clinical learning outcomes are other research areas needing investigation.

Developing tools to evaluate acute care clinical environments. Another gap noted in the literature was the absence of a tool integrating faculty perspectives that could be utilized to evaluate whether clinical learning environments were conducive for faculty to provide effective clinical instruction (Hooven, 2014). As stated in the literature review, many tools have been developed to evaluate clinical environments, but have either incorporated student perspectives (Dunn & Burnett, 1995; Chan, 2002; Hosoda, 2006) or nursing staff perspectives regarding teaching and learning in the acute care setting (Courtney-Pratt et al., 2014; Matsumura et al., 2004). Findings from this study could assist in the development of a tool integrating faculty perspectives when evaluating clinical environments, assisting in identifying if influencing factors are present prior to facilitating clinical learning. Based on the tool findings, faculty and nursing programs could develop interventions to alleviate these barriers before

providing clinical instruction on acute care units which could assist faculty in providing quality learning experiences for students while in the acute care setting.

Conclusion

The clinical preparation of nursing students is in need of imminent change with research confirming a lack of preparedness among new nurse graduates entering practice (Athlin, Larsson, & Soderhamn, 2012; Burns & Poster, 2008; Fero, et al. 2010; Lasater & Nielsen, 2009b; Perkins & Kisiel, 2013). The Flott Facilitation of Clinical Learning in Nursing Theory assists in bridging a noted gap in the literature by providing faculty insight into both positive and challenging aspects of the traditional model of clinical instruction. This theory highlighted ways in which faculty actively *determine strategies to facilitate learning* when developing higher level thinking, facilitating skill/task performance, and enhancing professional behaviors while providing acute care clinical instruction. In addition, this theory clarified the *facilitation of learning process,* which involves a cycle faculty utilize to ensure individual student learning needs are met while evaluating for student progression both during individual clinical experiences and throughout clinical rotations. Influencing processes noted to impact the provision of clinical instruction were also identified, including *dealing with a larger system, negotiating multiple relationships,* and *growing as a facilitator of learning.* Finally, it was determined that these influencing processes and an ability to effectively facilitate learning led to varying degrees of faculty satisfaction when *performing the faculty role,* leading to implications affecting nursing faculty retention. To best improve and develop current and future clinical learning models, faculty insight regarding the facilitation of learning process must be understood and acknowledged. With the insight provided by this study and the developed grounded theory, future research can investigate strategies to overcome highlighted barriers, assisting in the refinement of clinical models, enhancing faculty satisfaction with the role, and reducing the preparedness gap noted in new nurse graduates.

References

Akhtar-Danesh, N., Baxter, P., Valaitis, R. K., Stanyon, W., & Sproul, S. (2009). Nurse faculty perceptions of simulation use in nursing education. *Western Journal of Nursing Research, 31*(3), 312-329. doi: 10.1177/0193945908328264

Althouse, L. A., Stritter, F. T., & Steiner, B. D. (1999). Attitudes and approaches of influential role models in clinical education. *Advances in Health Sciences Education, 4*, 111-122. Retrieved from http://www.springer.com/education+%26+language/journal/10459

American Association of Colleges of Nursing (2002). *Using strategic partnerships to expand nursing education programs* [Issue brief]. Retrieved from http://www.aacn.nche.edu/aacn-publications/issue-bulletin/using-strategic-partnerships

American Association of Colleges of Nursing (2010). *Addressing the nursing shortage: A focus on nurse faculty* [News article]. Retrieved from http://www.aacn.nche.edu

American Association of Colleges of Nursing (2012). *Nursing faculty shortage fact sheet* [News article]. Retrieved from http://www.aacn.nche.edu/media-relations/FacultyShortageFS.pdf

American Association of Colleges of Nursing (2014). *Annual Report 2014: Building a framework for the future* [Issue brief]. Retrieved from http://www.aacn.nche.edu/aacn-publications/annual reports/AnnualReport14.pdf

American Association of Colleges of Nursing (2015). *Diversity in the nursing workforce and student populations* [Fact sheet]. Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/enhancing-diversity

American Nurses Association. (2010). *Nursing: Scope and standards of practice*. Silver Springs, MD: American Nurses Association.

Anderson, L. W., & Krathwohl, D. R. (2001). *A taxonomy for learning, teaching and assessing: A revision of Bloom's taxonomy of educational objectives* (1st ed.). New York, NY: Longman.

Athlin, E., Larsson, M., & Soderhamn, O. (2012). A model for a national clinical final examination in

the Swedish bachelor programme in nursing. *Journal of Nursing Management, 20,* 90-101. doi: 10.1111/j.1365.2834.2011.01278.x

Babenko-Mould, Y., & Laschinger, K. S. (2014). Effects of incivility in clinical practice settings on nursing student burnout. *International Journal of Nursing Education Scholarship, 11*(1), 145-154. doi: 10.1515/ijnes-2014-0023

Beeman, R. Y. (2001). New partnerships between education and practice: Precepting junior nursing students in the acute care setting. *Journal of Nursing Education, 40*(3), 132-134. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ofs&AN=507758043&site=ehost-live

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation.* San Francisco, CA: Jossey-Bass.

Bettancourt, L., Munoz, L. A., Merighi, M. B., & Fernandes dos Santos, M. (2011). Nursing teachers in clinical training areas. *Revista de Escola de Latino-Am. Enfermagem, 19*(5), 1197-1204. Retrieved from http://kc7za5wx4c.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&rft.genre=article&rft.atitle=Nursing+teachers+in+clinical+training+areas%3A

Billett, S. (2007). *Learning in the workplace: Strategies for effective practice.* Crows Nest, Australia: Allen & Unwin

Bisholt, B., Ohlsson, U., Engstrom, A. K., Johanssen, A. S., & Gustafsson, M. (2014). Nursing students' assessment of the learning environment in different clinical settings. *Nurse Education in Practice, 14*(3) 304-310. doi: 10.1016/j/nepr.2013.11.005

Blondy, L. C. (2007). *A correlational study between the critical thinking skills of nursing faculty and their perceived barriers to teaching critical thinking skills to nursing students* (Doctoral dissertation). Retrieved from ProQuest information and learning company. (UMI Number: 3288871.)

Bloomfield, L., & Subramaniam, R. (2008). Development of an instrument to measure the clinical learning environment in diagnostic radiology. *Journal of Medical Imaging and Radiation Oncology, 52,* 262-268. doi: 10.1111/j.1440-1673.2008.01928.x

Bowles, C., & Candela, L. (2005). First job experiences of recent RN graduates. *Nevada RNformation, 14*(2), 16-19. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2009011316&site=ehost-live

Breymeier, T. L. (2012). *Clinical learning needs: Student nurse perceptions of the traditional clinical environment and the simulation environment* (Doctoral dissertation). Retrieved from ProQuest (UMI 3498578)

Brown, J. S., Collins, A., & Dugoid, P. (1989). Situated cognition and the culture of learning. *Educational Researcher, 18*(1), 32-42. Retrieved from www.jstor.org

Budgen, C., & Gamroth, L. (2008). An overview of practice education models. *Nurse Education Today, 28,* 273-283. doi: 10.1016/j.nedt.2007.05.005

Burns, P., & Poster, E. C. (2008). Competency development in new registered nurse graduates: Closing the gap between education and practice. *The Journal of Continuing Education in Nursing, 39*(2), 67-73. Retrieved from http://www.healio.com/nursing/journals/jcen

Burrows, D. E. (1997). Facilitation: A concept analysis. *Journal of Advanced Nursing, 25,* 396-404. doi: 10.1046/j.1365-2648.1997.1997025396.x

Caffarella, R. S., & Zinn, L. F. (1999). Professional development for faculty: A conceptual framework of barriers and supports. *Innovative Higher Education, 23*(4), 241-254. Retrieved from http://link.springer.com.cuhsl.creighton.edu/article/10.1023%2FA%3A1022978806131#

Campbell, S. E., & Filer, D. A. (2008). How can we continue to provide quality clinical education for increasing numbers of students with decreasing numbers of faculty? *Annual Review of Nursing Education, 6,* 45-63. Retrieved from

https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009811135&site=ehost-live

Cangelosi, C. R., Crocker, S., & Sorrell, J. M. (2009). Expert to novice: Clinicians learning new roles as clinical nurse educators. *Nursing Education Perspectives, 6,* 367-371. Retrieved from http://libraryproxy.csm.edu:2247/login.aspx?direct=true&db=rzh&AN=2010487274&site=ehost-live

Chan, D. (2002). Development of the clinical learning environment inventory: Using the theoretical framework of learning environment studies to assess nursing students' perceptions of the hospital as a learning environment. *Journal of Nursing Education, 41*(2), 69-75. Retrieved from http://collegeofsaintmarylibrary.worldcat.org/oclc/121290429

Chan, D. S. (2003). Validation of the clinical learning environment inventory. *Western Journal of Nursing Research, 25*(5), 519-532. doi: 10.1177/0193945903253161

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Chuan, O. L., & Barnett, T. (2012). Student, tutor, and staff nurse perceptions of the clinical learning environment. *Nursing Education in Practice, 12,* 192-197. doi: 10.1016/j.nepr.2012.01.003

Chunta, K., & Edwards, T. (2013). Multiple-patient simulation to transition students to clinical practice. *Clinical Simulation in Nursing, 9,* e491-e496. doi: http://dx.doi.org/10.1016/j.ecns.2013.04.015.

Coffman, S. (2012). From static lab to simulation lab: Students reflect on their learning. *Clinical Simulation in Nursing, 8,* e355-e340. doi: 10.1016/j.ecns.2011.01.003

Collins, A., Brown, J. S., & Holum, A. (1991). Cognitive apprenticeship: Making thinking visible. *American Educator, 15*(3), 6-11, 38-46.

Conger, M. M. (1999). Evaluation of an educational strategy for teaching delegation decision making to nursing students. *Journal of Nursing Education, 38*(9), 419-422. Retrieved from

http://www.healio.com/nursing/journals/jne

Cook, L. J. (2005). Inviting teaching behaviors of clinical faculty and nursing students' anxiety. *Journal of Nursing Education, 44*(4), 156-161. Retrieved from https://collegeofsaintmarylibrary.on.worldcat.org/search?

Cooper, J. R., Martin, T., Fisher, W., Marks, J., & Harrington, M. (2013). Peer-to-peer teaching: Improving communication techniques for students in an accelerated nursing program. *Nursing Education Perspectives, 34*(5), 349-350. Retrieved from http://www.nln.org/newsroom/newsletters-and-journal/nursing-education-perspectives-journal

Coram, C. (2016). Expert role modeling effect on novice nursing students' clinical judgment. *Clinical Simulation in Nursing, 12,* 385-391. doi: http://dx.doi.org/10.1016/j.ecns.2016.04.009

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research.* Los Angeles: Sage.

Courtney-Pratt, H., Fitzgerald, M., Ford, K., Johnson, C., & Wills, K. (2014). Development and reliability testing of the quality clinical placement evaluation tool. *Journal of Clinical Nursing, 23*504-514. doi: 10.1111/jocn.12158

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: Sage.

Dale, B., Leland, A., & Dale, J. G. (2013). What factors facilitate good learning experience in clinical studies in nursing: Bachelor students' perceptions. *ISRN Nursing, 2013,* 1-7. doi: http://dx.doi.org/10.1155/2013/628679

Davis, A. H., Kimble, L. P., & Gunby, S. S. (2014). Nursing faculty use of high-fidelity human patient simulation in undergraduate nursing education: A mixed-methods study. *Journal of Nursing Education, 53*(3), 142-150. doi: 10.3928/01484834-20140219-02

Del Bueno, D. (2005). A crisis in critical thinking. *Nursing Education Perspectives, 26*(5), 278-282. Retrieved from www.nln.org

Delunas, L. R., & Rooda, L. A. (2009). A new model for the clinical instruction of undergraduate nursing

students. *Nursing Education Perspectives, 30*(6), 377-380. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010487282&site=ehost-live

DeMeester, D. A. (2013). *The meaning of the lived experience of nursing faculty on a dedicated education unit.* (Doctoral dissertation). Retrieved from ProQuest. UMI: 3553635

Dickson, C., Walker, J., & Bourgeois, S. (2006). Facilitating undergraduate nurses clinical practicum: The lived experience of clinical facilitators. *Nurse Education Today, 26,* 416-422. doi: 10.1016/j.nedt.2005.11.012

Donaldson, J. H., & Carter, D. (2005). The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students. *Nurse Education in Practice, 5,* 353-359. doi: 10.1016/j.nepr.2005.05.006

Duffy, K., & Watson, H. E. (2001). An interpretive study of the nurse teacher's role in practice placement areas. *Nurse Education Today, 21,* 551-558. doi: 10.1054/nedt.2001.0582

Dunn, S. V., & Burnett, P. (1995). The development of a clinical learning environment scale. *Journal of Advanced Nursing, 22*(6), 1166-1173. Retrieved from http://libraryproxy.csm.edu:2247/login.aspx?direct=true&db=rzh&AN=1996007673&site=ehost-live

Dunn, S. V., & Hansford, B. (1997). Undergraduate nursing students' perceptions of their clinical learning environment. *Journal of Advanced Nursing, 25*(6), 1299-1306. Retrieved from http://libraryproxy.csm.edu:2247/login.aspx?direct=true&db=rzh&AN=1997027989&site=ehost-live

Edgecombe, K., Wotton, K., Gonda, J., & Mason, P. (1999). Dedicated education units: A new concept for clinical teaching and learning. *Contemporary Nurse, 8,* 166-171.

Elder, L., & Paul, R. (2010). *The Thinker's Guide to Analytic Thinking.* Dillon Beach, CA: Foundation for Critical Thinking

Embo, M., Driessen, E., Valcke, M., & van der Vleuten, C. P. (2015). Integrating learning assessment and

supervision in a competency framework for clinical workplace education. *Nurse Education Today, 35*341-346. doi: http://dx.doi.org/10.1016/j.nedt.2014.11.022

Enenbach, L. A. (2016). *Exploring reflective journaling, clinical stress, and professional confidence in undergraduate pediatric nursing clinical.* (Doctoral dissertation). Retrieved from http://www.csm.edu/sites/default/files/Enenbach_dissertation.pdf

Feldman, H. R., Greenberg, M. J., Jaffe-Ruiz, M., Kaufman, S. R., & Cignarale, S. (2015). Hitting the nursing faculty shortage head on: Strategies to recruit, retain, and develop nursing faculty. *Journal of Professional Nursing, 31*(3), 170-178. doi: http://dx.doi.org/10.1016/j.profnurs.2015.01.007

Felstead, I. (2013). Role modelling and students' professional development. *British Journal of Nursing, 22*(4), 223-227. Retrieved from http://info.britishjournalofnursing.com/

Fero, L. J., O'Donnell, J. M., Zullo, T. G., Dabbs, A. D., Kitutu, J., Samosky, J. T., & Hoffman, L. A. (2010). Critical thinking skills in nursing students: Comparison of simulation-based performance with metrics. *Journal of Advanced Nursing, 66,* 2182-2193. doi: 10.1111/j.1365-2648.2010.05385.x

Fisher, D., & Frey, N. (2014). *Better learning through structured teaching: A framework for the gradual release of responsibility.* (2nd ed.). Alexandria, VA: ASCD.

Flott, E. A., & Linden, L. (2016). The clinical learning environment in nursing education: A concept analysis. *Journal of Advanced Nursing, 72*(3), 501-513.doi: 10.1111/jan.12861

Forbes, H. (2010). Clinical teachers' approaches to nursing. *Journal of Clinical Nursing, 19,* 785-793. doi: 10.1111/j.1365-2702.2009.03078.x

Franklin, A. E., & Gubrud-Howe, P. (2014). Comparison of expert modeling versus voice-over powerpoint lecture and presimulation readings on novice nurses' competence of providing care to multiple patients. *Journal of Nursing Education, 53*(11), 615-622. doi: 10.3928/01484834-20141023-01

Ganley, B. J., & Linnard-Palmer, L. (2012). Academic safety during nursing simulation: Perceptions of

nursing students and faculty. *Clinical Simulation in Nursing, 8,* e49-e57. doi: 10.1016/j.ecns.2010.06.004

Ganzer, C. A., & Zauderer, C. (2013). Structured learning and self-reflection: Strategies to decrease anxiety in the psychiatric mental health clinical nursing experience. *Nursing Education Perspectives, 34*(4), 244-247.

Gazza, E. A. (2009). The experience of being a full-time nursing faculty member in a baccalaureate nursing education program. *Journal of Professional Nursing, 25*(4), 218-226. doi: 10.1016/j.profnurs.2009.01.006

Gazza, E. A., & Shellenbarger, T. (2005). Successful enculturation strategies for retaining newly hired nursing faculty. *Nurse Educator, 30*(6), 251-254. Retrieved from http://www.lww.com/Product/0363-3624

Gazza, E. A., & Shellenbarger, T. (2010). The lived experience of part-time baccalaureate nursing faculty. *Journal of Professional Nursing, 26,* 353-359. Doi: 10.1016/j.profnurs.2010.08.002

Glaser, B. G., & Strauss, A. L. (1967/2012). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine de Gruyter.

Godson, N. R., Wilson, A., & Goodman, M. (2007). Evaluating student nurse learning in the clinical skills laboratory. *British Journal of Nursing, 16*(15), 942-945. Retrieved from http://info.britishjournalofnursing.com/

Gonzal, K., & Newby, C. (2013). Facilitating clinical reasoning in the skills laboratory: Reasoning model versus nursing process-based skills checklist. *Nursing Education Perspectives, 34*(4), 265-267. Retrieved from http://www.nln.org/newsroom/newsletters-and-journal/nursing-education-perspectives-journal

Grindel, G., Bateman, L., Patsdaughter, A., Babington, M., & Medici, G. (2001). Student contributions to clinical agencies. *Nursing and Health Care Perspectives, 22*(4), 197-202.

Gruendemann, B. J. (1971). An abstract for action [Review of the book *An abstract for action,* by J. P. Lysaught]. *AORN Journal, 14*(1), 128. doi: 10.1016/S0001-2092(07)61880-8

Hafler, J. P. (Ed.). (2011). *Extraordinary learning in the workplace: Innovation and change in professional education.* doi: 10.1007/978-94-007-0271-4_8

Hall, M. A., Daly, B. J., & Madigan, E. A. (2010). Use of anecdotal notes by clinical nursing faculty: A descriptive study. *Journal of Nursing Education, 49*(3), 156-159. doi: 10.3928/01484834-20090915-03

Hansman, C. A. (2001). Context-based adult learning. *New Directions for Adult and Continuing Education, 89,* 43-51. doi: 10.1002/ace.7

Hartigan-Rogers, J. A., Cobbett, S. L., Amirault, M. A., & Muise-Davis, M. E. (2007). Nursing graduates' perceptions of their undergraduate clinical placement. *International Journal of Nursing Education Scholarship, 4*(1), 1-12. doi: 10.2202/1548-923X.1276

Hegge, M., Bunkers, S., Letcher, D., Craig, G., Klawiter, R., Olson, R., Tschetter, L., & Winterboer, V. (2010). Clinical academic partnership: Mutual ownership for clinical learning. *Nurse Educator, 35*(2), 61-65. doi: 10.1097/NNE.0b013e3181ced854

Henderson, A., Briggs, J., Schoonbeek, S., & Paterson, B. (2011). A framework to develop a clinical learning culture in health facilities: Ideas from the literature. *International Nursing Review, 58,*196-202. doi: 10.1111/j.1466-657.2010.00858.x/abstract

Henderson, A., Twentyman, M., Eaton, E., Creedy, D., Stapleton, P., and Lloyd, B. (2009) Creating supportive clinical learning environments: An intervention study. *Journal of Clinical Nursing, 19*(1) 177-182. doi: 10.1111/j.1365-2702.2009.02841.x

Hengameh, H., Afsenah, R., Morteza, K., Hosein, M., Marjan, S. M., & Ebadi, A. (2015). The effect of applying direct observation of procedural skills (DOPS) on nursing students' clinical skills: A randomized clinical trial. *Global Journal of Health Science, 7*(7), 17-21. doi:10.5539/gjhs.v7n7p17

Hobus, M. E. (2008). *A nursing educator's and nursing students' perspectives of critical thinking in a baccalaureate nursing program: A case study* (Doctoral dissertation). Retrieved from ProQuest information and learning company. (UMI Number 3306513.)

Hooven, K. (2014). Evaluation of instruments developed to measure the clinical learning environment: An integrative review. *Nurse Education Today, 39*(6), 316-320. doi: 10.1097/NNE.0000000000000076

Hosoda, Y. (2006). Development and testing of a clinical learning environment diagnostic inventory for baccalaureate nursing students. *Journal of Advanced Nursing, 56*(5), 480-490. doi: 10.1111/j.1365-2648.2006.04048.x

Hossein, K. M., Fatemeh, D., Fatemeh, O. S., Katri, V. J., & Tahareh, B. (2010). Teaching style in clinical nursing education: A qualitative study of Iranian nursing teachers' experiences. *Nursing Education in Practice, 10,* 8-12. doi:10.1016/j.nepr.2009.01.016

Houghton, C. E., Casey, D., Shaw, D., & Murphy, K. (2012). Students' experiences of implementing clinical skills in the real world of practice. *Journal of Clinical Nursing, 22,* 1961-1969. doi: 10.1111/jocn.12014

Hsu, L. L. (2007). Conducting clinical post-conference in clinical teaching: A qualitative study. *Journal of Clinical Nursing,* 16(8), 1525-1533. doi: 10.1111/j.1365-2702.2006.01751.x

Ironside, P. M., & McNelis, A. M. (2010). *Clinical education in prelicensure nursing programs: Results from an NLN national survey 2009.* New York, NY: National League for Nursing.

Ironside, P. M., McNelis, A. M., Ebright, B. (2014). Clinical education in nursing: Rethinking learning in practice settings. *Nursing Outlook, 62,* 185-191. doi: http:dx.doi.org/10/1016/j.outlook.2013.12.004

Jaeger, K. R. (2012). *Simulation enhancement of clinical reasoning skills in undergraduate nursing programs: Faculty perspectives* (Doctoral dissertation). Retrieved from ProQuest information and learning company. (UMI Number: 3536683.)

Jeffries, P. R. (2005). A framework for designing, implementing, and evaluating simulations used as teaching strategies in nursing. *Nursing Education Perspectives, 26*(2), 96-103. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a2h&AN=16653273&site=ehost-live

Jones, A. (2007). Putting practice into teaching: An exploratory study of nursing undergraduates' interpersonal skills and the effects of using empirical data as a teaching and learning resource. *Journal of Clinical Nursing, 16,* 2297-2307. doi: 10.1111/j.1365-2702.2007.01948.x

Kaddoura, M., VanDyke, O., Cheng, B., & Shea-Foisy, K. (2016). Impact of concept mapping on the development of clinical judgment skills in nursing students. *Teaching and Learning in Nursing, 11,* 101-107. doi: http://dx.doi.org/10.1016/j.teln.2016.02.001

Kaplan, B., & Ura, D. (2010). Use of multiple patient simulators to enhance prioritizing and delegating skills for senior nursing students. *Journal of Nursing Education, 49*(7), 371-377. doi: 10.3928/01484834-20100331-07

Karayurt, O., Mert, H., & Beser, A. (2008). A study on development of a scale to assess nursing students' performance in clinical settings. *Journal of Clinical Nursing, 18,* 1123-1130. doi: 10.1111/j.1365-2702.2008.02417.x

Kesten, K. S. (2011). Role-play using SBAR technique to improve observed communication skills in senior nursing students. *Journal of Nursing Education, 50*(2), 79-87. doi: 10.3928/01484834-20101230-02

Kubin, L., Wilson, C. E., & Wilson, J. (2013). Comparison of student learning among three teaching methodologies in the pediatric clinical setting. *Journal of Nursing Education, 52*(9), 501-508. doi: 10.3928/01484834-20130819-07

Krautscheid, L., Kaakinen, J., & Warner, J. R. (2008). Clinical faculty development: Using simulation to demonstrate and practice clinical teaching. *Journal of Nursing Education, 47*(9), 431-434. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010021395&site=ehost-live

Krichbaum, K. (1994). Clinical teaching effectiveness described in relation to learning outcomes of

baccalaureate nursing students. *Journal of Nursing Education, 33*(7), 306-316. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=1995001077&site=ehost-live

Langan, J. C. (2003). Faculty practice and roles of staff nurses and clinical faculty in nursing student learning. *Journal of Professional Nursing, 19,* 76-84. doi: 10.1053/jpnu.2003.17

Lasater, K., & Nielsen, A. (2009a). Reflective journaling for clinical judgment development and evaluation. *Journal of Nursing Education, 48*(1), 40-44. Retrieved from http://eds.b.ebscohost.com.cuhsl.creighton.edu/ehost/pdfviewer/pdfviewer?sid=d6444ea7-a4c9-4e83-a285-45b010762e77%40sessionmgr103&vid=1&hid=111

Lasater, K., & Nielsen, A. (2009b). The influence of concept-based learning activities on students' clinical judgment development. *Journal of Nursing Education, 48*, 441-446. doi: 10.3928/01484834-20090518-04

Lee, J., Mast, M., Humbert, J., Bagnardi, M., & Richards, S. (2016). Teaching handoff communication to nursing students: A teaching intervention and lessons learned. *Nurse Educator, 41*(4), 189-193. doi: 10.1097/NNE.0000000000000249

Lekan, D. A., Corazzini, K. N., Gilliss, C. L., & Bailey, D. E. (2011). Clinical leadership development in accelerated baccalaureate nursing students: An education innovation. *Journal of Professional Nursing, 27*(4), 202-214. doi: 10.1016/j.profnurs.2011.03.002

Letizia, M., & Jennrich, J. (1998). Development and testing of the clinical post-conference learning environment survey. *Journal of Professional Nursing, 14,* 206-213. Retrieved from http://www.professionalnursing.org/

Levett-Jones, T., & Lathlean, J. (2009). The Ascent to Competence conceptual framework: An outcome of a study of belongingness. *Journal of Clinical Nursing, 18,* 2870-2879. doi: 10.1111/j.1365-2702.2008.02593.x

Lewin, K. (1936/2015). *Principles of topological psychology.* New York, NY: Mcgraw-Hill.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Pak, CA: Sage.

Lofmark, A., & Wiklad, K. (2001). Facilitating and obstructing factors for development of learning in practice: A student perspective. *Journal of Advanced Nursing, 34*(1), 43-50. Retrieved from http://onlinelibrary.wiley.com.cuhsl.creighton.edu/doi/10.1046/j.1365-2648.2001.3411739.x/abstract

Lysaught, J. P. (1970). *An abstract for action.* New York, NY: Mcgraw-Hill.

MacFarlane, E., Milliken, J., Ouellet, L. L., Thrasher, C., Gartner, J., Harder, N., & Stevenson, K. C. (2007). Overcoming the challenges of providing clinical/practice education. *Canadian Nurse, 103*(6), 18-22. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=mdc&AN=17622031&site=ehost-live

MacIntyre, R. C., Murray, T. M., Teel, C. S., & Karshmer, J. F. (2009). Five recommendations for prelicensure clinical nursing education. *Journal of Nursing Education, 48*(8), 447-453. doi: 10.3928/01484834-30090717-03

Mahara, M. S. (1998). A perspective on clinical evaluation in nursing education. *Journal of Advanced Nursing, 28*(6), 1339-1346. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648

Mamhidir, A., Kristofferzon, M., Hellstrom-Hyson, E., Persson, E., & Martensson, G. (2014). Nursing preceptors' experiences of two educational models. *Nurse Education in Practice, 14,* 427-433. doi: http://dx.doi.org/10.1016/j.nepr.2014.01.010

Mangena, A. & Chabeli, M. M. (2005). Strategies to overcome obstacles in the facilitation of critical thinking in nursing education. *Nurse Education Today, 25,* 291-298. doi: 10.1016/j.nedt.2005.01.012

Matsumura, G., Callister, L. C., Palmer, S., Cox, A. H., & Larsen, L. (2004). Staff nurse perceptions of the contributions of students to clinical agencies. *Nursing Education Perspectives, 25*(6), 297-303. Retrieved from

https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2005043881&site=ehost-live

McMillan-Coddington, D. (2013). Reflection through journal writing to educate registered nursing students on patient care. *Teaching and Learning in Nursing, 8,* 63-67. doi:http://dx.doi.org/10.1016/j.teln.2012.09.004

McNelis, A. M., Fonacier, T., McDonald, J., & Ironside, P. (2011). Optimizing prelicensure students' learning in clinical settings: Addressing the lack of clinical sites. *Nursing Education Perspectives, 32*(1), 64-65. Retrieved from www.nln.org

Meakim, C., Boese, T., Decker, S., Franklin, A. E., Gloe, D., Lioce, L., Sando, C. R., & Borum, J. C. (2013). Standards of best practice: Simulation standard I: Terminology. *Clinical Simulation in Nursing, 9,* S3-S11. doi: http://dx.doi.org/10.1016/j.ecns.2013.04.001

Megel, M. E., Nelson, A. E., Black, J., Vogel, J., & Uphoff, M. (2013). A comparison of student and faculty perceptions of clinical post-conference learning environment. *Nurse Education in Practice, 33,* 525-529. doi: 10.1016/j.nedt.2011.11.021

Merriam-Webster. (n.d.). Retrieved September 1, 2015 from http://www.merriamwebster.com/dictionary/acutecare

Moos, R. H. (1973). Conceptualizations of human environments. *American Psychologist, 28*(8), 652-665. Retrieved from http://dx.doi.org.cuhsl.creighton.edu/10.1037/h0035722

Moran, L. (2000). *A phenomenological study of how student nurses learn critical thinking in the nursing clinical practice setting* (Doctoral dissertation). Retrieved from ProQuest information and learning company. (UMI Number 9998400.)

Moscaritolo, L. M. (2009). Interventional strategies to decrease nursing student anxiety in the clinical learning environment. *Journal of Nursing Education, 48*(1), 17-23. Retrieved from http://creighton.summon.serialssolutions.com/search?s.fvf%5B%5D=ContentType%2CNewspaper+Article%2Ct&s.q=moscaritolo

Moscato, S. R., Miller, J., Logsdon, K., Weinberg, S., & Chorpenning, L. (2007). Dedicated education

unit: An innovative clinical partner education model. *Nursing Outlook, 55,* 31-37. doi: 10.1016/j.outlook.2006.11.001

Mulready-Shick, J., & Flanagan, K. (2014). Building the evidence for dedicated education unit sustainability and partnership success. *Nursing Education Perspectives, 35*(5), 287-293. doi: 10.5480/14-1379

Mulready-Shick, J., Flanagan, K. M., Banister, G. E., Mylott, L., & Curtin, L. J. (2013). Evaluating dedicated education units for clinical education quality. *Journal of Nursing Education, 52*(11), 606-614. doi: 10.3928/01484834-20131014-07

Murray, H. A. (2008). *Explorations in personality.* New York, NY: Oxford University Press.

Nasrin, H., Soroor, P. & Soodabeh, J. (2012). Nursing challenges in motivating nursing students through clinical education: A grounded theory study. *Nursing Research and Practice, 2012,* 1-7. doi: 10.1155/2012/161358

National Council of State Boards of Nursing. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in prelicensure nursing education. *Journal of Nursing Regulation, 5*(2), S3-S64.

National League for Nursing. (2005). Position statement: Transforming nursing education. *Nursing Education Perspectives, 26*(3), 195-197. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009010971&site=ehost-live

National League for Nursing. (2008). Summary of the survey on clinical education in nursing. *Nursing Education Perspectives, 29*(4), 238-245. Retrieved fromhttps://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009987241&site=ehost-live

National Board for Professional Teaching Standards (NBPTS) (2011). *Executive Summary: Student learning, student achievement: How do teachers measure up?* Arlington, VA: National Board for Professional Teaching Standards.

Nehls, N., Rather, M., & Guyette, M. (1997). The preceptor model of clinical instruction: The lived experiences of students, preceptors, and faculty-of-record. *Journal of Nursing Education, 36*(5), 220-227. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=1997025325&site=ehost-live

Nelms, T. P., Jones, J. M., & Gray, D. P. (1993). Role modeling: A method for teaching caring in nursing education. *Journal of Nursing Education, 32*(1), 18-23. Retrieved from http://www.healio.com/nursing/journals/jne

Newton, J. M., Billett, S., Jolly, B., & Ockerby, C. M. (2009). Lost in translation: Barriers to learning in health professional clinical education. *Learning in Health and Social Care, 8*(4), 315-327. doi: 10.1111/j.1473-6861.2009.00229.x

Newton, J. M., Jolly, B., C., Ockerby, C. M., & Cross, W. M. (2010). Clinical learning environment inventory: A factor analysis. *Journal of Advanced Nursing, 66*(6) 1371-1381. doi: 10.1111/j.1365-2648.2010.05303.x

Nickle, P. (2007). Cognitive apprenticeship: Laying the groundwork for mentoring registered nurses in the intensive care unit. *Canadian Association of Critical Care Nurses, 18*(4), 19-27. Retrieved from http://www.caccn.ca/

Niederhauser, V., Schoessler, M., Gubrud-Howe, P. M., Magnussen, L., & Codier, E. (2012). Creating innovative models of clinical nursing education. *Journal of Nursing Education, 51*(11), 603-608. doi: 10.3928/01484834-20121011-02

Nielsen, A. E., Noone, J., Voss, H., & Mathews, L. R. (2013). Preparing nursing students for the future: An innovative approach to clinical education. *Nurse Education in Practice, 13,* 301-309. doi: http://dx.doi.org/10.1016/j.nepr.2013.03.015

Nishioka, V. M., Coe, M. T., Hanita, M., & Moscato, S. R. (2014a). Dedicated education unit: Nurse perspectives on their clinical teaching role. *Nursing Education Perspectives, 35*(5), 300-307. doi: 10.5480/14-1381

Nishioka, V. M., Coe, M. T., Hanita, M., & Moscato, S. R. (2014b). Dedicated education unit: Student perspectives. *Nursing Education Perspectives, 35*(5), 294-300. doi: 10.5480/14-1381

Nowell, L. S. (2016). Delegate, collaborate, or consult? A capstone simulation for senior nursing students. *Nursing Education Perspectives, 37*(1), 54-55. doi: 10.5480/13-1174

Oermann, M. H. (1998). Work-related stress of clinical nursing faculty. *Journal of Nursing Education, 37*(7), 302-304. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ofs&AN=507668927&site=ehost-live

Oermann, M. H. (2004). Reflections on undergraduate nursing education: A look to the future. *International Journal of Nursing Education Scholarship, 1*(1), 1-15. doi: 10.2202/1548-932X.1011

O'Mara, L., McDonald, J., Gillespie, M., Brown, H., & Miles, L. (2014). Challenging clinical learning environments: Experiences of undergraduate nursing students. *Nurse Education in Practice, 14,* 208-213. doi: http://dx.doi.org/10/1016/j.nepr.2013.08.012

Palmer, S. P., Cox, A. H., Callister, L. C., Johnsen, V., & Matsumara, G. (2005). Nursing education and service collaboration: Making a difference in the clinical learning environment. *The Journal of Continuing Education in Nursing, 36*(6) 271-276. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2009069457&site=ehost-live

Papathanasiou, I. V., Tsaras, K., & Sarafis, P. (2014). Views and perceptions of nursing students on their clinical learning environment: Teaching and learning. *Nurse Education Today, 34,* 57-60. doi: http://dx.doi.org/10.1016/j.nedt.2013.02.007

Parker, B. C., & Myrick, F. (2012). The pedagogical ebb and flow of human patient simulation: Empowering through a process of fading support. *Journal of Nursing Education, 51*(7), 365-372. doi: 10.3928/01484834-20120509-01

Paton, B. I. (2007). Knowing within: Practice wisdom of clinical nurse educators. *Journal of Nursing*

Education, 46(11), 488-495. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=105927950&site=ehost-live

Paul, R., & Elder, L. (2006). *The Thinker's Guide to the Art of Socratic Questioning.* Dillion Beach, CA: Foundation for Critical Thinking

Perkins, C., & Kisiel, M. (2013). Developing the recognition and response skills of student nurses. *British Journal of Nursing, 22*, 715-724. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2012198337&site=ehost-live

Piscopo, B. (1994). Organizational climate, communication, and role strain in clinical nursing faculty. *Journal of Professional Nursing, 10*(2), 113-119. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=1994186228&site=ehost-live

Powell, R. M. (2011). Improving students' delegation skills. *Nurse Educator, 36*(1), 9-10. doi: 10.1097/NNE.0b013e3182001e2e

Rafiee, G., Moattari, M., Nikbakht, A., N., Kojuri, J., & Mousavinasab, M. (2014). Problems and challenges of nursing students' clinical evaluation: A qualitative study. *Iranian Journal of Nursing and Midwifery Research, 19*(1), 41-49. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3748540/

Rhodes, M. L., Meyers, C. C., & Underhill, M. L. (2012). Evaluation outcomes of a dedicated education unit in a baccalaureate nursing program. *Journal of Professional Nursing, 28*(4), 223-230. doi: 10.1016/j.profnurs.2011.11.019

Rich, K. L., & Nugent, K. E. (2010). A United States perspective on the challenges in nursing education. *Nurse Education Today*, 30, 228-232. doi: 10.1016/j.nedt.2009.10.015

Richardson, H., Gilmartin, M. J., & Fulmer, T. (2012). Shifting the clinical teaching paradigm in undergraduate nursing education to address the nursing faculty shortage. *Journal of Nursing Education, 51*(4), 226-231. doi: 10.3928/01484834-20120210-04

Roberts, S. T., Vignato, J. A., Moore, J. L., & Madden, C. A. (2009). Promoting skill building and confidence in freshmen nursing students with a "skills-a-thon." *Journal of Nursing Education, 48*(8), 460-464. doi: 10.3928/01484834-20090518-05

Roughton, S. E. (2013). Nursing faculty characteristics and perceptions predicting intent to leave. *Nursing Education Perspectives, 34*(4), 217-225. Retrieved from http://www.nln.org/newsroom/newsletters-and-journal/nursing-education-perspectives-journal

Ryan, C., Shabo, B., & Tatum, K. (2011). Using experienced clinicians to facilitate clinical education. *Nurse Educator, 36*(4), 165-170. doi: 10.1097/NNE.0b013e31821fdbb2

Ruth-Sahd, L. A. (2011). Student nurse dyads create a community of learning: Proposing a holistic clinical education theory. *Journal of Advanced Nursing, 67*(11), 2445-2454. doi: 10.1111/j.1365-2648.2011.05690.x

Saarikoski, M., Isoaho, H., Warne, T., & Leino-Kilpi, H. (2008). The nurse teacher in clinical practice: Developing the new sub-dimension to the Clinical Learning Environment and Supervision (CLES) Scale. *Internation Journal of Nursing Studies, 45*(8), 1233-1237.

Saarikoski, M., & Leino-Kilpi, H. (2002). The clinical learning environment and supervision by staff nurses: Developing the instrument. *International Journal of Nursing Studies, 39*, 259-267. doi: 10.1016/S0020-7489(01)00031-1

Salyers, V. L. (2007). Teaching psychomotor skills to beginning nursing students using a web-enhanced approach: A quasi-experimental study. *International Journal of Nursing Education Scholarship, 4*(1), 1-12. Retrieved from http://www.bepress.com/ijnes/vol4/iss1/art11

Sand-Jecklin, K. (2009). Assessing nursing student perceptions of the clinical learning environment: Refinement and testing of the SECEE inventory. *Journal of Nursing Measurement, 17*(3), 232-246. doi:10.1891/1061-3749.17.3.232

Sanderson, H., & Lea, J. (2012). Implementation of the clinical facilitation model within an Australian rural setting: The role of the clinical facilitator. *Nurse Education in Practice, 12,* 333-339. doi:10.1016/j.nepr.2012.04.001

Schoening, A. M. (2013). From bedside to classroom: The nurse educator transition model. *Nursing Education Perspectives, 34*(3), 167-172. doi: 10.2202/1548-923X.1381

Shahsavari, H., Yekta, Z. P., Houser, M. L., & Ghiyasvandian, S. (2013). Perceived clinical constraints in the nurse student-instructor interactions: A qualitative study. *Nurse Education in Practice, 13,* 546-552. doi: http://dx.doi.org/10.1016/j.nepr.2013.05.006

Skaalvik, M. W., Normann, H. K., & Henriksen, N. (2011). Clinical learning environment and supervision: Experiences of Norwegian nursing students – a questionnaire survey. *Journal of Clinical Nursing, 20*(15) 2294-2304. doi: 10.1111/j.1365-2702.2011.03727.x

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: Sage.

Suplee, P. D., Gardner, M., & Jerome-D'Emilia, B. (2014). Nursing faculty preparedness for clinical teaching. *Journal of Nursing Education, 53*(3), S38-S41. doi: 10.3928/01484834-20140217-03

Tanner, C. (2006). The next transformation: Clinical education [Editorial]. *Journal of Nursing Education, 45*(4), 99-100. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2009153623&site=ehost-live

Tanner, C. A. (2010). Transforming prelicensure nursing education: Preparing the new nurse to meet emerging health care needs. *Nursing Education Perspectives, 31*(6), 347-351. Retrieved from http://eds.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=7d5721ff-1bb6-4c6a-a7d5-fb15f0637af2%40sessionmgr4009&vid=1&hid=4205

Tanner, C. A., & Bellack, J. P. (2011). Then and now. *Journal of Nursing Education, 50*(1), 3-6. doi:10.3928/01484834-20101220-01

Taylor, K. L., & Care, W. D. (1999). Nursing education as cognitive apprenticeship: A framework for clinical education. *Nurse Educator, 24*(4), 31-36. Retrieved from http://journals.lww.com/nurseeducatoronline/Pages/default.aspx

Teel, C. S., MacIntyre, R. C., Murray, T. A., & Rock, K. Z. (2011). Common themes in clinical education

partnerships. *Journal of Nursing Education, 50*(7), 365-372. doi: 10.3928/01484834-20110429-01

Teel, C., Smith, A. E., & Thomas, D. (2008). Spread too thin: Faculty perspectives about faculty-student ratios in Kansas. *The Kansas Nurse, 83*(9), 3-6. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010515098&site=ehost-live

Tiwari, A., Lam, D., Yuen, K. H., Chan, R., Fung, T., & Chan, S. (2005). Student learning in clinical nursing education: Perceptions of the relationship between assessment and learning. *Nurse Education Today, 25,* 299-308. doi:10.1016/j.nedt.2005.01.013

Trickett, E. J., & Moos, R. H. (1973). Social environment of junior high and high school classrooms. *Journal of Educational Psychology, 65*(1), 93-102. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=1974-03923-001&site=ehost-live

Twibell, R., Ryan, M., & Hermiz, M. (2005). Faculty perceptions of critical thinking in student clinical experiences. *Journal of Nursing Education, 44*(2), 71-79. Retrieved from http://collegeofsaintmarylibrary.worldcat.org/oclc/110843741

Shell, R. (2001). Perceived barriers to teaching for critical thinking by BSN nursing faculty. *Nursing and Health Care Perspectives, 22*(6), 286-291. Retrieved from http://www.nln.org/search?query=nursing%20and%20health%20care%20perspectives

Sherwin, S., & Stevenson, L. (2010). Creating an optimum environment for learning. *British School of Nursing, 5*(9), 455-457. Retrieved from https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2010863788&site=ehost-live

Ulrich, B., Krozek, C., Early, S., Ashlock, C. H., Africa, L. M., & Carman, M. L. (2011). Improving retention, confidence, and competence of new graduate nurses: Results from a 10-year longitudinal database. *Nursing Economic$, 28*(6), 363-375. Retrieved from

https://login.cuhsl.creighton.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=2010884714&site=ehost-live

Volk, S., Homan, N., Tepner, L., Chichester, M., & Scales, D. (2013). The rewards and challenges of becoming a clinical instructor. *Nursing for Women's Health, 17*(6), 539-542. doi: 10.1111/1751-486X.12083

Vygotsky, L. (1978). *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University Press.

Webster, M. T. (2006). *Perceptions of nursing students and nursing faculty members regarding the clinical preparation of baccalaureate nursing students* (Doctoral dissertation). Retrieved from ProQuest information and learning company. (UMI Number 3250146.)

Welding, N. M. (2011). Creating a nursing residency: Decrease turnover and increase clinical competence. *MedSurg Nursing, 20,* 37-40. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2010960982&site=ehost-live

Wenger, E. (2009). A social theory of learning. In Illeris, K. (Ed.), *Contemporary theories of learning: Learning theorists…in their own words* (pp. 209-218). New York: Routledge.

Whalen, K. S. (2009). Work-related stressors experienced by part-time clinical affiliate nursing faculty in baccalaureate education. *International Journal of Nursing Education Scholarship, 6*(1), 1-18. doi:10.2202/1548-923X.1813

Williams, K., & West, E. A. (2012). Approaches to nursing skills training in three countries. *International Nursing Review, 59,* 230-236. Retrieved from http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)14667657

Wiseman, R. F. (1994). Role model behaviors in the clinical setting. *Journal of Nursing Education, 33*(9), 405-410. Retrieved from http://www.healio.com/nursing/journals/jne

Woolley, N. N., & Jarvis, Y. (2007). Situated cognition and cognitive apprenticeship: A model for teaching and learning clinical skills in a technologically rich and authentic learning environment. *Nurse Education, Today, 27,* 73-79. doi: 10.1016/j.nedt.2006.02.010

Yaghoubinia, F., Heydari, A., & Roudsari, R. L. (2014). Seeking a progressive relationship for learning: A theoretical scheme about the continuity of the student-educator relationship in clinical nursing education. *Japan Journal of Nursing Science, 11,* 65-77. doi: 10.1111/jjns.12005

Yang, Y. C., Newby, T. J., & Bill, R. L. (2010). Using Socratic questioning to promote critical thinking skills through asynchronous discussion forums in distance learning environments. *The American Journal of Distance Education, 19*(3), 163-181. doi: 10.1207/s15389286ajde1903_4

Yates, P., Cunningham, J., Moyle, W., & Wollin, J. (1997). Peer mentorship in clinical education: Outcomes of a pilot programme for first year students. *Nurse Education Today, 17*, 508-514. Retrieved from http://www.nurseeducationtoday.com/

Yonge, O. J., Anderson, M., Profetto-McGrath, J., Olson, J. K., Skillen, D. L., Boman, J., …Day, R. (2005). An inventory of nursing education research. *International Journal of Nursing Education Scholarship, 2*(1), 1-11. doi: 10.2202/1548-923X.1095

Young, M., Simpson, V., McComb, S. A., Kirkpatrick, J. M., La Lopa, J. M., & Bullard, K. S. (2014). Toward creating an optimal acute care clinical learning environment: Insights from staff, faculty, and students. *Journal of Nursing Education, 53*(3), S42-S45. doi: 10.3928/01484834-20140211-06

Yoo, M. S., & Chae, S. (2011). Effects of peer review on communication skills and learning motivation among nursing students. *Journal of Nursing Education, 50*(4), 230-233. doi: 10.3928/01484834-20110131-03

Appendix A

Permission to Recruit Email to Deans/Directors of BSN Programs

Dear [official title and proper name of Dean/Director of BSN Program]:

I am a doctoral student at College of St. Mary in Omaha, NE currently pursuing my Ed.D. with an emphasis in Health Professions Education. I am also a nursing faculty member at a private university in Omaha. I am currently working on a research study entitled: "Facilitating Student Learning in the Acute Care Clinical Environment: Nursing Faculty Perspectives." The purpose of this grounded theory study is to understand processes and experiences of BSN program nursing faculty when teaching students in the acute care clinical environment and while using the traditional clinical learning model. I believe that better understanding of this process could assist in enhancing clinical models of instruction to best prepare nursing students for professional practice in the future.

I am interested in recruiting nursing faculty working in your educational institution's BSN program(s) for participation in this study. I would like to interview eight to twelve BSN nursing faculty at their consent. I will offer complete anonymity for the participants and educational institution contributing to the proposed research. If you are able to assist, I will provide you proof of approval from the Institutional Review Board at the College of Saint Mary once received and I will seek additional approval from your institution if necessary. Participation would involve an interview taking approximately 45-60 minutes of time at a location of the faculty's choice and require approximately 30-45 minutes of additional time at a later date that would require review of interview transcription and preliminary data analysis results to ensure accuracy of participant data.

If you agree to have your faculty invited to participate in this study please reply to this email stating your approval and I will be in contact with you once IRB approval has been granted. You may email me or call me at (402) 619-0365 to clarify any questions or concerns you have regarding this study. If I have not received a response from you in two weeks, I may contact you by phone to determine your willingness to participate.

Sincerely,

Elizabeth A. Flott, Ed.D(c), RN
Primary Investigator
EFlott7327@csm.edu
(c) (402) 619-0365

Appendix B

Educational Institution IRB Approval for Study

February 16, 2016

Dear Ms. Flott,

Congratulations! The Institutional Review Board at College of Saint Mary has granted approval of your study titled *Facilitation of Student Learning in the Acute Care Clinical Environment: Nursing Faculty Perspectives.*

Your CSM research approval number is **CSM 1601**. It is important that you include this research number on all correspondence regarding your study. Approval for your study is effective through March 1, 2017. If your research extends beyond that date, please submit a "Change of Protocol/Extension" form which can be found in Appendix B at the end of the College of Saint Mary Application Guidelines posted on the IRB Community site.

Please submit a closing the study form (Appendix C of the IRB Guidebook) when you have completed your study.

Good luck with your research! If you have any questions or I can assist in any way, please feel free to contact me.

Sincerely,

Vicky Morgan

Dr. Vicky Morgan
Director of Teaching and Learning Center
Chair, Institutional Review Board * irb@csm.edu

Appendix C

Email to Deans/Directors to Assist in Nursing Faculty Recruitment

Date: February 25, 2016

IRB #: CSM 1601

Dear [official title and proper name of Dean/Director of BSN Program]:

Thank you for agreeing to assist in notifying eligible faculty about my dissertation research study entitled "Facilitating Student Learning in the Acute Care Clinical Environment: Nursing Faculty Perspectives." I have received and attached IRB approval for this study from the College of Saint Mary and any additional approval request from your educational institution.

I would appreciate your assistance in contacting potential eligible nursing faculty participants at your institution. Participation is completely voluntary and the decision to not participate will not adversely impact the participants' relationship with the investigator, College of Saint Mary, or their employer. Eligible nursing faculty are those who meet the following eligibility criteria:

- Have a full-time or part-time appointment in a prelicensure BSN program. This includes traditional or accelerated BSN programs.
- Have at least one year of teaching experience
- Have provided clinical instruction to prelicensure nursing students in an acute care setting utilizing the traditional clinical model of instruction for at least one semester anytime during the past two years.

Those that are not eligible to participate in this study include:

- Those who are adjunct faculty
- Those who have less than one year of teaching experience
- Those providing clinical instruction in non-prelicensure BSN programs, including RN-BSN and LPN-BSN programs

Participation would involve completing a demographic form taking approximately 5 minutes, completing an interview taking approximately 45-60 minutes at a location of their choice, and reviewing an individual transcript with preliminary data analysis findings requiring approximately 30 minutes of additional time at a later date to ensure accuracy of participant data. A second interview may be requested to obtain additional data which would take approximately 30-45 minutes at a later date.

I will be sending an additional e-mail immediately following this e-mail inviting nursing faculty to participate in this study. If you are still able to assist in this research, please forward this invitation e-mail to all eligible BSN faculty members. This e-mail invites eligible faculty to contact me via email or phone if they are interested in participation. My contact information is listed below. If you wish to discuss this study or if you have any further questions, please feel free to call or email me and thank you for assisting in this research study.

Sincerely,

Elizabeth A. Flott, Ed.D(c), RN
Primary Investigator

(c) (402) 619-0365
EFlott7327@csm.edu

Appendix D

Invitation to Participate Email for Nursing Faculty

Date: February 19, 2016

IRB #: CSM 1601

Dear Nursing Faculty:

I am a student at College of Saint Mary in Omaha, NE pursuing my Doctor of Education degree with an emphasis in Health Professions Education. I am also a nursing faculty member at a private university in Omaha, NE. I am currently beginning work on my dissertation. The purpose of my study is to understand the process nursing faculty in BSN programs utilize when facilitating student learning in the acute care setting while using the traditional clinical learning model. The traditional clinical model is the most commonly used model in clinical education and involves one faculty member facilitating learning to approximately eight to ten nursing students on one acute care unit. You may receive no direct benefit from participating in this study, but information gained will provide insight regarding ways to enhance clinical instruction and best prepare nursing students for professional practice in the future.

This study is a qualitative grounded theory study. You have been identified as a faculty member potentially meeting criteria for this study. In order to be eligible to participate, the following criteria must be met:

- Have a full-time or part-time appointment in a prelicensure BSN program. This includes traditional or accelerated BSN programs.
- Have at least one year of teaching experience
- Have provided clinical instruction to prelicensure nursing students in an acute care setting utilizing the traditional clinical model of instruction for at least one semester anytime during the past two years.

Those that are not eligible to participate in this study include:

- Those who are adjunct faculty
- Those who have less than one year of teaching experience
- Those providing clinical instruction in non-prelicensure BSN programs, including RN-BSN and LPN-BSN programs

If you are willing to participate, I would like to schedule an interview with you which would last approximately 45-60 minutes in length and will be at a location of your choosing. The questions will focus on the process you utilize when facilitating student learning in the acute care setting. You will also be asked to complete a demographic form prior to starting the interview which will take approximately 5 minutes. You will be asked to bring one example of a nursing student's completed clinical paperwork assignment to discuss how student learning is evaluated in the clinical setting. Any identifying student information on the paperwork should be removed prior to arriving at the interview. After the study is completed, a review of your individual transcript and preliminary data analysis decisions may be required and will likely take an additional 30 minutes. A second interview may be requested at a later date to gain additional information which would take approximately 30-45 minutes. The information from this study may be published in journals and presented at professional meetings.

Participation in this study is completely voluntary. If you decide to participate, an informed consent document will be provided and your identity will be kept confidential. There is no cost to participate in this study except for time to complete the interview, demographic form, and review of interview information. You may withdraw from the study at any time. If you decide not to respond or participate, your decision will not impact your relationship with College of Saint Mary or any other entity. If you are willing to assist in this study or have questions regarding this study, please contact me via the email address or telephone number below. If I have not heard from you within two weeks of receiving this email invitation, you may receive an additional email invitation to determine your willingness to participate. Thank you for considering participating in this research study.

Sincerely,

Elizabeth A. Flott, Ed.D(c), RN
EFlott7327@csm.edu
(c) (402) 619-0365

Appendix E

Informed Consent Document

IRB#: CSM 1601 Approval Date: February 16, 2016 Expiration Date: March 1, 2017

FACILITATION OF STUDENT LEARNING IN THE ACUTE CARE CLINICAL ENVIRONMENT: NURSING FACULTY PERSPECTIVES

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask**.**

Why are you being asked to be in this research study?

You are being asked to participate in this research study because you are a full-time or part-time nursing faculty member in a Midwestern Bachelor of Science in Nursing (BSN) prelicensure degree program with at least one year of experience and you have provided clinical instruction and evaluation to nursing students in an acute care setting utilizing the traditional clinical model of instruction at least one semester over the past two years.

What is the reason for doing this research study?

The purpose of this study is to understand the process Midwestern BSN nursing faculty utilize when facilitating student learning in the acute care setting while using the traditional clinical model of instruction. Gathering nursing faculty input regarding this process is important to understand how the traditional clinical model and acute care setting impact nursing faculty's ability to prepare students for practice. This study will seek to answer the following questions: 1) What process do nursing faculty at Midwestern BSN education programs utilize when facilitating student learning using the traditional clinical model in the acute care setting? 2) How do Midwestern BSN nursing faculty facilitate student learning in the acute care setting when utilizing the traditional clinical model? 3) How does the traditional clinical model of instruction influence Midwestern BSN program nursing faculty when facilitating student learning in an acute care setting? 4) How does the acute care setting influence Midwestern BSN nursing faculty when facilitating student learning? 5) What other factors assist or inhibit Midwestern BSN nursing faculty when facilitating student learning in the acute care setting? 6) How do Midwestern BSN nursing faculty determine when effective facilitation of student learning has occurred after providing instruction in the acute care setting?

Participant Initials _____

ADULT Consent Form - PAGE TWO

What will be done during this research study?

Each participant will schedule a time and location to meet with the researcher that is convenient for the participant. During this meeting, the participant will fill out a short demographic form for background information that the researcher will provide. This will take approximately 5 minutes to complete. Following completion of the form, a one-on-one interview will be conducted which will be audio-recorded to gain information regarding the process utilized when providing clinical instruction to nursing students in the acute care setting. As part of this interview, each participant will be asked to bring an example of a completed student clinical assignment to assist in understanding how students are evaluated in the clinical setting. The interview will take approximately 45-60 minutes to complete. Participants may be asked to complete a second interview to obtain more detailed information regarding the process of facilitating student learning in the acute care setting. This additional interview would take approximately 30-45 minutes.

At a later date, the researcher will invite participants to review their own individual transcribed interview for accuracy. The estimated time commitment for this review is 30 minutes.

What are the possible risks of being in this research study?

There are no known risks to you from being in this research study.

What are the possible benefits to you?

You are not expected to get any direct benefit from being in this research study.

What are the possible benefits to other people?

Participant experiences of providing clinical instruction to nursing students in the acute care setting utilizing the traditional clinical model can provide insight regarding ways to enhance clinical instruction which is of benefit to future nursing students.

What are the alternatives to being in this research study?

Instead of being in this research study, you can choose not to participate.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Participant Initials _____

ADULT Consent Form - PAGE THREE

Will you be paid for being in this research study?

You will not be paid or compensated for being in this research study.

What should you do if you have a concern during this research study?

Your well-being is the major concern of the researcher for this study. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. Your name, position, and employer will not be associated with any of the information you provide. You will be identified on the demographic form, transcribed interviews, and memos by an assigned pseudonym only. Student identifying information will not be collected or recorded.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in scientific journals or presented at scientific meetings but your identity will be kept strictly confidential.

What are your rights as a research participant?

You have rights as a research participant. These rights have been explained in this consent form and in The Rights of Research Participants that you have been given. If you have any questions concerning your rights, talk to the investigator or call the Institutional Review Board (IRB), telephone (402)-399-2400.

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with the College of Saint Mary (also add any other sites to this statement, if needed).

You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed promptly.

Participant Initials _____

ADULT Consent Form - PAGE FOUR

Documentation of informed consent.

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep.

If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant: **Date:** **Time:**

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator: **Date:**

Authorized Study Personnel:

Principal Investigator: Elizabeth A. Flott, Ed.D(c)., R.N. Phone: (402) 619-0365

Secondary Investigator: Lois Linden, Ed.D., R. N. Phone: (402) 399-2612

Participant Initials _____

Appendix F

Rights of Research Participants Form

THE RIGHTS OF RESEARCH PARTICIPANTS*
AS A RESEARCH PARTICIPANT AT COLLEGE OF SAINT MARY
YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYTHING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.

3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.

4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.

5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.

7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400. *ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER, IRB WITH PERMISSION

Appendix G

Demographic Information Form

IRB #: CSM 1601

Thank you for participating in this study. Prior to starting our interview I am requesting that you please complete this demographic information form to the best of your ability. This will take approximately five to ten minutes to complete:

Nursing Faculty Participant Information

What is your current age? _____

What is your gender? _____

How long have you been a registered nurse? _____

How many years have you been a nursing faculty member? _____

As a student, what type of clinical model was utilized during your nursing education (traditional or other)? _____

What is the highest degree you have obtained? _____

How many years have you instructed nursing students in the acute care clinical environment? _____

What type of educational assistance/orientation did you receive to prepare you for the nursing faculty role, if any?

_____

Nursing Student/Clinical Instruction Information

What type(s) of acute care units have you instructed students on during the past two years (med-surg, OB, etc.)?

_____

How many semesters/terms have you been instructing students on this/these units over the past two years?

_____

What level of student have you instructed in the acute care setting during the past two years (senior, junior, etc.)?

_____

How many hours or weeks do you typically instruct a group of students on your acute care unit?

_____

How many students, on average, do you typically instruct at one time in the acute care clinical setting?

Do your students receive any simulation experiences prior to participating in your clinical experience/rotation? _____

Appendix H

Semi-Structured Interview Guide

IRB #: CSM 1601

1. Tell me what a typical day is like for you when you are facilitating student learning in the acute care clinical environment.

    Probes: How do you structure the clinical day?
    What preparation do you go through before facilitating student learning in the acute care clinical environment?
    Are there times when you have to adjust the structure of your day? Tell me about that.

    Additional probes approved after initial coding of first four interviews:

    How do you determine which students to focus on when facilitating learning during the clinical day?
    Tell me what you do when you are concerned about a student's lack of preparation for the clinical day. Tell me how this changes the plan or structure of your day?

2. Tell me about strategies you utilize to facilitate student learning in the acute care clinical environment.
    Probes: What approaches or strategies do you utilize when determining students' knowledge level prior to caring for patients?
    What approaches or strategies do you utilize when instructing students how to perform clinical skills?
    What approaches or strategies do you utilize when fostering critical thinking or clinical reasoning skills?

    Additional probes approved after initial coding of first four interviews:

    How do you individualize facilitation of learning for students in the clinical setting?
    How do you determine what level students are at in the clinical setting regarding integration of theory into practice?
    Tell me if you have students in the clinical setting who also have a corresponding theory course. If so, is there any correlation when evaluating student learning regarding theory and clinical performance?

3. What assists you in determining strategies to utilize when facilitating student learning?

    Probes: Tell me about the level of student you currently teach in the acute care clinical environment. How does this influence strategies you utilize to facilitate learning?

Describe how accreditation and/or curriculum requirements and/or recommendations influence teaching strategies you incorporate in the acute care clinical environment.
How does student preparation influence your ability to facilitate student learning?

4. The traditional clinical model of instruction typically requires one nursing faculty member to facilitate learning for up to ten students in one acute care setting. How does the structure of this traditional clinical model of instruction influence your ability to facilitate student learning?

    Probes: How many students, on average, do you instruct in the acute care setting? Tell me how this influences your ability to facilitate student learning.
    Tell me about a time when you had multiple students needing assistance at the same time. How do you go about ensuring all student needs are met?
    How does this model of instruction impact relationships you have with others on the acute care unit, if at all? Tell me about that.

    Additional probes approved after initial coding of nine participant interviews:

    How does the number of students influence your ability to influence critical thinking or clinical reasoning?

5. How does the acute care clinical learning environment impact your ability to facilitate student learning?

    Probes: How does your relationship with other staff nurses and healthcare members in the unit impact your ability to facilitate student learning?
    How does the organizational culture regarding nursing education impact your ability to facilitate student learning?
    How does the physical space and structure of the environment impact your ability to facilitate student learning?

    Additional probes approved after initial coding of first four interviews:

    How did you develop a trusting relationship with the nurses on the acute care unit where you provide clinical instruction?
    How do you, as a faculty member, maintain a positive relationship with staff nurses while maintaining your primary role as facilitator of learning for students? Have been there instances where this role needed to be clarified? Explain.

6. Think about one of the acute care units on which you currently provide student instruction. Describe how you felt when arriving to that acute care unit for the first time to facilitate student learning.

    Probes: How many semesters have you provided clinical instruction on this unit?

Has this environment changed at all since your first time providing instruction? Tell me about that.
How have relationships on the acute care unit changed, if at all, since your first time providing student instruction on this unit? Has this impacted your ability to facilitate student learning?

7. What other factors have enhanced or inhibited your ability to facilitate student learning in the acute care clinical environment, if any?

    Probes: What educational preparation did you receive to prepare for the nursing faculty role in the clinical environment? How did this impact your ability to facilitate learning in the clinical environment?
    What other academic responsibilities do you have? How does this impact your ability to facilitate student learning in the acute care clinical environment?

8. Describe to me how you determine when effective facilitation of student learning has occurred in the acute care clinical environment.

    Probes: What are methods you utilize to evaluate student learning in the acute care clinical environment?
    What are ideal characteristics you would like students to have after successfully concluding your component of clinical instruction?
    How do you ensure every student receives feedback regarding clinical performance during each clinical day?
    How do you ensure every student is evaluated appropriately during each clinical day?

9. Tell me about the clinical document you brought today and the role it plays in determining whether students have effectively learned in the acute care clinical environment.

    Probes: What are elements of this assignment that would display a student has effectively learned in the acute care clinical environment?
    Are there expectations regarding pre-clinical assignments? If so, how does this impact students ability to effectively learn in the acute care clinical environment?
    How does this document assist in evaluating student performance in the acute care clinical environment?
    What types of feedback did you provide this student on this clinical document?
    Describe any post-clinical conference activities you require of students. How do you evaluate student learning during these activities, if applicable?

10. Tell me about your first day as a BSN nursing faculty member when instructing students in the clinical setting. How have you grown as a nursing faculty member when providing clinical instruction since that time?

    Probes: Tell me about ways you have adjusted facilitation of student learning since that time.

Do you feel you have improved in facilitating student learning in the clinical setting? Explain.

11. Is there anything you would recommend changing to improve clinical instruction of nursing students?

12. Is there anything else I should know to understand your experience better?

13. Is there anything you would like to ask me?

Appendix I

Email to Participants for Second Interview

Dear [Name of Participant]:

Thank you for agreeing to participate in a second interview for my study. This interview will focus on your feedback regarding this drafted grounded theory. I am interested in your thoughts regarding suggested additions, changes, or edits to this developing theory. Attached to this email is a visual depiction of the theory and a word document describing elements of the theory for better understanding. As this theory is a work in progress, please do not share the attached documents with other individuals.

Please keep in mind that this grounded theory does not represent one individual's experience, but rather, was constructed based on patterns determined by evaluating all participants' experiences who took part in the study.

The second interview will be recorded in the same manner as the initial interview in order for the researcher to transcribe, review, and consider all feedback received regarding this developing theory.

Your feedback is very valuable to this process. Thank you for agreeing to this second interview. Please do not hesitate to contact me at any time with questions and I look forward to our meeting.

Sincerely,

Elizabeth Flott, Ed.D(c), RN

EFlott7327@csm.edu
(402) 619-0365

Appendix J

Participant Questions for Second Interview

Thank you for agreeing to review the developed theory and for participating in this second interview. This interview is meant to gain participants' feedback regarding the developed theory and to ensure the theory is representative of faculty participant experiences. If you have suggestions for any changes, additions, or edits to the theory, please feel free to share your thoughts and all recommendations will be considered when finalizing this theory.

Please take note that this theory is representative of all participant experiences, not any one individual's experience. The researcher reviewed all data, analyzed the data for patterns, and developed this theory based on those patterns.

1. Please review the categories depicted in the green boxes on the left-hand side of the visual diagram and described in the text document.
    a. Tell me your thoughts on any changes or additions needed to enhance understanding of these categories.
    b. Are there any other relationships that you encounter that may be needed in the "Negotiating Multiple Relationships" category? Explain.
    c. Does the visual representation of these categories make sense to you as the reader? Explain.
    Is there anything that may make this visual depiction clearer?

2. Please review the facilitation strategies in the center of the visual diagram and described in the text document.
    a. Tell me your thoughts on any changes or additions needed to enhance understanding of these categories.
    b. Does the visual representation of these categories make sense to you as the reader? Explain.
    Is there anything that may make this visual depiction clearer?

3. Please refer to the facilitating learning process portion of the visual diagram and the related section of the text describing this process.
    a. Tell me your thoughts on any changes or additions needed to enhance understanding of these categories.
    b. Does the visual representation of these categories make sense to you as the reader? Explain.
    Is there anything that may make this visual depiction clearer?

4. Are there any comments or suggestions you would like to add regarding this theory?

Thank you again for taking the time to review and provide feedback regarding this developed theory. Again, because this theory is a work in progress, please refrain from sharing documents regarding the theory with other individuals.

Appendix K

Audit Trail Documentation Letter

August 24, 2016

Elizabeth Flott requested an Audit Trail be conducted for her qualitative dissertation, Facilitating Student Learning in the Acute Care Setting: Nursing Faculty Perspectives. The Audit Trail was conducted on August 21, 2016.

In my opinion, the study followed the established processes for qualitative studies, remaining consistent with the intended purpose statement, research questions and planned procedures approved by the Institutional Review Board. The themes identified during data analysis flowed directly from the transcribed audio tapes. The procedures utilized were clear, transparent, and well documented.

In summary, I attest that the criteria for trustworthiness, credibility, and dependability of the findings met the standards for data quality management. I served as auditor as part of my role as Doctoral Committee Chair for the Doctor of Education Program.

Sincerely,

Lois Linden

Associate Professor
College of Saint Mary
7000 Mercy Road
Omaha, NE 68106