An exploration of the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting; a qualitative descriptive study

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Abstract:

Over the previous twenty years nursing education has undergone major changes worldwide. Nurse training has shifted from an apprenticeship model in hospitals to being based in academic institutions. This move was envisioned to improve and maintain the quality of the nursing profession through research and evidence based practice informing a more holistic view of nurse education. As a result the role of the nurse educator has also needed to evolve (Gage & Hornblow, 2007).

New Zealand is suffering from a worldwide shortage of registered nurses in addition to an understaffed and aging nursing faculty (Schriner, 2007). Workforce analysts agree that the primary reason for the current shortage of registered nurses is this diminishing pool of faculty nurse educators (Penn, Wilson & Rosseter, 2008).

The literature review revealed a dearth of knowledge on this situation.
An exploratory study was performed using a qualitative descriptive method to discover the experiences of six expert clinical nurses (as defined by a Professional Development Recognition Programme) in the New Zealand tertiary sector who have transitioned to the role of faculty nurse lecturer. Data was gathered by semi-structured interviews and analyzed identifying emerging themes of orientation, peer support and unpreparedness.

The purpose of this study was to develop a rich understanding of the New Zealand expert nurse clinician's experiences when transitioning to the role of a

nurse faculty educator. The aim was to identify themes that will enable improved retention and recruitment of qualified individuals to the faculty nurse educator role to support the quality education of nurses. What was revealed and confirmed by this exploratory study was the expectation that negative facets far outweighed the positive facets of the role change from expert nurse clinician to faculty educator.

The findings from this research have implications for retention and recruitment of qualified individuals to the faculty nurse educator role. With the increasing need for registered nurses and worldwide shortages in nursing staff, faculties are being impeded in their ability to meet the student's educational needs. The findings from this study are important because one recommendation will be that appropriate support be given to new faculty educators. It is hoped this will result in less frustration, anxiety and doubt and new staff will remain in the faculty educator role which will support the quality education of nurses.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature: …….

Date: …….

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Chapter One

Introduction and background

Nursing education has undergone major changes over the previous twenty years and the role of nurse educator has evolved worldwide (Schriner, 2007). Nurse education has roots tracing back to the 1800s, firstly in Europe, then worldwide. Nursing as an occupation was not clearly defined and often was interlaced with household and child raising roles. From the 1880s to the First World War nursing in New Zealand changed rapidly as trained nurses took over from the untrained. This occurred as a result of hospital nurse training, commencing in the early 1900s, and by the introduction of the 1901 Nurses Registration Act (Wilson, 2001). In the 1930s in New Zealand a traditional apprenticeship model was the norm. The culture and skills of nursing were immersed in the hospital system which was dominated by the medical profession. Nursing abided by the medical-hospital model and decision making, protocols and uniforms of the hierarchical state hospital system. Changes occurred when it was recognised that many of the duties and tasks that registered nurses completed were of a ritualistic character as opposed to evidenced based practice. Nursing student's knowledge of wider issues was limited and the apprenticeship model where they had the dual role of employee and learner was unsatisfactory. Inadequate and unreliable learning outcomes resulted from this apprenticeship model and resulted in a shift from nurse training within hospitals to nurse training being based in academic institutions (Gage & Hornblow, 2007).

In 1970 restructuring of nursing education was widely accepted as necessary by the nursing profession and the wider health system. This restructuring would develop a profession with a body of knowledge that was evidenced based and the subsequent linking of theory to practice by its members. Following the recommendations of the Carpenter Report (1971), nursing was included in the tertiary education sector. Although Carpenter recommended nursing education be placed in advanced colleges of health sciences or universities; initially the

apprenticeship model was replaced with a diploma in nursing studies offered through the polytechnics, as there was no discrete nursing pathway to follow (Smythe, 2008). These diploma programmes were based on a nursing model rather than a previous training system which came from a bio-medical model. The bio-medical model comes from the perspective that good health constitutes being free from disease, pain, or defect. The model's focus on the physical processes, such as the pathology, biochemistry and the physiology of a disease, does not consider the role of social factors or individual subjectivity. The model also overlooks the fact that the treatment should be result of negotiation between doctor and patient. The pioneer nurse scholars had no option but to take papers from allied disciplines initially such as social anthropology. This was, however rapidly followed with nursing degrees being offered by both polytechnics and universities throughout New Zealand by the late 1970s. Initially nurse training continued until the 1990s in both hospital training setting and polytechnics. The last nursing students graduated in 1992 from hospital based training as in 1991 the nursing profession set a baccalaureate as the basic educational preparation for nurses (Vision 2000, Nursing Council of New Zealand 1991).

Therefore nursing education overlaps both education and health institutions with resulting dual governance. Nurse faculty educators as well as being competent in clinical nursing skills of communication, professional judgement, nursing care, legal responsibilities , health education, ethical accountability and interprofessional health care are now also required to be capable in skills such as reflective thinking, research writing, critical analysis and scholarship as these skills accompany degree education(Education Act, 1989). The continued trend for higher education for nurses means that post-graduation courses are also offered, originally at Victoria and Massey universities and now across all New Zealand universities (Wood, 2001).

New Zealand, like the rest of the world, now has an aging workforce of nursing educators and nursing faculties are often understaffed (Kigma, 2006). Workforce analysts agree that although there are many reasons for the current shortage of registered nurses worldwide, that the primary reason for this is the diminishing

pool of nurse faculty (Penn, Wilson, Rosseter, 2008). With this shortage of nurse faculty, expert clinical nurses (as defined by a Professional Development Recognition Programme) are being recruited to join the faculty so schools may maintain and expand their educational programs. Faculty nurse educators are currently expected to educate, to perform administrative duties, as well as in some cases undertake research. The expansions of the role from educator to include research and administration duties have created challenges (Gage & Hornblow, 2007).

Previous studies have provided to the information and knowledge of processes to help adjust and prepare for the faculty role. However these mainly quantative studies have not attempted to depict the meaning of the experience of being a new faculty educator.

Aim of study

The aim of this study was to use a qualitative descriptive method to describe and give a rich understanding of the experiences of six expert clinical registered nurses in New Zealand who have transitioned to the role of faculty nurse educator. The findings from this study are important because they will inform future faculty nurse educators and this will reduce anxiety, frustration and apprehension about the educator role. The research will provide insights into the lived experiences of faculty nurse educators and will uncover some of the difficulties they faced while transitioning. It is hoped that from this, better support systems will be put in place for beginning staff so that they become retained in their positions and also that qualified individuals become recruited. The retention and recruitment of qualified individuals to the faculty educator role will then support the quality education of nurses.

Context of the study

The study was conducted in a Nursing Faculty in a New Zealand Tertiary Institution. The participants were all expert clinical registered nurses who had transitioned to faculty educator role within the last five years. They were all experiencing or had experienced the full range of responsibilities of the role and were working a minimum of 0.6FTE

Structure of the thesis.

The first chapter opens with an overview of nursing education and provides the setting for the present study. Chapter Two reviews and critiques international and New Zealand research and other literature related to the study. The research design, qualitative descriptive methodology and its application are discussed in Chapter Three.

The findings of the study are presented in Chapters Four to Six. The findings are presented in these chapters in themes based on the participant's interviews. Staying close to the participant's words avoided inaccurate representation as this explains what the participant experiences and knows, not what the researcher thinks or experiences (Polit, Beck, & Hungler, 2001). Emerging themes were developed by examining the transcripts repetitively until major themes emerged. The relatedness of these themes emerged and the three main themes were then identified.

Chapter 4's theme relates to Orientation "new stuff to learn" with sub themes; the role and processes, expectations and resources. Peer Support and peer learning ("my peer was a saving grace") are presented in chapter 5 and Unprepared "new stuff to learn" in chapter 6 with sub themes; academic culture and language and teaching preparation.

Chapter Seven discusses the findings and the limitations of the study. The implications of the research are presented, as are recommendations for future research.

Chapter Two

Literature review

Introduction

In this chapter New Zealand and international research and other literature will be examined. The traditional purpose of a literature review is to inform the researcher on what is known about the phenomena or topic, share the results of other related studies, identify a gap in the current literature and provide a framework for determining the importance of the study (Punch, 2010). The search involved two main electronic databases: Cinahl and ProQuest. The following keywords were used nurse faculty, nurse education, teaching nursing, teacher preparation, work role transitions, nurse faculty shortage, nurse educator and expert nurse clinician.

The literature review highlighted the need for a New Zealand study of new nursing faculty as an area where more information was needed as there was a dearth of studies. The literature review spanned a period of the previous twenty years; it identified that most studies and derivative articles were generated overseas. Previous studies were, for the most part, quantitative inquiries focusing on how new nursing faculty adjusted and prepared for their new work-role. These studies have not attempted to depict the reality of the experience of being a new faculty educator.

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Work-role transitions

Louis (1982) argues that work-role transition refers to the phase during which an individual adjusts to their new role and work setting. She found similar issues for all work- role transitions of being overwhelmed, surprised and underprepared.

The pressure of delivering tangible outcomes whilst endeavouring to build professional and individual credibility caused anxiety and stress.

Work-role transitions can be defined as a change in employment, an alteration of existing work duties and activities or a change in employment status. Work-role transitions can be voluntary or involuntary responses to professional opportunities and uncertainty with career prospects. When there is no delineation between the existing role and taking on more responsibility the transition can occur in a haze. The advantage of a planned transition is it allows for reflection, planning and setting of specific goals making the transition less stressful (Ashforth & Saks, 1996).

Work –role transition is the human experience connected with entering a new community of practice. It is an active, developmental process with critical tasks, emotional work, and a flow through role boundaries to a new identity, knowledge base and the values of a new role. With the complexity of modern workplaces and organisations, work-role transitions can be extremely challenging. The time of transition makes the individual vulnerable as they lack in depth knowledge of the organisation and the culture of the work environment, what is expected of them in their role and there is a lack of networks and their subsequent support (Niessen, Binnewies & Rank, 2010).

Rosser and King (2003) claim that work- role transitions are hampered often by unrealistic expectations and given that any work- role transition creates doubt and anxiety that these feeling are compounded when the change is into a specialised environment. Within the specialised environment care is needed to ensure learning objectives are multidimensional and in the beginning short term goals need to be consistent and show the philosophy and principles that the newcomer represents and that these match the organisation's mission and values.

Ulpukka (2008) believes work-role transitions can also occur without physical movement but when psychological conditions of the role changes, such as when there is major restructuring within the workplace. Work- role changes are never

plain and clear-cut. Motives to find a more fulfilling and challenging work role can be connected with the individual trying to avoid those things they dislike in the workplace as well as circumstantial changes. To fulfil the expectations of the new role information is needed on the organisation structure, how to complete tasks, developing of relationships, clarifying of the role and maintaining a positive image. When people are being promoted or moving within the organisation their information needs differ from newcomers so information needs to be personally interpreted to discover that which is relevant to the new role.

Nicholson (1984) contends work-role transitions are significant for development of the individual and organisations. He theorised that there is a transition cycle. This cycle includes a preparation phase with its speculation about the challenges and tasks of the new role. Following is the phase of stress when the individual is astonished by the differences between their new and old role. The third phase is the adjustment as the individual adapts in response to the new work environment and manipulates the environment to meet personal needs. During this phase the individual develops working relationships, clarifies the role and its expectations and gains information. The information will include procedures and organisational structures related directly to the new work role.

Furthermore Glen and Waddington (1998) identified factors facilitating role transition using Nicholson's theoretical frame work. These included the need for formal orientation and preparation for the new role including professional, clinical and organizational facets. This orientation also needed to include time management and stress management. The selection of a robust mentor is crucial as they can guide and reinforce schemas that occur in the daily routine of the role as well as being able to clarify queries that the newcomer has. Peer support also needs to be readily available to aid the professional growth and development of the newcomer. Clear role description outlining boundaries, tasks and expectations were also found to facilitate a positive work-role transition. As well, the newcomer can create a daily log or record to help alleviate pressures from multiple sources such as management, students and peers. This will enable

clear assessment of their planning of short and long term goals and the effectiveness of their abilities in the role.

Therefore seeking constructive feedback and support from a mentor, other professionals in the team and constant self-evaluation can contribute to a smooth transition. Effective relationships with open dialogue between the newcomer and others within immediate team and those within the organisation are essential to facilitate a successful stress free work-role transition (Bass, Rabbett & Siskind, 1998.)

Recognizing that transition from any role to another induces feelings of difficulty, anxiety and insecurity is important and relevant to New Zealand nursing education sector. It has been shown that there is a strong connection between the amount of work experience, support and mentoring and increased job satisfaction, self-confidence and, therefore, retention of staff (Geerish, 2000).

Unprepared and Isolated

The limited number of qualitative studies predominantly found that individuals are often inadequately prepared for the role transition from expert nurse clinician to nursing faculty. Research completed by Siler and Kleiner (2001), writing in the United States, revealed a major theme that the negative facets far outweighed the positive facets of the educator role for the expert nurse clinician moving to the faculty role. The new faculty educator's expectations were often based on their experiences from being a student. This study reported that the new faculty educators were unprepared for the different culture and language that had not been encountered in multiple clinical settings. New nurse educators found faculty workload, administrative duties combined with lack of resources as areas for which they were unprepared. They expressed surprise at the depth of work expected from preparing lessons and teaching to attending committee meetings and planning days.

Workload was also found to be a major concern by newcomers and is compounded by the aging faculty in a Canadian study (Cash, Doyle, Tettenborn, Daines & Faria, 2011). The nurse faculty educators expressed wanting to be involved in leadership but, due to the heavy workload, they were unable to have an input. Therefore this leaves administration without the collective wisdom from the nurse faculty educators on matters directly impacting on nursing education. This is contrary to the ideology of nursing where advocacy and empowerment are major strengths and this compounds the faculty nursing educator's frustration. Consequently this leads to resignations and impacts on recruitment as nurse faculty educators feel marginalised, overworked and unheard (Cash, et al., 2011)

Diekelmann (2004) found that twelve experienced nurse clinicians joining faculty in the United States identified that they were unfamiliar with the language and culture of their new role. The new faculty educators described feelings of isolation and distance on entering the new culture. This isolation was impacted by not knowing the values, the mission, the hierarchy of the department and what each role encompassed. They felt that their colleagues were too busy to answer questions or were at times belittling in their answers. The lack of time to discuss decisions and teaching practices with colleagues contributed to feelings of anxiety and these nurse clinicians noted this perceived lack of support contributed to their feelings of isolation.

A study of six clinical nurses transitioning to faculty educator role in Ireland also identified that they were unaware of the culture and language of their new role. Collegial support was identified as a support structure that would have prevented feelings of isolation. They identified that an unfamiliar academic organisational culture, heavy workload and lack of knowledge about available resources all played a part in their feelings of isolation. The nurse faculty educators in this study reported that they felt unprepared for the practical application of theoretical content in the classroom setting, although they had completed an educational preparation teaching course. The nurse faculty educators felt there were inadequacies within the course as topics such as

marking and administrative duties were not covered. An opportunity to observe an experienced lecturer delivering teaching sessions to learn skills to enable them to deliver the theory content with more confidence would have lessened feelings of isolation. Collegial support was identified as another support structure that would have prevented feelings of isolation. (Dempsey, 2007).

The literature search identified only one New Zealand study in this domain; it examined the transition of six staff nurses from nurse clinicians who then moved into the role of clinical nurse educators in a District Health Board. This involved transitioning from experienced staff nurse to the role of novice senior nurse clinical educator. The roles of clinical nurse educator are not dissimilar to the faculty nurse educator roles because both are concerned with providing clinical practice education. However there are different role sets for each position. Faculty nurse educators provide clinical practice education but as part of their complete practice they are also involved in academia. The New Zealand study identified that new clinical educators also feel isolated and unprepared. As well they were unaware of role components and some of the language involved in being an educator. The participants all felt a formal orientation to their new role and having an opportunity to spend time with their predecessors would have alleviated the isolation and unpreparedness (Manning & Neville, 2009).

Literature supports that the characteristics of an effective faculty educator includes expertise in knowledge of how to teach adults (Gaberson & Oermann, 2007). Although new nurse faculty educators possess expertise in their field it should be acknowledge that they may not have the skill set and knowledge required for the academic setting. Billings (2003) stated “Excellence in teaching is not intuitive” (p.100), which reflects the need for new nurse faculty educators to engage in preparation for academia.

Anxiety and Doubt

Moving to the faculty educator role from clinical practice is a career change and many that enter the new role are only indistinctly aware of the difference therefore the transition brings more anxiety and shock than they expected (McArthur-Rouse ,2008).

Common themes to the studies were that the new faculty nurse educators all experienced some degree of anxiety and doubt about their ability to successfully fill their new role. Many new faculty members have anxiety about teaching skills and how to successfully interact with challenging or failing students. Doubts arise due to lack of understanding of the educator role and the new nurse faculty educators repeatedly questioned their abilities to be effective teachers, even though they constantly talked about their strong clinical skills. This cultural conflict exists for new nurse faculty educators as the values of the clinical practice which they bring to the new role are different from the values needed for success in academia. Changing some of the values of the faculty to match the values and skills for which nurse faculty are employed means that the culture of the institution will reflect the values of its faculty and alleviate anxiety (Schiner, 2007).

In addition, Young and Diekelmann (2002) reported that new nurse faculty lecturers describe anxiety about being equipped for the practice of lecturing. Doubts arose due to lack of understanding of the educator role and the strategies needed to develop and deliver the lectures. The new nurse faculty educators repeatedly questioned their abilities to be effective teachers and anxiety levels rose higher when use of media they were unfamiliar with was involved. The levels of anxiety could be reduced by including not only principles and theories of adult learning, but skills of teaching with the background practices of connecting, constructing, interpreting and use of technologies into orientation (Young & Diekelmann, 2002).

A United States study of twelve new nurse faculty educators identified that they were all concerned about their performance as teachers rather than research and lesson preparation. These educators then judged themselves against the

success or failure of their students which at times had a flow on effect of causing doubt in their ability to teach. In some cases when faced with poor student evaluations, stress levels increased and faculty educators took measures to retain their jobs, but not to increase their expertise in teaching (Siler & Kliener, 2001).

Feelings of doubt over the ability to manage the educator role with the need to develop lesson plans, learning objectives , constructing test and exam items, evaluation of students coupled with finding time for scholarly work and maintaining up to date clinical skills also added to the anxiety level (Penn, et al., 2008). A study completed in Midwestern United States on new faculty nurse educators with no previous teaching experience reported that all worried that they would not know something a student asked. This transferred to the concept that the not knowing would destroy credibility with the students and increased anxiety levels. The new nurse faculty educators also expressed surprise and anxiety at the workload expected as well as needing to learn the new academic language (Anderson, 2009).

The reality of teaching and not being educationally prepared were common themes that created doubt about their role as faculty educators in a study of seven new faculty members in the United States. They repeatedly talked about their expert clinical skills while repeatedly questioning their ability to teach. Doubt levels in their abilities were increased when there was a lack of clarity about their role and lack of orientation (Schiner, 2007).

McArthur-Rouse (2008) exploring the experiences of new academic nursing staff in the United Kingdom also identified that lack of clarity of the faculty nurse educator role led to questioning about whether they were fulfilling the role effectively and this, coupled with lack of structure to their daily work caused anxiety. The new staff commented that they had not always shared their main issues with their mentors and that with more practical guidance around functional aspects of teaching anxiety levels may have been reduced. The findings reported that the new academic nursing staff found the mentorship had

been helpful to some degree but a more structured formal system of mentorship with clearly defined boundaries and goals may have been more beneficial.

These studies identified the common themes that new nurse educators both clinical and faculty reported confusion, anxiety, isolation and that a formal transition process would have been beneficial.

Orientation and Mentoring

Formal orientation programmes have been found to be crucial in retaining and motivating staff, increasing and maintaining morale and reducing the anxiety levels of new staff. New staff need to be introduced to the culture, structure, standards and protocols of the new workplace. They also need to know the expectations at both organizational and faculty level and what they can expect from the organisation. This formal orientation stresses the why, defines the philosophy behind the workplace mission, the values and provides a framework for the tasks of the role. However provision of training programs tends to emphasize only the technical components of the role (Robbins, 2002).

Expert nurse clinicians come with expertise and mastery of nursing skills and nursing knowledge when hired as a faculty educator. Challenges for the new nurse faculty educator include anxiety regarding teaching skills, how to manage interactions with challenging and failing students, heavy workload and finding time for the research component expected. Provision of a formal orientation program where the new nurse faculty educator is expected to complete graduate education courses and faculty based sessions leads to less anxiety, doubt and therefore retention of staff (Penn, et al., 2008).

In the United States the provision of a nursing education certificate program in the orientation program which includes curriculum development, teaching methods, teaching in the classroom, on line teaching, marking, testing, teaching on-line and the role of the educator, develops a personal philosophy of teaching which then provides a framework for the new faculty nurse educator to use when working with students (Murphy, 2007).

Another challenge for the new nurse faculty educator comes from understanding and conforming to the curriculum. The curriculum development is monitored not only by the Nursing Council of New Zealand but also the New Zealand Qualifications Authority. The new nurse faculty educator therefore needs orientation to the education requirements because as an expert nurse they come with knowledge of the nursing criteria but little knowledge of educational obligations (NZQA Development of Degrees, 1995).

Ragsdale and Mueller (2005) found that moving a lecture- based orientation program to an interactive orientation which included facilitator workshops and interactive activities such as case studies, icebreakers and group discussions ensured engagement with their adult learners, the sharing of information and integration of this information. The program was designed to deliver workshops twice monthly with a mini orientation program given to new employees simultaneously with the signing of contract. This change in orientation delivery led to reduced turnover, shorten orientation phase and laid the base for successful career in the Franciscan Health system.

Information on topics such as curriculum development, teaching in the classroom setting and evaluation of students was found to be necessary to prevent frustration and role stress in novice faculty in a Canadian study. These skills can be delivered optimally through a formalised orientation program aligned with orientation to the institution as well as the nursing faculty. This orientation should include mission statements, goals, policies and procedures. In addition as faculty evaluation process may cause anxiety disclosure of the process of evaluation, as well as promotional policies with key dates, needs to be emphasised. Additionally regular meetings outside the faculty to enable free disclosure of perceptions and guest speakers delivering topics including creative teaching strategies, lesson plan development, handling and documenting student issues, and faculty obligations within classroom setting and outside, coupled with on-going professional development throughout the year meant that 91% of novice faculty were with the faculty 3 years later(Baker, 2010).

As well new faculty nurse educators during their orientation need to be informed of faculty resources, how to access these resources such as equipment, library, and the use of computerised systems and copying services. If new faculty nurse educators are to be involved in simulation or web based courses, they need to be orientated to these areas, offered courses on the pedagogy of on-line teaching and learning as well as being offered technical support so that their focus can be then on content. If this occurs the new faculty nurse educators will have less stress levels and function more efficiently and effectively (Gazza & Shellenbarger, 2005).

Mentoring is a process for transmission of knowledge and emotional support, where the more experienced person acts a guide or coach and objectives should include professional development and results in increasing self-confidence and self-esteem. To have a successful mentoring program requires a commitment from mentor and mentee and should be formalised. Mentors take on several roles; educator, facilitator and colleague. Regular planned meetings should occur to discuss issues and address concerns. Successful mentors make sure that their mentee learns crucial knowledge and skills by teaching and role modelling and with the mentor providing opportunities for mentee to access educational experiences. A successful mentoring relationship focuses on more than career development. Professional and personal connections need to be established between mentor and mentee to facilitate a positive relationship which enhances the work-role transition. When barriers of power and difference are reduced with constructive relationships more open communication can occur building trust and allowing for greater opportunity for learning (Noonan, Ballinger & Black, 2007)

Caring and connecting are two other important components of successful mentoring. The development of collegial relationships as well as focusing on the professional development between mentor and mentee leads to invaluable work friendships and employee retention. Effective mentoring which results from this

collegial relationship leads to quality nursing education by the new nurse faculty educator and increases job satisfaction and produces future mentors (Smith & Zsohar, 2005).

McArthur-Rouse (2008) concur that moving to the faculty educator role from clinical practice is a career change and many that enter the new role are only indistinctly aware of the difference. Therefore the transition brings more anxiety, shock and isolation than they expected. Conversely mentoring new faculty educators will nurture a collegial, caring environment which will lead to retention of staff. In addition to the benefits to new faculty educators that mentoring programmes offer, there are benefits to the mentors and the faculty. Mentors report that their own development is improved through the mentoring experience which some find stimulating and refreshing. Mentees often have new links within the broader workplace which enables new links to the mentor and as the mentee becomes part of the team they can provide social support to their mentor (Hessler & Ritchie, 2006).

Jacelen, Zucker, Staccarini, & Henneman (2003) found that mentoring and support from experienced staff aided professional development; networking and self-esteem of the new nurse faculty educators. Decreased anxiety will then occur with mentoring as new nurse faculty educators struggle with the role of academia. In addition the research found that mentoring partnership was not just a strategy for learning for the mentee but promoted reciprocal learning and refreshed the mentor. Positive mentors provide additional advice and counsel based on their own personal experiences as a new faculty educator and their acquired knowledge from working with students and institution.

One of the most important strategies for retaining and recruiting women in a faculty is through mentoring. This includes one to one matching with mentors both formal and informal within and outside their own programs. The mentor provides a view of the lived experience of being an expert nurse clinician moving to the faculty educator role and possible ways to deal with issues or problems that arise. The mentor can build confidence in the mentee through positive

comments, coaching and opportunities to observe and share in the teaching. Mandatory support for travel and professional development to network and gain new experiences also enhances the experience for the new faculty educator (Sherman, Beaty, Crum & Peters, 2010).

Mentoring a new faculty member even those with doctorates requires commitment and time as the nurse faculty educator role includes teaching, research, practice and service. The mentor needs to include all aspects of the role, the teaching, building of networks, informing regarding academic guidelines within the institute and values and mission of the faculty. Working side by side and role modelling is time consuming and requires support from the administration in allocation of specific funding and time for mentor and mentee to debrief and reflect (Hawkins & Fontenot, 2009).The mentor and mentee require allocated time to maintain competency in both the academic and clinical role as the New Zealand Nursing Council expects that faculty members who teach clinical courses maintain clinical competence (Nurses Act, 1997, Nurses Amendment Act, 1994).

Therefore the formal component of mentoring needs to be set up in advance with goals; expectations and a mechanism for renegotiating as this will encourage a climate of trust. Formal supervision which entails regular meetings to discuss issues and progress and informal supervision which includes debriefing each day is shown to produce confidence and job satisfaction and therefore retention of staff (Morley, Rugg & Drew, 2007).

Peer Learning

The new nurse faculty educator needs to take responsibility for their own learning goals, as personal development promotes skills of learning and also of learning to learn (Kolb, 1984). Peer learning has a variety of meanings across different settings. Mostly it can be described as cooperative learning with positive learning interactions facilitating reflection and exploration of ideas and

skills. Discourse and interaction happens between the newcomer and a more competent peer. The newcomer and peer learn from and with each other in ways that are jointly beneficial through sharing of ideas, knowledge and experience. The pedagogic origins of peer learning can be found in Vygotsky who highlighted the role of social interaction in learning (Tosey & Gregory, 2002).

Informal support through peer interaction advances the learning of new nurse faculty educators as they collaborate with more experienced peers on lesson plans, activities or research projects. When educators listened to each other sympathetically learning occurs as both the new faculty educator and the more experienced peer reflect on their own teaching practices, discipline perspectives and theories. It is the collegial sharing of insights, ideas and practices that provide a rich and unique opportunity to improve the quality of teaching (Darling-Hammond, 2008).

Classroom observation of the more experienced peer by the new nurse faculty educator allows insights into teaching skills, new vocabulary and ways students learn. The acquiring of skills and competencies occurs if this observation is followed by reflection. The act of sharing and reflecting between academic colleagues deepens understanding and builds a strong emotional base to support on-going learning both academic and social (Peel & Shortland, 2004).

Peer learning can provide an arena for the new nurse faculty educator to process their experiences with their teaching sessions, student management and issues. The sharing within a safe confidential supportive environment such as over lunch with an opportunity to problem solve, reflect and evaluate performance can ease the work-role transition. The interaction and dialogue between the new nurse faculty educator and more competent peer can be an important role in motivating and boosting confidence (Barnard, et al., 2011).

Some of the benefits of peer learning originate from the informality of the relationship. Approaching a peer for assistance in an informal situation perceived as safe, causes less anxiety and encourages open dialogue about uncertainties. However there is a view that the more experienced peer may

benefit more as reorganising and communicating information can lead to additional depth of understanding of their role and knowledge. Due to current heavy workloads challenges can arise with peer learning within the nursing faculty setting as adequate provision of time is required to facilitate successful peer learning through interactive positive relationships (Christiansen & Bell, 2010).

Tosey & Gregory (2004) agree that peer learning as an educational practice supports self-direction for adult learners and is particularly successful and suitable for professional practitioners. New nurse faculty educators can improve their teaching skills through modelling the practice observed and the giving and receiving of constructive feedback. Peer learning therefore can be enriching and invigorating. However these writers also discovered that peer learning requires time and effort. Today's tight financial climate, heavy room bookings and limited resources means finding a secure private space and time to meet which is essential for an effective peer relationship is difficult and challenging.

Conclusion

From the literature it is clear a number of feelings are induced during transition from one role to another. Feelings of isolation, anxiety, and doubt and role ambiguity are commonly reported by participants. In summary, there is also evidence that expert nurse clinicians are often inadequately prepared for the role in which they are entering. Orientation, mentoring, supportive peer learning and clarity of role can alleviate these feelings. Overall internationally and locally there is a dearth of studies related to the experience of being a new nurse faculty educator. As experience is situated and interpretation is context dependent, studies in North America and Europe do not automatically reflect the New Zealand context. There are no known phenomenological interpretative studies that make clear the meaning of being a new nurse faculty educator in a tertiary faculty setting in New Zealand. This study seeks to address that need. The following chapter describes the research design used to answer "What are

the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting?

Chapter 3.

Research Design

Introduction

In this chapter the research methodology will be presented. Included is the background to the qualitative research paradigm, followed by discussion of qualitative description as a qualitative method of data collection and analysis. The design is described, as is the selection of participations, data collection and analysis of ethical concerns.

Background

The research process happens in all fields including human endeavor. However all research should have a purpose, be systematic and include a way of making sense of our world with processes that are credible and recognized (Hesse-Biber & Leavy, 2006). The research method in this study uses a phenomenological interpretative approach to describe and interpret the experiences of expert nurse clinicians transitioning to and working as faculty educators. Phenomenology looks for and reveals human perceptions and subjectivity to develop an understanding of what it is like to experience a phenomenon directly. An intrinsic belief of phenomenology is the “lived experience”. Learning what it means to be an expert nurse clinician moving to the faculty educator role is then best understood by the people who live the experience in their everyday world. The process of research enquiry is guided by “beliefs”. In the qualitative paradigm these beliefs are designed to answer the questions: “What is the nature of reality?”, “what ways should the researcher discover the knowledge?” and, “in what is the relationship between the researcher and the knowledge?”

(Denzin & Lincoln, 2001). The terms ontology, epistemology, axiology and methodology are clarified by these questions.

Ontology refers to the assumptions made about the form and nature of reality, that it is the study of being (Denzin & Lincoln, 2001). That reality is then constructed by the participants. Epistemology, the scientific study of knowledge, refers to how knowledge of reality is gained, so how do you know what you know? The qualitative researcher uses the premise humans acquire knowledge of having lived through a type of experience and that the individual has retained that knowledge and can reflect accurately (Polit, Beck & Hungler, 2001). Here as the researcher is closely interacting with the participants there are implications for axiology (the role of values in a qualitative study). Therefore due to this close involvement by the researcher, preconceptions, personal values and biases are acknowledged (Ashworth, 1997).

Methodology refers to strategies used in the collection of data and the analyzing processes. In a qualitative methodology categories or themes emerge from the participants. This emergence provides context rich information that leads to the development of theories (Crotty, 1998).

Qualitative Descriptive Studies

Qualitative descriptive design was used and is appropriate as little is known about the phenomena. Qualitative descriptive studies do not adhere to existing frameworks but make use of naturalistic inquiry to establish the phenomena. This approach to inquiry provides interpretations of the human experience to understand more fully the richness of shared experiences and practices. The descriptive design was chosen to give a detailed understanding of variables which will eventually yield rich data. Given the many different guises and diverse combinations of sampling, data collection and analysis, qualitative description cannot be described as having been developed by one person. However epistemological credibility is satisfied by description (Sandelowski, 2010). The

philosophical underpinning qualitative descriptive study is in the interpretive paradigm. Interpretive studies utilize mostly qualitative methods and follow the belief that reality is subjective and is constructed by humans and absolute truth cannot be obtained. The qualitative researcher is after depth in their data and analysis and interested in understanding social meaning (Sandelowski, 2010).

Participants

The participants were expert nurse clinicians who had transitioned to the role of faculty nurse educator within the last five years at Tertiary Nursing Faculty within New Zealand and were holding at least a 0.6 FTE position. There were six women whose ages ranged from late twenties to early fifties. Three participants were New Zealand born while others had immigrated from the northern hemisphere. All participants had completed post graduate study with two undergoing masterate study.

Participant Selection and Providing Information

Invitations to attend information sharing sessions on the proposed study were circulated via computer e-mail system. Informed consent requires that participants have been provided with full information regarding the requirements of the research; they understand that information and make a free choice without coercion. According to Beauchamp (2011) informed consent is a participant's autonomous authorization to participate in research. As some participants were known to the researcher, the information session and collection of the consent forms was undertaken by a suitable proxy from outside the targeted faculty, but within education. Information sheets and consent forms were given out and a meeting arranged for a week later. There were no restrictions in relation to gender, ethnicity or age. However the participants had to be able to articulate their experiences. Participants were informed that the findings would be used in the researcher's thesis. Every effort was made to ensure no persuasive language or methods were used during the information session. Written consent was then obtained and interview times scheduled. The first six completed consent forms collected determined the choice of the

participants. The interviews were at a time convenient to the participants and in a neutral place.

Information sheets and consent forms are appendixed (appendix 1 and appendix 2).

Ethical Considerations

The principles of ethical research practice emphasize four guidelines underpinning codes of ethics: Informed consent; deception; anonymity and confidentiality; and accuracy (Denzin & Lincoln, 2011). Ethical approval was gained through Auckland University of Technology Ethics Committee.

Anonymity and confidentiality

The ethics of research demand safeguards to protect all participants' identities (Denzin & Lincoln, 2011). Anonymity and confidentiality are mutually exclusive with anonymity dealing with concealing the identity of the participants and their area of work. Confidentiality relates to access of the data.

To maintain anonymity and confidentiality the participants were asked to provide a pseudonym for their research identity.

The audio taped interviews were transcribed by a professional who signed a confidentiality contract. Collected data has been securely archived for six years at the Auckland University of Technology after which it will be destroyed. Access to the data was and will be restricted to the researcher and the supervisor of the study.

The Confidentiality Agreement is outlined in appendix 3.

Deception

The ethics of research consistently oppose deception (Denzin & Lincoln, 2011). The research followed the process approved by the ethics committee and the reasons why research was being undertaken were transparent throughout. Participants were informed at the beginning of the interview of the aim of study

and that they did not have to answer any question they were uncomfortable with. Participants were given contact details for my supervisor to verify any information in the consent form if they so wished. (Appendix 2).

Accuracy

Accuracy of data is crucial and must be assured. Fabrication or omission of data is unethical and non-scientific (Denzin & Lincoln, 2011). Once data had been collected the trail was clear and transparent. The decisions and interpretations made throughout the data analysis were confirmed by the audit trail. The final report includes details of the limitations of the design or process identified.

The Position of Maori in Relation to research

After consultation with the representative for Komiti Tangata Whenua, it was clear that there was no effect on Maori related to the study. Though some participants may be Maori, the study does not contain a Maori dimension. All participants brought their culture with them. Any Maori perspectives that arose were discussed with the Kai Awhina (Maori pastoral support person) for the faculty (Smith, Hoskins, & Jones, 2012).

Respect of individual culture and backgrounds was shown to all participants in allowing different time and places for interviews with time allowed for prayer and sharing of food if required.

Data Collection method

Purposive sampling was utilized as this provided the necessary data for the purpose of the study and ensured the individuals being selected were typical of the population being studied. Therefore the data collected had depth and was information rich (Onwuegbuzie & Leech, 2007).

An individual interview was used as this enables the participant to tell “their” story. At the beginning of each interview the participant was reminded about the

intention of the study and written consent was verified. Semi-structured interviews (Mutch, 2009) were used as these are a way of seeking understanding of people's belief, behavior and key aspects of their lived world without inflicting prior labeling which may limit the findings. The semi-structured interview allowed the researcher to obtain a broad range of information about the phenomena as it had a sequence of topics to be covered as well as some suggested questions. The questions were designed to clarify the meaning of a response or to ensure complete information was obtained. These questions reflected the aims of the study and probed the nurse faculty educators to gain an understanding of their' experiences during transitioning to their new role. However it also allowed for flexibility so that specific stories or answers given by the participant could be followed up (Kvale & Brinkman, 2009).

Confidentiality Agreement appendixed (appendix 3).

Data Analysis

Hermeneutic methods using the science of interpretation were used for data analysis. Hermeneutic exponents believe that there are certain truths that adjust how we see things. They also contend that language conditions the ways individuals make sense of their world. Hermeneutics then allows a range of interpretations: some are closer to the truth but no interpretation is final (Ricoeur, 1981). The researcher analyzed the lived experiences of the participants, identifying notable themes or explanations for further elaboration. The explanations formed then inform the understanding, resulting in a new understanding and this circularity encapsulates the hermeneutic circle. Hermeneutics is a method where the researcher endeavors to gain an understanding, and an awareness of the meaning of the individual's experience through the interpretation of their words (Punch, 2010). The interviewer is aware that as a member of the nursing faculty this may impact on interpretation. In qualitative descriptive studies, an important focus is that there are no pre-conceptions of the researcher that impede the participants. Therefore the

interview data was transcribed verbatim to maintain data integrity and minimize interviewer bias (Polit, Beck, & Hungler, 2001). The only exception to verbatim transcribing was the omitting of any identifying names of individuals or work areas. The transcriber was alerted to delete any identifying references to persons or areas of employment; therefore confidentiality was maintained.

Recurrent notable themes or explanations were identified and then reduced further to categories. The next step was utilizing the highest level of hermeneutic analysis of identifying patterns that may occur to explain how meaningful themes discovered relate to each other and give greater depth of insights to the interpretation. This results in an exhaustive description of the lived experience. Therefore the interpretations of the research matched the lived experience so validity was established and can be defended (Young & Dieklemann, 2002). The content was read several times to ensure that emerging themes that give understanding of the reality of the role were fully understood.

Conclusion

This chapter has outlined the background to the qualitative research design with a discussion of qualitative descriptive study (Sandelowski, 2010). The methodology is appropriate as it allows the participants to tell" their" stories and enabled the researcher to obtain a broad range of information. Descriptive studies are frequently used to increase understanding of phenomena when there is little research in a specific area or to obtain a fresh perspective on well researched phenomena, so it was very relevant to this study (Tarzian & Cohen, 2006). Issues related to consent and ethical considerations have been discussed as has the method of data collection and analysis. The next three chapters contain the findings of the study.

Chapter 4

Orientation: "baptism by fire"

This chapter presents the first finding, which was that only one participant received a structured, appropriate and timely formal orientation to their faculty nurse educator role, to the faculty and the Tertiary Education Institute. The chapters' name has emerged from feedback from one of the participants. Although orientation to the faculty is espoused it did not happen in reality; issues around role clarification caused significant problems as did issues around the management and educational processes of the faculty and the resources available.

The role and processes

The findings make clear that five out of the six participants received no formal orientation to the nurse educator role. Although formal orientation is part of the faculty plan, there appears to be a disconnection between the formal process claimed and its implementation. Each participant expressed their disappointment, frustration and subsequent anxiety in different ways.

For example Stephanie talked about, *"I didn't get any formal orientation at that time. I felt it was like it was 'baptism by fire. I think also coming in at that time, they were still developing the degree and so there wasn't time to actually, I felt they didn't have the time, to orientate me. Everything was reactive, as the semester was starting, you'd put things in to develop for the next semester and this happened for the first year. It was very, very exhausting."*

Vicki felt lost in her new role as she shared her thoughts, "*In my orientation period there was probably time given to observing another lecturer, but no direction in the sense of "hey, why don't you go and sit in on this lecture or that lecture". It wasn't until I was in the role for a wee while that that was offered or suggested to me. Until that point I didn't realize it was a good thing and perhaps it was ok for me to do that. Initially I didn't get any formal orientation. No kind of real structure or anything around it, (I was) given a list of people and told these are the people you need to be supporting clinically. I wasn't quite sure what that meant. All I knew was I was responsible for their learning."*

Mary commented "*I did the dreaded Health and Safety orientation but no other orientation. When I started I was doing one day a week casual, with a lot of orientation from one colleague. Not from faculty. I don't think I had any formal orientation. I know when I started I was told the orientation was a buddy system, so that was my orientation."*

Dissatisfaction was voiced by Sally "*No orientation to students learning or the role. No orientation to the Institute, its values, its roles. I suppose I got the orientation to you need to go and do Health and Safety stuff, this is where you might find this, but it's not what I would call being an induction to an organization. I think that an orientation to the bigger organization, its values and to the faculty, its values and how it works would have been beneficial. To see how any organization works in the bigger picture is always good. You know, we are always told we need to have so many students, they need to be FTEs (Full time equivalent student) and I never really knew what that was. What does that mean? I've no idea what it means. So, you know, you kind of sort of learnt along the way. I always felt that "sink or swim", it was definitely that sort of vibe coming into working at the Institute*

Jill had a shared experience "*No orientation initially and then when it was discovered that I was quite nervous I did some work with a teacher from academic support. I had standard orientation package with Health and Safety, Information Technology which was useful".*

Although Stephanie, Vicki, Mary, Sally and Jill had insufficient orientation, Joanne did receive an orientation but it was inadequate for the role shift that was required of her.

Joanne*," I did have an orientation … but I felt I was floundering in the Academic Liaison Nurse role (a part of the nurse faculty educator role) for the whole semester. Part of it was I was in an inpatient setting, whereas I'd worked in a community setting, so that was a double role shift. So it was role shift from community to inpatient from clinical nurse to a lecturer. I found that first semester a real challenge".*

Though there were structures and processes within the faculty most of the participants found challenges with knowing these as a result of the sub optimal orientation program they received.

Stephanie explained *"There were processes in place, but sometimes people didn't follow them, or they weren't being affirmed or reiterated by staff. Probably in the last year it's become a lot more obvious, we're now putting processes in place to guide us. It was very unstructured, people doing their own thing. Now there were processes in place, but I felt – in my experience – people did different practices, they had processes, but the application wasn't followed through. If the processes were followed and applied as structured it would have absolutely been of benefit when I started"*

Vicki expressed that she felt disadvantaged by the late orientation process which, for her came too late in her initial employment. However being Maori, the Maori concept of whanau helped her to understand her role ahead of an official orientation.

"*It was a barrier in not knowing the processes within the institute. Not understanding why we couldn't change things. I've discovered I really knew nothing of the processes and the business of the academic institute as well as within my own faculty. My knowledge has increased over the months. I received a one day orientation 5 months later, with a powhiri to the whole of the institute.*

They put structures up and showed us all how programs come about, who's in charge of that ….. It should have been in the first week. Coming into this environment and being Maori I've been invited to a lot of meetings, which has helped my understanding of the faculty role."

Jill also felt frustration from the lack of time given to her orientation, "*Seemed double standards, some followed process other not. Flexibility and consistency would have been good too. The first year was extremely stressful for me, horrendously stressful for me; it took an awful lot of perseverance. I had a preceptor program leader who was so busy I hardly spent any time with her, and so I did not get much mentor support at that point of time. A formalized good length orientation and mentor with (a) structured program would have been extremely beneficial"*

Stephanie expressed that she was perturbed by the lack of her ability to answer simple questions. She perceived as a staff member, she should be able to give out relevant information. *"I remember being asked a simple question and I didn't know. The reason I didn't know was I'd never been told. I had no idea of the processes. I'd never thought to think about it. If I'd had a formal orientation a lot of this would have been addressed and I wouldn't have felt inadequate.*

It can be seen by Stephanie's and most of the other new faculty nurse educators above expressed comments that an effective comprehensive orientation would have decreased stress and allowed them to work efficiently.

In contrast to the frustration experienced by Stephanie, Vicki, Mary, Sally and Jill the benefit of a formal orientation program implemented as designed can be seen by Joanne's experience. This is amply illustrated "*I had a written orientation from the Nursing Faculty, which I followed. My preceptor met me in the car-park and she followed the orientation closely. Part of that orientation was an organizational orientation, so I went to I think 5 – 7 sessions over a period of about 4 weeks. They were half day sessions, and it was an orientation to Institute, Human Resources, Health & Safety, all of those base organization things. My nursing orientation to the faculty included just the nuts and bolts of*

things, when meetings, where the meetings, what meetings do we go to, how do I claim for car-parking money, where do I get an Identity card, where to I order a uniform, so a lot of those things the preceptor did with me. Plus she pretty much tucked me under her wing, so I shadowed her. I did pretty much everything she did. I did no teaching at all for the first semester, I observed and so I sat through, with the students, the whole programme of lectures. My orientation was supportive and I felt valued as a member of the team. "

Joanne expresses what a difference an effective orientation made to her adopting her new role as a nurse faculty educator in contrast to those participants who did not. One of those who did not was Vicki who expressed, *"Lack of understanding of the role was a barrier and lack of communication around what the role was. In the beginning, the need for clarity around what I do – I feel orientation would have been of huge benefit, to enable me to prioritize work".*

Vicki's experience was shared by other participants

Sally explained, *"I got most of my orientation further down the track. It's a whole school of knowledge, whole school of thought, whole different way of working and you can get quite confused, … Again, I think you learnt on the job, but it would have been great if the orientation had a time where you are introduced to that culture, the language, the cultural practices of how to access resources, and who can you access, who can you draw in for your students. I got more of an understanding of(my) role further along my journey……, it would have been nice to have done some of that before teaching*

Jill agreed "*A more structured orientation around some of the faculty things would of helped around large groups teaching."*

Stephanie added, *"With orientation it would make you a lot more focused and directed. I'd have felt more confident and competent and I would have been able to help the students more really as I would have had some of that knowledge and skills behind me"*

What has become evident from the participants expressed views is that a formal orientation can increase confidence and morale, reduce anxiety and contribute to a successful transition from clinical practice to nursing education. In addition, a thorough orientation allows the opportunity to understand the organizational structure, how each will fit into that structure and to make their contribution to the goals of that organization.

Expectations

Several participants voiced concern around not knowing what the expectations of their new role were or they felt their expectations were not met. Inconsistencies were found to exist between what some of the new nurse faculty educators expected and what they experienced. The faculty has a generalized job description which is Academic Lecturer: Practice. Primary Objective; to establish and maintain the highest standard of teaching and effective learning environment for students…… There follows a list of accountabilities which some participants saw and others did not. However when comparing the official job description when the participants were employed and what was experienced, there appeared a disjunction.

As Vicki expressed *"I feel I wasn't given a good understanding of the role and expectations. Not set out in any shape or form what the expectations were. I actually thought my role was going to be more of a clinical role. I didn't realize there was as much lecturing theory and I also thought it was more a community clinical role. Then upon arriving I was asked to go into the inpatient papers and lecture around that, it wasn't my background area of expertise so I found that challenging".*

"*I did talk to our direct line managers as well, around some of the team expectations; the team weren't clear on what I was going to do and how my time was going to split. So at times there were things double-booked in my diary and I didn't know who I should be pleasing, because I couldn't please everyone"*

What is apparent from Vicki's experience is that there would appear to be poor communication between the employing faculty and the operational faculty. This idea is reiterated by the following participants.

Jill expressed *"I had no prior knowledge around expectations re meetings and admin (administration). There was definitely some expectations of the team that were actually unrealistic given that I was in a new role".*

Sally reiterated Jill's experience *"I had very little knowledge of the role prior to coming in because I was kind of on the spot, and Mandy asked me if I'd like to come. I said "oh yes that would be quite good". I didn't actually understand kind of what it was all about, so it was quite different to what I initially thought it would be…… Additional Support in the role would have been nice I always felt that "sink or swim" feeling, it was definitely that sort of vibe coming into working at the Institute".*

Joanne echoed Sally and Jill's discomfort *"I came to the interview – what had been advertised appeared to be what the interview was all about. Actually when I arrived at the job it was a little bit different, so my expectation was not met, it didn't relate to what I was told".*

Mary expressed surprise at the amount of pastoral care and planning expected of her*." I've changed my view of what a faculty role is since doing the role. I think we spend an awful lot of time on what we call pastoral care; I don't think that's acknowledged. That is students ringing and texting you, coming to see you with issues related to their studies, but may be more personal issues, reasons that may be why they're struggling with study. Financial issues, trouble with relationships, sickness – I don't think people realize how much of our time that takes up and it is really difficult to say, to the student actually were not here for that go to Student Support. We can't do that because we're nurses and human and it is really difficult to do (send student away without supporting them yourself). That's a big aspect I didn't realize would be part of our job."*

Stephanie continues the theme of unexpected *"My idea of what a faculty educator was totally different from reality. My views have not changed, it's got worse. If the processes were followed and applied as structured it would have absolutely been of benefit when I started. You would have been very clear in direction of where you were going, your scope – in terms of the scope of practice".*

All the participants have expressed their experiences which show the importance of clarifying the nurse faculty educator role at interview with guidance on the workload, faculty expectations around attendance at meetings and to explain the full dimension of the role to avoid role ambiguity which is a known stressor when changing roles (Chien-Yu, Hsiao-Yen & An-Tien, 2012).

Resources

Resources for their new academic role in the form of technology, previous lecturer's tools and notes, timetables, classrooms and clinical suites were available and accessed well by all the participants. However time to fully get their heads around the information was found to be lacking and was the major issue. All of the participants voiced that there was a lack of time and that this was the major barrier to feeling that they were being effective in their new role. Although the faculty management work staffing levels to a formula to include preparation and lecturers' new learning to be teachers, the reality is that the new nurse educators found the workload unmanageable. They were unable to incorporate their learning into the practical setting.

As Joanne explained *"The thing I noticed the most I gained such a lot of information from the teaching toolkit and the Certificate of Tertiary Teaching, but you were unable to put them into practice. You were unable to teach and develop programs, your lectures and resources the way you are taught to do; you are unable to do it. There's no 'fat' in the system to cover your leave, so it's lack of resources. Lack of resources and time, it's the time resource I think. We have or we can get anything much else we need and we do have a lot of resources at our finger tips. But in order to use them, e.g. I-pads, to the best ability you need to be*

able to think what can I do with these, what's the best way for students to use them as a resource, not just put them in a classroom and hope they don't spend all the time on 'Face book'.

Although formal teaching preparation is provided by the institute for new teaching staff, the preparation does not emphasize what is involved in lecture and clinical preparation for a continuous teaching timetable that runs almost continuously throughout the academic year.

As Mary expressed *"Things like planning, I knew there'd be a lot of planning but again I don't think it's recognized how much planning there is to do. Time is spent, as far as I know people do planning in weekends, holidays and evenings. I know other people are struggling with time to fit it in, even though there's supposed to be dedicated time for it. I know from co-coordinating I don't get any less contact hours. It's a barrier to the educator role, to be a co-coordinator. There are some hours that are reduced, but nowhere enough for the co-ordination role".*

Sally also expressed her anxiety at the time pressures. *"We have such great time pressures that we can't deliver planning in our role. In an ideal world if we did have time it would take the stress off the person. Time pressures are why I was reluctant to approach people because I felt their workload was heavy. You work with your peers and you know they're all so stressed to the max".*

Jill also expressed her discontent at the lack of orientation to the true dimensions of the role. *"I wouldn't of said it was an easy transition although I'd done quite a bit of teaching beforehand. There were some barriers from various members of staff and expectations of workload, what I should be doing. Needing to attend all the faculty meetings added to workload, as well as all the staff meetings and planning days. We're supposed to have, team meetings so those actually took time away from the work you are meant to do. Floundered with new technology and no help and not having orientation re strategies for difficult student and cliques made it more nerve racking".*

As well Jill found that what was supposed to be prepared was not always available when it was needed. *"There was some time for preparation for lesson prep but if taking on someone else's session not always (were) the resources available even something as basic as lesson plans not available. The lesson plans not always available on the learning management system either, so you would have to find who had the PowerPoint for that (and find out) how it is supposed to run. Time constraints meant this caused me more anxiety".*

Stephanie wanted help." *I wasn't really familiar with the resources, definitely not really. I'm a good fiddler, I suppose, I fiddled with things to make that work. Learning, how to use the resources, e.g. the computers, the technical things we needed to learn, developing presentations – all those type of things. Developing materials. It wasn't just PowerPoint – ways of delivery, that's what I mean…One of the management at that time was very supportive in the way that she could be. If I needed particular resources I could go to her and she would usually be able to give me that, but I didn't know what to ask for"*

Vicki expressed her lack of understanding of the true dimension of the nurse educator's role." *Understanding of the amount of administration work and time it took I didn't have any knowledge of that area"*

However, though all participants struggled with the lack of time when it came to resources, Joanne and Vicki had a different and a much more positive experience.

Vicki stated, "*about resources that's been well supported, doing lectures for other lecturers they'll give you the tools and resources that they use and you're free to do it your way. A good support is being able to use others' resources, use the information and adapt it. It'd be hard to start from scratch".*

Joanne also expressed how much she appreciated receiving support. *"Equipment technology, I had never used a modern lecture theatre, but I was taught by my preceptor. Other equipment – I had used Information Technology stuff. There were things I learned to do. Because if I wasn't teaching I had the time to learn*

and I was able to go and spend time with the Information Technology people and sit in on tutorials. Large portion of time in orientation was hugely beneficial and eased my role change".

It is evident from the verbatim of the participants' experiences that what is espoused and what happens in reality is mostly incongruent. When a new faculty nurse educator successfully gains employment from a published job description the new staff member psychologically prepares themselves for what they expect from this description. However when adopting the new role they then find that the job description lacks the true dimension of the role stress, anxiety, doubt, discontent and frustration occurs.

Chapter 5.

Peer support and peer learning: "My peer was a saving grace"

This chapter outlines the second finding from the data, which was the importance of peer support and learning. Effective preceptors act as mentors and role model the academic role, transmit knowledge and provide emotional support to new faculty which then aids the new nurse faculty educators to learn the practice of being an educator.

Peer support

Formal mentoring did not occur for all participants, four of the six did not have a formal mentor. The participants all had expectations of peer support and peer learning, some of which were fulfilled and some were not .The formality of the approach to peer support varied as some participants had more structured arrangements with regular meetings and others were informal with no planned meetings.

In contrast peer learning was a very strong influence in welcoming and supporting new faculty. The informal support is not recognized necessarily at an official organizational level but what becomes evident from the participants statements is how essential it is in the orientation period. Peer learning can be described as interacting with each other and includes collaborative learning with interactions that share ideas, knowledge and experience. Peer learning was seen by all participants as beneficial but the opportunity for this varied greatly.

As Vicki expressed *"I had a mentor, but it's not structured. My understanding of what a mentor is and what my mentor's was is different. She was also a team*

leader, so her job is different. I feel a mentor in the same role and same site would have been better. A full time person available more often and a structured learning programme to the partnership would have been more beneficial. I would have liked the mentor to explain the role and directions for the day, and make themselves available – not me having to find them. It makes you more vulnerable not having direction and access".

She continued "*Other Peer support was minimal as they all had heavy workloads. But I also think my colleagues were very good about looking at what my areas of expertise were and looking at aligning with the programme and the subjects that were being taught. I could bring in my expertise and was more confident delivering that information. But I was anxious with unknown material."*

Although Vicki had a mentor and Stephanie, Jill, and Sally did have informal peer support it was felt by the participants to be inadequate for their role transition.

For example Stephanie "*I think my early initial experiences was really finding my way; there was no particular person who actually journeyed with you from the beginning. I got a lot of support from one colleague who was fantastic but she was with me for only 6 months. She was a peer support – it was not official. She was a buddy and she gave me guidance around what I needed to do, but it was initiated by myself and her. But due to her workload she was not always available when I needed her…… Without the peer stepping up to help I would have sunk and been disillusioned. I think it was a saving grace to have my peer".*

The informality experienced by Stephanie was echoed by Jill. She felt frustrated at the level of support available *"The team gave some support but everyone was under a high workload and therefore those people were too busy to give enough support. Peer support was not as good as I expected. I did get some orientation from another team member and I did not do heaps of teaching the first semester. I did some teaching later and then got orientated by my peer in relation to marking and clinical stuff".*

Sally also voiced her frustration at the lack of peer support initially although later in her employment, she did receive limited peer support. She states "*My peers, if they had the time, they would have been a bit more helpful. We have such great time pressures that they can't deliver that in our role. In an ideal world if we did have that, it would take the stress off the person….. You work with your peers and you know they're all so stressed to the max it would have been helpful to have someone, may be from outside, from another faculty. That you could have said," this is difficult for me", how do you strategize for that. It doesn't necessarily have to be within the faculty. A mentor from somewhere within the Institute that you could go and talk to about issues and concerns would be helpful. To be able to do this in a safe place and environment would have been very beneficial. I did receive some (peer learning) after being in the role for a little time. The peer learning was beneficial as we were similar in nature and I think that kind of helped having someone like that. It was still very much like you are on your own and I suppose I swam rather than sunk in my role. It was nice to think that I had that person to call on. I think for any new person coming in peer support is important. I think it's probably time constraints and workload impacts heavily on the ability for this to be done".*

Although Joanne received peer support, it was inadequate for part of the role shift required of her. As Joanne stated Joanne "*I was asked if I would I would be Academic Liaison Nurse (an aspect of the faculty role) in the Dedicated Education Unit (DEU) on a surgical ward. I didn't know what a DEU was and I had not worked in a surgical ward for 30 years. While I was given a very basic "this is what an Academic Liaison Nurse" does once you get into clinical it gets really busy and I didn't really get any help. I didn't know what I was doing and having a peer with me which would have been beneficial.*

In contrast, the benefit of having peer support can be seen by Mary's experience. The other new nurse faculty educators comments that effective peer support would have decreased stress and allowed them to more successfully manage their new role emphasizes the importance of including peer support in a structured formal orientation.

As Mary stated, "*When I started I was doing one day a week casual, with a lot of orientation from one colleague. Not from faculty. When I started full-time I felt totally supported by my team. I've been really supported, by colleagues, been supported to go to relevant conferences, do the training……. I feel supported because of my previous experience and colleagues. I was lucky to be buddied with someone who was excellent, who showed me around the Information Technology system, how to book rooms, everything really she went through the whole shebang. I was lucky – I'm not sure that everybody gets that. I'm quite positive about my role, I love the job – really enjoyed doing it. I've had lots of collegial support, which has actually made the transition a positive experience. The team I work with are really supportive".*

Moreover, in addition cultural support was identified as being important by two participants. They experienced stress living in one culture and working in another.

For example Vicki stated *"I like the environment, support from peers when time constraints allows. Being Maori I've been invited to a lot of meetings, which has helped my understanding of the faculty role and helped me connect to other colleagues who aren't on site. This colleague support has been a positive, it's an asset".*

But Stephanie also wanted a formal cultural mentor as she stated,*" Another a huge thing would be cultural mentoring, that would be have been really helpful for me in this environment. I really stress it was important for me, was to get cultural mentoring. Around having a practitioner that works with me…. a mentor is a credible person who is able to comment or give advice around the focus of what you are teaching, a resource person – really important".*

Peer Learning

As stated in the opening of this chapter peer learning and buddying was an important factor in welcoming and supporting new members of faculty to adapt

to their role transition. The dysfunction between new nurse faculty educator's expectations and the reality was re-iterated

As Stephanie expressed "*I don't think it was adequate – you need an opportunity to buddy with somebody, or be involved with that person in developing or updating. Peer teaching would have been great opportunity to get your foot in there with another person who already has experience where you can peer teach. That would have been a wonderful experience.*

Jill stated that she was upset by lack of peer learning available to her initially *"I think it would be interesting and helpful to be able to observe how your peers teach. Peer teaching should occur in the formal orientation period and would have been of enormous benefit. Debriefing and talking with peers would be helpful initially as it was beneficial when I got that from a peer from the academic centre eventually. I would have enjoyed my role much better. More peer* support, *better orientation and a mentor would have reduced the stress to normal levels when changing a job. I like my job now".*

In contrast however, Vicki, Joanne and Sally express what a difference the opportunity to peer learn made to them. Witnessing peers teach helped them to successfully adapt to their new role as nurse faculty educators more rapidly than those educators that did not.

As Vicki expressed "*By watching peers teach I think what I've learned is that the lecturers work differently, and it's ok to work in a different way. You're using the same information, but how you deliver that might be different".*

Sally also expressed the benefits of peer learning "*And then you go and watch somebody else and you think I quite like that, and then you adapt it to how it fits you. So I did a lot of peer watching. No formal orientation, I think it was mostly more peer review, where you sat in and watched someone and then next time you have a go. I think it would have been good to get feedback from a peer who sat in on the classroom on occasions and give ideas and positive reinforcement".*

Joanne agreed "*Peer learning situation was good because my preceptor just did what she does and I was able to see the way she does things and she was very thorough. I was able to see the way that I believed was the correct way to do things. I could also observe the other people in the department, so I chose to model myself on my preceptor. It worked well with the way I am as well…….Plus she pretty much tucked me under her wing, so I shadowed her. I did pretty much everything she did. I did no teaching at all for the first semester, I observed and so I sat through, with the students, the whole programme of lectures".*

In conclusion it can be seen peer support and peer learning were identified as important to a successful stress free role transition. The mentor needs to be a positive role model and be available to actively support the mentee. Equally the mentee needs time to shadow their mentor to develop skills and learn their new work environment. All participants expressed the need for a formal mentoring programme to be established with adequate resources to support it, so the mentor role could be implemented effectively.

Chapter 6

Unprepared: "New stuff to learn"

This chapter outlines the third finding, which is that five of the six participants felt unprepared for the nurse faculty educator role. Though all of the participants were experts in their clinical fields most of the participants felt unprepared for the practical side of teaching. This was irrespective of whether they had completed an educational course on teaching and learning or not. Additionally the participants were all surprised and unprepared for the level of administration required within their new role. What became evident to the participants was that the world of academia and the tertiary education institute have different values, social norms and ideology from nursing and the clinical environment from whence they had come. Although the participants anticipated that some adjustments would be needed they all experienced transition shock when entering the new educational community of practice.

Academic culture and language

An expert nurse clinician's socialization is different from academics so the role transition brings the potential for cultural shock and confusion. Cultural shock can be described as a personal disorientation and trauma that people may feel when faced with an unfamiliar way of life to what they have been used to (Roskell, 2013). When entering academia and a new culture, the participants discovered that the structure and social norms were not always available in written form. The new nurse faculty educators also discovered that in addition to the nursing language they were familiar with, education has a' language' of its own which they had to learn.

For example Vicki reported *"Expert to novice I think coming from DHB, the culture I understood and knew, into an academic environment where the core business is teaching, I think I understood the academic expectations and the role in that sense, but the structure and culture of an academic environment was quite new to me. I was trying to put everybody into a nursing hierarchy and structure – a health structure. It has now occurred to me it's an education structure. It was a barrier in not knowing the processes within the institute. Not understanding why we couldn't change things……. My knowledge has increased over the months".*

Stephanie echoed Vicki's statement. She states *" It's a whole school of knowledge, whole school of thought, whole different way of working and you can get quite confused, it's different the language they use, the concepts they used – you needed to learn that yourself. Again, I think you learnt on the job, but it would have been great if the orientation had a time where you are introduced to that culture, the language, and the cultural practices"*

Three other participants also reiterated the need for an explanation of values, social norms and the language of the new workplace early in their employment.

As Mary expressed "*The academic language, the different regulations is quite a biggie. Guidelines, getting your head around a lot of different acronyms, "like what does that stand for?" The language of education is totally different from health, e.g. talking about nursing as an 'industry' is quite different as I never thought of nursing as an industry.*

Sally struggled at times with the language "*Some of the language, definitely the language. Sometimes people would be talking about and you're thinking I should know, but I don't. They use abbreviations that I have no idea about and the faculty members do not necessarily coming forward to tell you what it was. They assume that you know, so I think that was kind of a barrier. It's about the language they use, in nursing we have our own language, and in education they have their own language".*

Joanne agreed *"It's about learning the language they used and the understanding of the culture. Even challenging what they do – because you know it's outdated and needs to change. Lots of new stuff to learn, new ways of learning the language (of) academia"*

These experiences of the participants show that adjustments had to occur to enter academia which had not been obvious to the new nurse faculty educators whilst practicing as expert nurse clinicians. Explaining behavioural customs and language can reduce the culture shock for new faculty and ease role transition.

Teaching preparation

The participants were all expert nurse clinicians but five out of six expressed feeling not being confident and doubting their teaching skills as they became familiar with the academic environment. Some participants had taught skills to peers as clinicians on a needs basis and one participant had completed post-graduate papers in education. However teaching in the academic setting requires a skill set of its own which has to be developed and is not a natural consequence of clinical expertise.

As Sally expressed "*I found it initially quite difficult moving from what I knew clinically to an educator role. Not really knowing how to educate, not having any education background as such. Although I had done some preceptoring and things like that. But it was different to be standing in front of a 60 students and actually teaching. I found that challenging. So having a mass of 60 people looking at you was an uncommon thing and scary.*

These thoughts were repeated by Vicki, she explained "*Prior knowledge of how students learnt? Not really, I had knowledge in the sense of how registered nurses learnt and pitching things at that level, but it was mainly needs based, so we would structure workshops…….But I was not sure I could teach at graduate level.*

What is evident is that the provision of teaching courses initially would be a worthwhile strategy and is confirmed by the experiences and comments from the participants. This would have helped alleviate the participants doubt and stress levels about the effectiveness of their teaching, as stated by Stephanie. "*I would teach in my role, but that was for practitioners, for my peers. This was not to undergraduate students. Definitely had no formal idea of how undergraduate students learn. One thing I quickly learned when I first started, in my approach and in my teaching I expected students to be at a different level of knowledge. My first learning's was not to do that and teach them at a post-graduate level, I had to really go back to the basics. It came to a point where I had to understand those things. Wasn't something that was told to me, I had to learn that, as I did the job. There was no offer of teaching skills initially. It came after and it was the Certificate of Tertiary Teaching, but that was 6 – 7 months after I started. Having this at the beginning would have been absolutely perfect"*

Jill also shared that the new faculty educator's role was not an easy transition. She stated *"I wouldn't of said it was an easy transition although I'd done quite a bit of teaching beforehand….. I actually had expressed at interview that I had not done a lot of large group teaching sessions and I would need support with that. But I didn't actually get any when I first started. When it was discovered that I was quite nervous I did some work with a teacher from academic support. We went through some of my sessions and looked at some different ways of restructuring them and getting the students to do some things which meant I wasn't talking all the time which was actually really useful".*

Vicki has some introduction to her teaching role which helped her a little but not entirely fit her role as she explained "I've *done the teaching toolkit since I've been here, that's helped. It confirmed stuff that I knew, but didn't know there were terms for, it formalized some knowledge I'd got from practical into a structure. Helped me plan lessons better in the sense talked about attention spans of people. How much information to deliver in one block before you have a break or change in what it is you're doing…..Whether it is your introducing using a visual aid or breaking up into small groups or back to talking. I think having a*

toolkit helped; it might have been a good thing to have had prior to lecturing and as part of an orientation programme at the start which would have lessened the frustration.

Sally also expressed the importance of teaching preparation for her new nurse faculty educator's role as she stated "*further along my journey I did Certificate of Tertiary Teaching. Its orientation to teaching and it would have been nice to have done some of that before teaching. The course did have some really good stuff, some good aspects because they would tell you how you might manage difficult situations in the classroom. It tells you about strategies and it would have been quite helpful before you started practicing. Because you could think and use the stuff instead of 6 months down the track when you're only just starting to do the course.*

In contrast Joanne expressed how the opportunity to attend a teaching course at the beginning of her employment enabled a less stressful and more successful adaptation to her new role as nurse faculty educator. She stated "On *how to teach, I did the teaching toolkit, it wasn't part of the Institute orientation, but it was on top of it. I attended toolkit sessions, so when I started it was a week before the holidays so everyone was on holiday and there was only two of us in the department. They'd booked me into the toolkit for that week, so I went down to the toolkit every day and found it massively useful. I learned lots of things, learned about classroom management. I also learnt about group work, how to maintain control of the classroom, lots of things I found really useful. I had never been taught them because I'm not a teacher, and haven't had teacher training. I found it really useful and the same month that I started I also started to work my way through the Certificate of Tertiary Teaching, which was a 4 semesters, 4 paper course, so I started that immediately and I found that helpful and added to the toolkit".*

In addition, the benefit of prior post-graduation studies in teaching and practical experience can be seen by Mary's experience. However, there were still

adaptations to be made by her as she stated, *"I think I came in with enough knowledge about student learning, but I've learnt stuff since. But I didn't feel I was unprepared when I came in because I'd been running a mandatory training course 20 days a year, so I did a lot of education any way and I'd done post-graduate studies in education, so I felt prepared. So it was a positive to do post-graduate education before I started. But prior work experience was helpful, more useful. I then went to do the teaching toolkit which was ok. This would have been of more benefit at the start. By the time I received it, it was a recap of stuff I already knew. I'm doing the Certificate of Tertiary Teaching at the moment, which is really helpful, but I've been here for 18 months… it's useful like it's the case of you don't know what you don't know until you're shown it. It's light bulbs going off! I think all new staff should be sent on to Certificate of Tertiary Teaching straight away especially the design and delivery."*

To conclude what has become evident from the participants statements is that they did not identify scholarship and research as areas of concern. However five out of six of the participants did not know what a good lecturer was and whether they were fulfilling the role of nurse faculty educator effectively. These concerns were part of the "cultural shock" they experienced. There was a consensus from their statements that there was a need for more practical guidance regarding the functional aspects of teaching and learning as they made the transition from expert nurse clinicians to the nurse faculty educator role. This would have alleviated the stress, doubt and frustration that most experienced as new nurse faculty educators.

Chapter 7.

Discussion and Recommendations

Introduction

The previous three chapters have presented the findings of this study. By using the qualitative research paradigm to discover and identify themes, the aim of this study was to enable improved retention and recruitment of qualified individuals to the nurse faculty educator role in order to support the quality education of nurses. The research question was "What are the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting?"

The final chapter will open with discussion of the three main themes identified by the findings of the study as areas the participants felt needed further development: orientation, unprepared and peer support and peer learning. The implications of the study for the retention and recruitment of qualified individuals to the faculty nurse educator role to support the quality education of nurses are considered along with further research. Finally the limitations of the study are identified along with recommendations for future research.

In the main the review of current and past literature and the findings from this study reveal that the work role transition from expert nurse clinician to nurse faculty educator is a stressful and intimidating period. The time of transitition is commonly associated with stress, vulnerability, anxiety and doubt (Niessen, Binnewies & Rank, 2010).

Orientation

The organizational configuration around the orientation process has a major impact when a work role shift is occurring. The new nurse faculty educators all

came in with sound self efficacy as they were all recognized experts in their specialized area of clinical nursing practice. This was clearly demonstrated by comments from all of the participants and expressed clearly by Vikki "I was coming from being an expert in my field" and repeated by Joanne "*My* background is in a specialized area, so when I moved from my role I was an expert". The participants all came with a thorough knowledge of the nursing profession and the theoretical content associated with the professional nursing field. However many found themselves losing their self efficacy during their first few months in their new role. Self-efficacy is developed from social cognitive theory which suggests that beliefs about ones' self-efficacy can be changed or increased by the effects of personal and environmental factors and the acquisition of skills developed within a social group (Bandura, 1977).

Therefore maintaining and increasing new nurse faculty educators' self-efficacy is essential as people with high self-efficacy work hard, persist and approach difficult situations as challenges instead of ignoring or avoiding them. This leads to retention of the workforce (Jin, Watkins & Yuen, 2009). To maintain the new nurse faculty educators' self efficacy it is essential that organizational structures are arranged to support new faculty members by providing an efficient, relevant orientation. Formal orientation programmes have been found to be crucial in keeping and motivating staff, increasing morale and reducing anxiety (Robbins, 2002). This formalized orientation needs to include orientation to the overall institution as well as the nursing faculty. Essential elements should include the review of mission, goals, values, organizational structures, policies, procedures and curricula (Bell-Scriber & Morton, 2009).

The knowing and understanding of the organizations values is important as some of the values of clinical practice that the new nurse faculty educators bring are different from the values needed for success in academia. Understanding the values and culture of the institution will alleviate anxiety (Schiner, 2007). Standardization of the role and an orientation that includes continuing clarification of the role*;* its boundaries, responsibilities, workload and faculty expectations help to avoid role ambiguity and will reduce stress, anxiety and

doubt when experiencing a work role transition (Chien-Yu, Hsiao-Yen, & An-Tien, 2012).

The new faculty nurse educator has knowledge of nursing criteria but little knowledge of educational obligations. Therefore the orientation also needs to include education requirements so the new faculty nurse educator can conform to and understand curriculum requirements to alleviate doubt, frustration and stress. Curriculum development in New Zealand is not only monitored by the New Zealand Nursing Council but also the New Zealand Qualifications Authority (NZQA Development of Degrees, 1995).

Faculty nurse educators leave their jobs when they believe management and the organization hierarchy fail to respond to their everyday concerns and queries, or they believe organizational practices are out of pace with reality. Today's socio-political and cultural health and education climate has resulted in nursing education policy being controlled by institutionally driven directives and not by the hands of the profession. Therefore a formal structured support for constructive two-way feedback in a safe environment is important and essential to ensure the new nurse faculty educators feel heard and trust is facilitated between nurse educators and management (Cash et al, 2011).

Unprepared

The new nurse faculty educators all come with expertise in their field but they have not necessarily have had the full skill set and knowledge required for the academic setting. Being able to teach is not intuitive and "New stuff to learn" reveals the need for the new nurse faculty educators to complete a graduate education course to alleviate stress and to deliver content in an effective and educationally sound manner. This course should include the components of curriculum development, teaching methods, teaching in the classroom, lesson planning, marking, testing, e-learning and the role of the educator which then provides a framework for the new faculty nurse educator to use when working with students (Billings, 2003; Murphy,2007).

Many educational researchers view teacher self efficacy as a major factor for effective teaching. Therefore, as well as gaining knowledge on "how to teach" it is important that the new faculty nurse educators retain their self- efficacy to ensure delivery of a quality education to student nurses (Martin, Mccaughtry, Hodges-Kulinna, & Cothran, 2008). Educators lacking instructional efficacy assume a custodial view of education typified by cynicism about student motivation and anger over student misbehaviour. A teacher with good self efficacy encourages students, creates more effective and explicit lesson plans, engages students in relevant academic discussions and spends time with struggling students, therefore ultimately increasing student learning (Bandura, 1977).

Self-efficacy can be seen as the belief that engaging in certain behavior*s is* most likely to bring about the preferred outcome. This belief emerges from the cognitive theories of social learning and is based on the response-outcome expectancies, so self efficacy also affects the way people face challenges and the choices that a person makes. Therefore their levels of anxiety about their performance as teachers could be reduced by not only including principles and theories of adult learning, but skills of teaching with the background practices of connecting, constructing, interpreting and knowledge of technology into the orientation period. Reduction of anxiety and stress levels would mean new faculty nurse educators would then be less likely to focus solely on measures to retain jobs and would continue increasing their expertise in teaching (Bandura, 1977, Young & Diekelmann, 2002, Siler & Kliener, 2001).

In addition, to relieve stress and anxiety new faculty nurse educators need to be enrolled in courses on how to access and use resources such as equipment used by the faculty, the library, computerised systems within the faculty, relevant databases simulation*s* and web based courses. The importance of continuing education, learning, training and development are usually considered to be valuable practices and investment not only for the organization but also for the individual, who will then function more efficiently and effectively. Contemporary studies have revealed that ongoing training and development affect*s* job

attitudes and that the provision of an effective professional development program has a positive effect on an employee's commitment to stay with an organization (Gazza & Shellenbarger, 2005, Chew & Chan, 2008).

Peer support and peer learning

"My peer was a saving grace" demonstrates the need for effective, supportive preceptors who act as mentors and ~~role~~ model best practice, transmit knowledge and provide emotional support. This collaborative learning with interactions and sharing of ideas enables the new nurse faculty educators to learn the practice of being an educator. Bandura (1977) believed that self efficacy came from watching others and receiving feedback in direct and indirect ways. As well Vygotsky highlighted the importance the role of social interaction has on learning and when collegial sharing of ideas, practices and insight occurs a rich learning environment transpires (Tosey & Gregory, 2002).

Sharing within a safe confidential supportive environment and the opportunity to reflect, evaluate and problem solve can ease the work role transition. Both formal and informal interaction between mentor and mentee can have an important role in boosting the confidence of the new nurse faculty educator (Barnard et al., 2011). In addition a formal cultural mentor for minority nurse faculty educators would provide additional support in their new environment. Minority faculty can face additional challenges as they often provide support for minority students as well as experiencing stress from working in one culture and living in another (Moody, 2004).

Due to the current socio-economic climate heavy workloads are the norm for nurse faculty educators so the adequate provision of time can be a challenge for the preceptoring relationship (Gage & Hornblow, 2007). However when the organization establishes the resources and time for a mentor programme, both formal and informal learning encounters between expert and novice will lead to the development of knowledge, skills and identity. The new nurse faculty educator will then have reduced stress levels, anxiety and doubt (Smith & Zsohar, 2005). As a result of dual governance, both mentor and mentee require

allocated time to maintain competency in both academic and clinical roles as the New Zealand Nursing Council expects that faculty members who teach clinical courses maintain clinical competence (Nurses Act, 1997, Nurses Amendment Act, 1994,).

Thus if the organization provides allocated time for the mentee to shadow their mentor to develop their skills and learn about their new work environment, individual success and retention in the academic setting will occur. It is fair to deduce that the organizations with the most sustainable learning are those who best support formal and informal learning. It can be seen that faculties that have a programme and resources to support formal and informal learning produces new faculty nurse lecturers having more sustainable learning. The flow- on effect will then be the delivery of a sound quality education to nursing students (Christiansen & Bell, 2010).

Implications of this research

The findings of this thesis demonstrate a lack of preparedness of the expert nurse clinicians moving to the nurse faculty educator role. Highlights discovered included the difficulties that the expert nurse clinicians had moving to the faculty educator role and the need for them to undertake a formal tertiary teaching preparation course so they can teach adult nursing students with an educationally sound approach.

The ways that new nurse faculty educators are integrated into their new role requires review. A shifting and changing socio-political and cultural health and education environment demands a different approach if they are to fit the world of the future and remain within the tertiary nurse faculty setting.

A commitment from management is required to identify and prepare new nurse faculty educators educationally, administratively and to allow time for research. Leadership within the tertiary setting must work out a way of budgeting for this support to be provided at optimum levels

New nurse educators need to commit to and access orientation programs and formal mentoring when provided. The establishing of a positive relationship with a mentor or another role model within the faculty will ease the transition. The new nurse educator should identify and take all opportunities to attend education on teaching pedagogy and methods to develop and improve their teaching skills. This will then ensure the retention and recruitment of qualified individuals to the faculty nurse educator role to support the quality education of nurses.

Research Strengths and Limitations

The participants in this study were all articulate, knowledgeable and willing to discuss and describe their experience during the work role transition. Limitations of this study include that research using qualitative descriptive studies based on hermeneutic phenomenology cannot predict future events. Qualitative descriptive research use can also be limited as the research and interpretative process is time consuming and requires commitment and involvement from researcher and participants. Strengths include providing new insights and understandings of phenomena that can be useful in identifying issues and concerns.

The size of the study is also a limitation. The research contains only six participant's voices and their experiences in their work role shift from one tertiary setting within New Zealand. However the literature supports many of the same themes and challenges in the work role transition from expert nurse clinician to nursing academia worldwide. Another limitation is that the participants conversed with me for only approximately one hour of their time and in that period data was cumulative. Excerpts only were placed into the research report of necessity. The risk of personal interpretation of the responses is acknowledged.

Recommendations for future research.

Additional research within nursing faculties in tertiary settings in New Zealand would validate these findings and identify whether the description is representative of other new nurse faculty educators.

Future research could explore "What keeps expert nurse clinicians in faculty and academia?"
"How can experienced nurse faculty educators establish beneficial partnerships with new members of faculty?"

Within the participants there were two minorities nursing faculty educators who experienced some different barriers. The need for a culturally diverse workforce is vital to meet the needs of an increasingly more culturally diverse population. Students have better outcomes when there is access to an educator from the same ethnic background. Future research could explore "What practices will encourage recruitment and retention of minority nursing faculty?"

The information gained from future studies would continue to clarify the form and nature of resources and support needed to recruit and retain qualified individuals to the faculty nurse educator role to support the quality education of nurses.

Concluding statement

This study used a qualitative phenomenological approach to explore the experiences of expert nurse clinicians moving to the faculty nurse educator role. Themes developed which showed that the expert nurse clinicians bring clinical expertise and professional knowledge to the work role transition to academia; however support is needed to develop the skills to be an effective nurse faculty educator and to alleviate stress, anxiety and doubt. This support should include a formal orientation program tailored to the needs specific to the new work role, including access to role models and mentoring from within the nursing faculty and the wider educational facility. As many expert nurse clinicians' tend to lack education in teaching, new nurse faculty educators should have an opportunity

to learn the skills of teaching pedagogy through a formal education program at university level, not through trial and error experience. Having the right support and resources can help in the transition and may mean the difference between retention and exodus. Role transition can be overpowering but clearly the desire to teach and the passion for learning for some nurse faculty educators offsets the barriers and challenges.

Finally for those undergoing or thinking of undergoing a work role shift from expert nurse clinician to the role of nurse faculty educator the findings could offer some insight into what is ahead.

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New Zealand Legislation

Education Act (1989). Section 162(ii) and Section (iii).

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Nurses Registration Act. (1901).

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Appendix 1: Participant Information Sheet

Date Information Sheet Produced:

25th March 2013

Project Title

An exploration of the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting: a qualitative descriptive study

An Invitation

My name is Toni Monson and I am a postgraduate student and this research will contribute to a Masters of Education. I am currently employed as a lecturer on Bachelor of Nursing at Manukau Institute of Technology. This research aims to explore your experiences as an expert nurse clinician who has made the work role transition to the position of nurse educator within a tertiary institution.

Your participation in this research is voluntary. You may withdraw from the research at any time without giving reasons and there will be no adverse consequences to yourself. As some of you may be known to me, the information session about the research project and the consent you will give to participate will be carried out by a lecturer from the Education department of Manukau Institute of Technology. There will be no advantages or disadvantages if you either choose to participate or not.

What is the purpose of this research?

The purpose of this research is to explore your experiences in making the transition from nurse clinician to faculty nurse educator within a tertiary institution. The completed research will form a thesis by which I will gain a Masters of Education qualification.

How was I identified and why am I being invited to participate in this research?

You have been identified as having moved to the role of faculty nurse educator from expert nurse clinician role and meet the criteria:

- having worked the last two years in a New Zealand tertiary education faculty
- been working a minimum of 0.6.FTE
- experiencing the full range of responsibilities of the role.

Your details were obtained through the Faculty of Nursing and Health Manukau Institute of Technology

Approved by the Auckland University of Technology Ethics Committee on 26th March 2013, AUTEC Reference number 12/328

What will happen in this research?

You participate in an individual interview and will take approximately one to two hours. The interview will take place at a location and time convenient to you. Your interview will be audio taped and you can request that the recording be stopped at anytime and request that part or all of the tape to be erased. The tapes will be transcribed and neither you nor your place of employment will be identified in any transcription, or subsequent research or publications.

What are the discomforts and risks?

You may experience some discomfort if unpleasant memories surface.

How will these discomforts and risks be alleviated?

You may stop the interview at anytime. For participants who are Maori the Kai Awhina will be available for support and advice. Counselling will also be available if needed for other participants.

How will my privacy be protected?

Every effort will be taken to ensure confidentiality is maintained as neither you or your place of work will be identified. All copies of tapes and transcripts will be held in a secure storage at AUT University. There is also an agreement that the transcriber maintains confidentiality.

What are the benefits?

Whilst there will be no direct benefit to you as a participant, the research will be useful in identifying factors that enabled successful role transition, as well as areas of concern. This could be important in the future for new faculty educators and may help in the recruitment and retention of qualified nurse educators in tertiary education institutes.

This research will benefit me as it will help to the completion of thesis for Masters of Education.

What are the costs of participating in this research?

There will be no financial cost, but participating will take one to two hours of your time.

What opportunity do I have to consider this invitation?

An information session will take place where you will have time to ask questions. After this, you will be given a week to consider this request before you need to give consent. Returning the signed consent form will indicate your willingness to participate.

You will be, however free to withdraw from the research project at any time by contacting the researcher or the supervisor by e-mail.

The completed transcript of your interview will be returned to you for verification before being analysed. At the completion of the research, you may request a summary of the research.

Will I receive feedback on the results of this research?

You can request a copy of the research report by indicating on your consent form in the appropriate place.

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Approved by the Auckland University of Technology Ethics Committee on 26th March 2013, AUTEC Reference number 12/328.

This version was last edited on 13 October 2010

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Anne Grey, Senior Lecturer, anne,grey@aut.ac.nz, 09- *921 9999 ext 7231.*

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz*, 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Toni Monson. Toni.monson@manukau.ac.nz, DDI 259 9680

Project Supervisor Contact Details:

Project Supervisor, Dr Anne Grey, Senior Lecturer, anne,grey@aut.ac.nz, 09- *921 9999 ext 7231.*

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Approved by the Auckland University of Technology Ethics Committee on 26th March 2013, AUTEC Reference number 12/328.

Appendix 2: Consent Form

For use when interviews are involved.

CONSENT TO PARTICIPATION IN RESEARCH

Title of project: An exploration of the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting: a qualitative descriptive study

Researcher: Toni Monson

I have been provided with a written and verbal explanation of this research project.

I have had an opportunity to ask questions and to have them answered and understood the explanations.

I consent to the interview being audio taped and I understand that I can request that the recording can be stopped at any time and for parts or all of the tape to be erased.

I understand that the tape will be transcribed and neither I nor my place of employment will be identified in any transcript or subsequent research report or publication.

I understand that I may withdraw myself or any information prior to completion of data collection, without explanation or being disadvantaged in any way.

If I withdraw I understand that all relevant tapes and transcripts, or parts thereof will be destroyed.

I understand that the initial findings will be available to me for feedback.

I agree/ do not agree that the data collected during this research can be kept by the researcher and used in conjunction with future research studies in this area.

I agree to participate in this research.

Participant's signature:

Name:

Date:

I would like to receive a copy of the research findings. Yes/No

Approved by the Auckland University of Technology Ethics Committee on 26/03/2013 12/328

Appendix 3:

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: An exploration of the experiences of expert nurse clinicians moving to the role of faculty educators in a New Zealand setting: a qualitative descriptive study

Project Supervisor: Dr Anne Grey

Researcher: Toni Monson

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

……..

……..

……..

……..

Date:

Project Supervisor's Contact Details (if appropriate):

Dr Anne Grey, Senior Lecturer, anne,grey@aut.ac.nz, 09- *921 9999 ext 7231.*

Approved by the Auckland University of Technology Ethics Committee on **March 2013, AUTEC Reference number 12/**

Note: The Transcriber should retain a copy of this form.

Appendix 4

TRANSCRIPT EXAMPLE

Joanne

It was a big change, a very big change, for me. I had never taught undergraduate students before, I had only taught mostly post-grad, registered nurses with an interest in the specialist area that I was working in, and so although I had lots of experience in teaching those people I didn't have any experience in teaching people that didn't have a foundation in nursing. And so, I quite quickly realized that their understanding around the wider issues that go with, anything to do with nursing, was absent and so you had to teach very differently. I had talked to families and so the language, the specialist language you would use when teaching to a group of nurses who are interested in that is different to the language you use to a family when you are talking to them about how to treat someone who is needing health care. So I had to use that kind of language with the students. So that wasn't such a big deal, it's just that it had to be, you have to really examine the way you teach things, so that you impart the foundation stuff that they need to understand to move on.

I did have an orientation. I didn't really, I had no understanding at all about the way that people learn, not really. Or different methods of teaching. I have done it, but it has been something I've developed intuitively not from any formal training. When I started there was, I had a written orientation from the Nursing Dept, which I followed. My preceptor met me in the car-park and she followed the orientation closely. Part of that orientation was an organizational orientation, so I went to I think 5 – 7 sessions over a period of about 4 weeks. They were half day sessions, and it was an orientation to Institute, HR, H&S, all of those base organization things. My nursing orientation to the department included just the nuts and bolts of things, when meetings, where the meetings, what meetings do we go to, how do I claim for car-parking money, where do I get an ID card, where to I order a uniform, so a lot of those things she did with me. Plus she pretty much tucked me under her wing, so I shadowed her. I did pretty much everything she did. I did no teaching at all for the first semester, I observed and so I sat through, with the students, the whole programme of lectures which I found frustrating. I didn't get an opportunity to teach half of a session with someone watching. Not at all. Actually it would have been really nice to have taught a session, I didn't really need. I felt what I really wanted to know really is the way I think I should teach these students, is it appropriate. I didn't get an opportunity to do that. When I did start teaching I was just left to do it, by myself. But my orientation was supportive and I felt valued as a member of the team.

So eventually you do sessions, where someone else pops in or someone helps do a session and then I got some feedback. But the first instances I had to really just 'go on the hoof', I

think about the feedback. You getting your feedback from the body language, whether they're paying attention, or whether you've lost them.

On how to teach, I did the teaching toolkit, it wasn't part of the Institute orientation, but it was on top of it. I attended toolkit sessions, so when I started it was a week before the holidays so everyone was on holiday and there was only two of us in the department. They'd booked me into the toolkit for that week, so I went down to the toolkit every day and found it massively useful. I learned lots of things, learned about classroom management. I also learnt about group work, how to maintain control of the classroom, lots of things I found really useful. I had never been taught them because I'm not a teacher, and haven't had teacher training. I found it really useful and the same month that I started I also started to work my way through the CTT, which was a 4 semester, 4 paper course, so I started that immediately and I found that helpful and added to the toolkit.

Peer learning situation was good because preceptor just did what she does and I was able to see the way she does things and she was very thorough. I was able to see the way that I believe the correct way to do things. I could also observe the other people in the department, so I chose to model myself on my preceptor. It worked well with the way I am as well.

But I didn't get a very good clinical orientation. I was asked if I would I would be Academic Liason Nurse (an aspect of the faculty role) in the DEU on a surgical ward. I didn't know what a DEU was and I had not worked in a surgical ward for 30 years. While I was given a very basic "this is what an Academic Liason Nurse" does once you get into clinical it gets really busy and I didn't really get any help. I didn't know what I was doing and no peer with me which would have been beneficial.

I got good orientation to the academic lecturing side, but to the clinical I felt I was floundering in the Academic liaison nurse role for the whole semester. Part of it was I was in an inpatient setting, whereas I'd worked in a community setting, so that was a double role shift. So it was role shift from community to inpatient from clinical nurse to a lecturer. I found that first semester a real challenge.

Barriers: The thing I noticed the most I gained such a lot of information from the teaching toolkit and the CCT, but you were unable to put them into practice. You were unable to teach and develop programmes, your lecturers and resources the way you are taught to do; you are unable to do it. Sometimes it is because it's a lecture theatre with stacked seating, so you cannot do group work as the students cannot turn around, they can't move, they're stuck in a small environment facing the front. You can't, and just the way we are taught to teach about the blended delivery, it's very very hard to do it. First of all the number of students you've got, but also with the amount of time that's available. It's lack of resources,

lack of timing allowing you, so that was a huge barrier. Really odd that they would spend all this time and money teaching a way that they want you to deliver then you are actually not given the resources to deliver in the actual job that you're in.

Why come into the job? I was ready for a change and I saw the advert and it sounded like something I would be interested in. I've always enjoyed teaching, I've enjoyed helping people to learn and it sounded very appealing. I came to the interview – what had been advertised appeared to be what the interview was all about. Actually when I arrived at the job it was a little bit different, so my expectation was not met, it didn't relate to what I was told.

My idea of what the role is has changed over the past few years, definitely. I see more clearly what it is I think it is easy for people to look at your title, Senior Lecturer and have an idea of what you might be doing. It's massively busy in the semester we teach in, there's a lot of content plus there's a lot of clinical stuff to cover. I think it's easy to think that you've got lots of holidays, that there is generous PD leave, but it's hard to fit it all in. But to fit it all in is a mighty challenge. It's a barrier trying to get leave and to develop your own lessons. If you're on a block course, that you have no choice but to attend. The reality is when you get back trying to fit 5 days into 2 days because nobody covers you and your students have to be seen. They may have been supervised in a general manner, but the day to day stuff isn't done. There's no 'fat' in the system to cover your leave, so it's lack of resources.

Equipment technology. I had never used a modern lecture theatre, but I was taught by my preceptor. Other equipment – I had used IT stuff. There were things I learned to do. Because if i wasn't teaching I had the time to learn and I was able to go and spend time with the IT people and sit in on tutorials. Large portion of time in orientation was hugely beneficial and eased my role change.

Just to say that I really like my role here, I love the variety. I like to be busy, maybe I seem to be complaining, but I don't mean to be like that. I think that in order for us to be able to deliver the best programmes and in order for us to be good teachers we actually need to have some time that you pinch a few hours here and there, stay late one day. It's about. You have to evolve your teaching as you go along. We end up doing it in the hour before we go to the classroom. That isn't the best way to teach and if that time was available that little pocket of time that you could have a fortnight that would make a huge difference to the role. I feel as though I am constantly not doing my best because of the time constraints. Lack of resources and time, it's the time resource as I think we have or we can get anything much else we need and we do have a lot of recourses at our finger tips. But in order to use them, e.g. I-pads, to the best ability you need to be able to think what can I do with these, what's the best way for students to use them as a resource, not just put them in a classroom and hope they don't spend all the time on 'Facebook'.

I felt the formal orientation and the peer learning was very beneficial. The major barrier was around time resource.