

**NATURE OF PRECEPTORSHIP AND ITS IMPACT ON CLINICAL
NURSING CARE FROM THE PERSPECTIVES OF RELEVANT
NURSING STAFF**

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DEFINITION OF TERMS

Newly hired

Equated to a person who had been employed in particular position for the first time. This includes newly qualified nurses or new graduate nurses who had just left the University with a bachelors degree or an experienced nurse who joined the workforce as a new staff member.

Newly hired experienced nurse

Equated to those nurses who had a minimum of one-years post-graduation clinical experience and came from another hospital either inside or outside Saudi Arabia.

Preceptorship

Represented an organised clinical education programme whereby an experienced, competent senior staff nurse facilitated the integration of a newly hired experienced nurse into her/his role and responsibilities in a new clinical setting. This integration into the new practice environment was achieved via the instigation of a professional, supportive, one-to-one relationship between the preceptor (senior staff nurse) and the preceptee (newly hired experienced nurse) over a flexible but limited time frame.

Preceptor

Equated to an experienced registered nurse (RN) who acted as a role model, guide, counsellor, teacher and resource person to assist the newly hired experienced nurse adjust and adapt to the new clinical setting during the preceptorship period.

Preceptee

Represented a newly hired experienced nurse who needs to be adjusted to the clinical area, and learn the necessary skills and procedures to practice independently and competently and provide the required quality of nursing care to patients.

Preceptorship goal

Preceptorship goal represented the desires of the organisation which were to facilitate the preceptees' integration and socialisation into their new role in order to provide the required quality of nursing care to patients competently and independently, within the boundaries of the organisation's standards of care.

Preceptorship requirements

These represented the generic and unit based skills, procedures and competencies that each preceptee needed to accomplish by the end of the preceptorship period in order to be qualified to provide independent nursing care for patients.

Clinical Resource Nurse (CRN)

In the study hospital, the clinical resource nurse was defined as a clinical nurse educator who acted as a resource person for a particular unit's nursing staff and was responsible for planning and developing a formal education programme. S/he provided appropriate learning resources to support new members of staff (preceptees) to meet the preceptorship requirements; foster their involvement in clinical decision making and enhance preceptees' professional competence and confidence.

ABSTRACT

THE UNIVERSITY OF MANCHESTER

ABSTRACT OF THESIS submitted by Elham Ali Bukhari for the degree of Doctor of Philosophy and entitled Nature of preceptorship and its impact on clinical nursing care from the perspectives of relevant nursing staff. **December 2011**

Background: previous studies have revealed that newly hired nurses experience stress and anxiety when entering a new clinical setting. Failure to support and prepare these nurses may affect their ability to deliver the required level of nursing care. Preceptorship is a time limited, organised clinical instructional programme, which promotes staff development, improves nursing education, reduces nursing shortages, promotes staff retention and decreases staff turnover. Little evidence expounds about how newly hired nurses perceive preceptorship. The impact of preceptorship on the clinical nursing care of newly hired experienced nurses has not been investigated or verified globally neither has it been investigated from a Saudi context.

Aims and Objectives: the study aimed to explore the nature of preceptorship and its impact on clinical nursing care as perceived by the nurses who had taken part in a preceptorship programme in Saudi Arabia. The study elicited the participants' understanding and expectations of the preceptorship programme in an attempt to identify those factors that may be directly related to the success or failure of the programme. Furthermore, it aimed to examine the role of preceptorship in developing the clinical practice of newly hired experienced nurses.

Methodology: a qualitative design based on the principles of naturalistic inquiry underpinned this study. Thirty national and international nurses of five different grades across wards in one Saudi hospital were first purposively and subsequently convenience sampled to take part in the study. Most participants were of international origin, possessing various levels of experience and education. Preceptees were younger and less experienced than other programme stakeholders. Data were generated using tape-recorded semi-structured individual and focus groups interviews. This action was also supported by a review of the hospital's preceptorship policy documents. All the interviews were transcribed verbatim and analysed concurrently using thematic analysis based on a constant comparative method.

Findings and discussion: Six themes were derived from the interview data to generate an account of participants' experiences. Social learning theory was used as an explanatory framework for understanding the study's findings. Thus, preceptorship was seen as an important supportive, learning process, although inconsistencies were highlighted related to the participants' understanding and expectations of the programme. The duration of preceptorship was also contested with some needing longer than allocated. Hence, confusion arose regarding when preceptorship should begin and end due to ambiguities within the preceptorship policy documentation. Furthermore, participants perceived preceptorship had a mixed impact on clinical nursing care depending on preceptee/preceptor preparation and workload. Surprisingly recruitment was found to have the biggest impact on the success or failure of the preceptorship programme an unexpected and new finding highlighted by this study.

Conclusion: preceptorship is important for the integration of newly hired experienced nurses into their new roles. The meaning of preceptorship as applied to each hospital needs to be defined and articulated clearly and concisely. In order to meet the objectives of preceptorship, policy documentation needs to be clearer, and recruitment processes need to be reviewed in order to match both preceptee experience and qualifications with organisational requirements.

DECLARATION

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

This work is dedicated to all my family members and to my mother in particular. I thank them for their continuous support and prayers.

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Chapter 1

INTRODUCTION

1.1 Introduction

This thesis is concerned with the nature of preceptorship and its impact on clinical nursing care. A major focus of the work is on the experiences and perceptions of the key stakeholders involved in preceptorship programmes namely preceptees, preceptors, nurse managers, nurse educators and clinical resource nurses¹.

The recruitment of competent highly qualified nurses is recommended by all health care organisations (Leigh *et al* 2005). Therefore, given the current, universal nursing shortage, it is accepted that teaching and educating newly hired² nurses within the clinical setting is important in order to produce competent practitioners and enhance retention rates. Continuous education enables nurses to build their knowledge, skills and attitudes by helping them integrate theory with practice (Guhde 2005).

Nevertheless, the need to recruit overseas nurses in order to solve the problem of nursing shortages globally and more especially in the Kingdom of Saudi Arabia to meet existing patient care demands is now an imperative. However, recruiting nurses from abroad can have a serious impact on both the quality of nursing care and patient safety (Habermann & Stagge 2010). Different nursing backgrounds, experiences and health systems need to be accommodated by the new employing organisation, which could be similar to or totally alien from the health care system encountered previously. Furthermore, when such nurses enter the workforce, they can experience stress and anxiety and/or an unexpected culture shock (Leigh *et al* 2005).

For example, immigrant staff can be frustrated by the difficulties they face in forming professional relationships with new colleagues, which may result in loss of confidence, and/or fear, which is often associated with lack of knowledge regarding

¹ **Clinical resource nurse**, in the study hospital, was defined as a clinical nurse educator who acted as a resource person for a particular unit's nursing staff and was responsible for planning and developing a formal education programme. S/he provided appropriate learning resources to support new members of staff (preceptees) to meet the preceptorship requirements; foster their involvement in clinical decision making and enhance preceptees' professional competence and confidence.

² **Newly hired** equated to a person who had been employed in particular position for the first time. This includes newly qualified nurses or new graduate nurses who had just left the University with a bachelors degree or an experienced nurse who joined the workforce as a new staff member.

new clinical practices (Ashurst 2008). As a result, such staff find it difficult to adapt to new clinical practices, workload demands or the need to integrate effectively into the new environment and/or culture. In essence, all of the latter have the potential to impact on the nurses' job satisfaction (Giallonardo *et al* 2010). Accordingly, failure to support and prepare these new nurses for their working role may affect their ability to deliver the level of clinical nursing care required (Leigh *et al*, 2005). This in turn may affect the retention of new nurses within the health system (Griffin *et al* 2002, Bain 1996).

There is consensus within the literature that using a preceptorship programme for nurses in any healthcare organisation is an important feature, helping to reduce the theory-practice gap (Kaviani & Stillwell 2000). For example, preceptorship helps to facilitate nurses' transition into new clinical settings or socialise them into a new role (Guhde 2005), foster professional development and enhance their confidence in practice (Bourbonnais & Kerr 2007). Preceptorship also improves the quality of nursing education and practice, thereby helping to reduce nursing shortages, by promoting recruitment and staff retention (Harbottle 2006). Thus, preceptorship has been shown to increase job satisfaction and decrease staff turnover (Charleston & Happell 2004, Lambert & Glacken 2004).

Recognition of the above benefits of preceptorship provided the necessary impetus for the development and implementation of preceptorship programmes for supporting, training and orientating new nurses to clinical settings internationally. Consequently, it is a strategy that organisations use globally to support new nurses, including newly qualified nurses, new graduate nurses and nurses re-entering the workforce (Farrell & Chakrabarti 2001). Currently, therefore preceptorship programmes are considered an important part of the orientation package for new nurses (Kaviani & Stillwell 2000). Hence, preceptors are seen as essential resources, whereby they act as 'ambassadors' for an organisation (Farrell & Chakrabarti 2001).

In the literature, preceptorship has been examined across a wide range of studies (Giallonardo *et al* 2010, Gleeson 2008, Nisbet 2008, Charleston & Happell 2005, Myrick & Yonge 2002, Kaviani & Stillwell 2000, Bain 1996). Some have examined the perceptions of preceptees, preceptors and nurse managers regarding

preceptorship (Nisbet 2008, Billay & Yonge 2004, Allen 2002, Ohrling & Hallberg 2001, Ohrling & Hallberg 2000) while others have explored the role of the preceptor (Ashurst 2008, Clynes 2008, Bourbonnais & Kerr 2007, Charleston & Happell 2005, Ohrling & Hallberg 2001, Ohrling & Hallberg 2000). Most studies however, were concerned with describing the development and implementation of preceptorship programmes within their particular setting (DeCicco 2008, Wood 2007, Ridge 2005, Griffin *et al* 2002, Diehl-Oplinger & Kaminski 2000), or evaluating its effectiveness (Lee *et al* 2009, Scells & Gill 2007, Leigh *et al* 2005, Davis *et al* 2004, Kelly *et al* 2002). Only a small number of studies have explored the effect preceptorship had on clinical performance (Kim 2007, O'Conner *et al* 2001) and on students' critical thinking (Myrick & Yonge 2004).

Although many studies have examined preceptorship, there is still a lack of empirical data regarding preceptorship in nursing (Harbottle 2006). Furthermore, there is no clear definition of what the term preceptorship means in the literature since each study appears to adopt a definition appropriate to itself (Kaviani & Stillwell 2000). Application of preceptorship programmes have been poorly and inconsistently developed within the clinical practice arena due to a lack of focus in respect of the guidance detailing how preceptors should engage in the preceptorship process (Duffy 2009, DeCicco 2008, Clark & Holmes 2007, Charleston & Happell 20004, Allen 2002). Additionally, despite organisations investing in preceptorship programmes, problems concerning patient safety and quality of nursing care still exist (Habermann & Stagge 2010). Hence, further research is required to explore the meaning and full potential of preceptorship, and to evaluate the impact preceptorship can have on preceptees' clinical development (Harbottle 2006, CNA 2004).

These empirically based recommendations for further research echoed my own informal conclusions based on my personal experiences of preceptorship as outlined briefly in the subsequent section and articulated more fully in section 3.10.1 in the methodology chapter page 143.

1.2 Researcher's background of the study

During my nine years as a qualified nurse, I have experienced preceptorship from the perspective of a preceptee, preceptor and clinical resource nurse within one surgical

paediatric unit in Saudi Arabia. Reflecting on these clinical experiences, I noted that some nurses who had experienced preceptorship had not appeared to gain any benefit from it. Such nurses were those who were newly hired experienced nurses³. Evidence amassed from the literature regarding newly qualified nurses experiencing difficulty settling into new health care systems equated with my own observations

For example, I observed that some newly hired experienced nurses had problems integrating into the clinical area when they come from different cultures. Thus, the latter were observed to be anxious and stressed, both before and after engaging in the preceptorship programme and seemed to fear failure. Although the latter group of nurses all undertook preceptorship, some still lacked the necessary skills and knowledge they needed to enable them to work safely in the clinical setting. Thus, I noted that most of these nurses asked to transfer to another unit following their preceptorship period or resigned as they found it too difficult to fulfil their new role and undertake the work required in a novel context. Hence, turnover rates increased accordingly.

Consequently, my concerns increased in respect of the quality, purpose and efficacy of the preceptorship process when implemented with newly hired experienced nurses within Saudi Arabia and more specifically in my own hospital. As a clinical resource nurse, I had tried to develop the preceptorship experience further by spending long periods with my preceptors and preceptees and developing the concept of team preceptorship within the paediatric unit. Despite this, I realised that to develop preceptorship within the paediatric unit on an individual basis was of little value as, in order for any significant advantages to be felt, the changes would have to be made within the whole organisation across all stakeholders— namely preceptees, preceptors, nurse educators, nurse managers and administrators.

However, before this could occur, the type of deficit and where this/these might be situated in the programme needed to be made clear. The fact that I was dissatisfied as a preceptee, preceptor and clinical resource nurse with the content and structure of

³ **Newly hired experienced nurse** equated to those nurses who had a minimum of one-year post-graduation clinical experience who came from another hospital(s) either inside or outside Saudi Arabia.

the hospital preceptorship programme motivated me to ask questions, although simply asking questions was not sufficient it was nevertheless a starting point. Hence, the questions invoked included the following: were the right processes or means of undertaking preceptorship to effectively precept new nurses being implemented, and if not, what was the right way? How should the organisation apply the principles of preceptorship? Why did some nurses leave soon after the preceptorship programme? Why did preceptees, preceptors and clinical resource nurses feel unhappy with the outcome of the preceptorship programme? What factors were causing preceptorship to be ineffective?

Based on my observations, it was evident that nurses were not acquiring the skills that they needed; hence, I concluded that a possible solution could be a longer preceptorship period to develop preceptee skills and facilitate their integration into the new role. It was clear from my observations that the nurses did not feel supported at any level be it preceptee, preceptor or clinical resource nurse. All of these facts urged me to ask whether the preceptorship format was appropriate, if the preceptorship period was sufficient, and whether the role that nurses were trying to fulfil as preceptees, preceptors and clinical resource nurses were appropriate and realistic in terms of workload demands and expectations. In other words, was the organisation asking too much from these nurses, was the preceptor prepared in the way they needed and expected to be? At the end, I came to realise that the only way to find the answers to these questions was to undertake a formal research project. Therefore, I decided to study for a PhD to gain the research skills necessary to answer such questions.

Hence, I decided to investigate how the newly hired experienced nurses and other programme stakeholders (preceptors, nurse managers, nurse educators and clinical resource nurses) in Saudi Arabia felt about preceptorship, what their expectations and needs were and whether or not the preceptorship programme invoked at the time was meeting such needs. Thus, it was important for me to ask what factors inhibited or promoted the success of the preceptorship programme. This study was unique as it was conducted in a setting, which was totally different from those previously researched in respect of its religious, cultural, political and philosophical drivers.

1.3 Study questions

Thus, the study questions included the following:

1. What are nurses' perceptions and expectations of preceptorship?
2. Does the preceptorship programme fulfil the nurses' needs and expectations?
3. What are the factors affecting the success or failure of the preceptorship programme?
4. What are the participants' perceptions regarding the influence preceptorship can exert on clinical nursing care?

1.4 Organisation of the thesis

This thesis has been organised into seven chapters, each commencing with an introduction and ending with a summary. The chapters are divided as follows: Chapter II comprises the literature review. The aim of this chapter was to critically analyse and discuss the research that has been conducted in the area of preceptorship in order to highlight any knowledge gaps and shape my methodological choice. This enabled me to build an argument regarding the conduct of the current study and establish how this study adds to the body of knowledge relating to preceptorship. Each section of this second chapter examines a specific aspect of preceptorship; for example, its meaning, development and any related issues. The final sections of this chapter include a discussion related to how the literature has informed the development of the thesis aim and the subsequent methodological approach followed by the study's aim and objectives and finally the reasons for conducting this study.

Chapter III examines the methodology and study methods adopted within the study. It presents in detail the methodology and research methods that were chosen for implementation in this study, including ethical considerations, the process of gaining access to the setting and study participants. In this chapter, a detailed overview of the demographic characteristics of the study participants is also provided.

Chapters IV and V present the six themes that emerged from the individual and groups interviews. Findings are explored and supported by selected quotations from the interviews, which are used to illustrate the study participants' views regarding preceptorship. Each chapter discusses three themes and their related sub-themes.

Chapter IV discusses participants' perceptions regarding the meaning of preceptorship, time in relation to preceptorship and the impact of preceptorship on the clinical nursing care of preceptees and preceptors. While chapter V examines factors associated with the success or failure of the preceptorship programme. This also includes three emergent themes and their related sub-themes namely: recruitment and its role in the success/failure of the preceptorship programme, preceptor preparation and selection, and support for preceptorship.

Chapter VI, the discussion chapter, presents and discusses the study findings in relation to the research questions and supports and compares my own study data with those found in the published literature. Social learning theory has been used as an explanatory framework for this analysis in order to derive meaningful conclusions. This chapter is also sub-divided into three interrelated sections based on the study questions. At the end of this chapter, trustworthiness, limitations of the study and how the thesis contributes to the body of knowledge are also discussed.

Finally, chapter VII examines the conclusions and considerations. In this chapter, I present the overall study conclusions. The latter is followed by considerations for future recruitment, education, nursing management and clinical practices. Furthermore, considerations for future research are also stated.

1.5 Summary

In this chapter, a general introduction of preceptorship and its importance as a programme for supporting and educating the new nurses from a wider context has been explored. It has highlighted that confusion exists when educators, practitioners and researchers attempt to define preceptorship and accentuated that there is a lack of empirical evidence regarding preceptorship. Preceptorship impacts on preceptees' clinical development reinforcing the need for further empirical research in this area. How my own thinking influenced the study was examined briefly a factor that will be revisited/further reflected upon in chapter three. Finally, the research questions have been clearly stated to signpost for the reader the main issues this thesis has attempted to address.

Chapter II
LITERATURE REVIEW

2.1 Introduction

Preceptorship is not a new concept in nursing but represents an important strategy for clinical nursing education (Myrick & Yonge 2005). Preceptorship is arguably an important dimension of nursing, whereby experienced nurses help new nurses gain knowledge and consolidate their ability to care for patients in the practice setting (Myrick & Yonge 2003). Preceptorship appeared in the US during the 1960's as a clinical teaching method, following the development of nurse-practitioner programmes (Myrick & Yonge 2005). By the 1970s, preceptorship had become an highly effective, clinical teaching programme. Since then, it has been applied not only to the education of undergraduate nursing students, but also to post-registered, new staff nurses. Today it is used as an integral part of many hospital orientation programmes worldwide (Hardyman & Hickey 2001).

In this chapter, the literature has been reviewed, analysed critically, presented and discussed, based on the questions of the study. The sequence of the literature review runs systematically from general to specific themes. It starts with a general discussion of the meaning of preceptorship programmes and closes with a more specific examination of the effects of preceptorship on clinical nursing care. Accordingly, the chapter includes the following points:

1. What is preceptorship,
2. Historical development and implementation of preceptorship programmes in the clinical setting,
3. Definition of the preceptor and preceptee,
4. Preceptor and preceptee role and responsibilities,
5. Factors associated with the success or failure of a preceptorship programme,
 - 5.1 Preceptor selection and preparation,
 - 5.2 The preceptor-preceptee relationship,
 - 5.3 Role of support in a preceptorship programme,
6. Preceptorship and clinical nursing care,
7. Previous methodological approaches to the study of preceptorship and how this has shaped the design of the proposed study,

8. How the literature has informed the development of the thesis aim and the subsequent methodological approach,
9. Aim of the study,
10. Objectives of the study,
11. Why the study is needed.

2.2 Search method

The aim of the literature review was to identify and assess evidence appropriate to the topic - in this case, preceptorship - specifically related to newly hired experienced nurses and the impact a preceptorship programme can exert on the clinical nursing care of such nurses. To increase its rigour, the review was carried out systematically to minimise the potential for publication and selection bias by maximising the reliability and completeness of the findings (Khan *et al* 2003). To facilitate this process a set of inclusion and exclusion criteria were established to focus the search more strategically

2.2.1 Inclusion criteria

Inclusion criteria for the review were that the studies: must be published in English, examine preceptorship and be drawn from primary data sources. In addition, the review was limited to the period from January 2000 to December 2010 in order to provide recent and up to date evidence illustrating what was already known about the topic under study.

2.2.2 Other Inclusion Criteria

In addition to the above generic inclusion criteria, the search also focused on those texts that

- Specifically related to newly hired experienced preceptees⁴;
- Explored how preceptorship impacted on the clinical development/performance and/or clinical competence of newly hired nurses;
- Examined the preceptor role;

⁴For the purpose of the search, preceptees are the persons from any type of health care discipline, who are undergoing a period of preceptorship. Health care disciplines included but were not limited to nursing, medicine, pharmacology, radiotherapy and physiotherapy.

- Examined preceptor characteristics;
- Examined the preceptor-preceptee relationship;
- Examined programme stakeholder perceptions.

2.2.3 Exclusion Criteria

The exclusion criteria stipulated that the search should omit:

- All non English-language publications;
- Those studies examining preceptorship for undergraduate nursing students;
- Plus any study that did not match the inclusion criteria

2.2.4 Data sources and search strategy

A broad-based literature search across different professional fields, which included nursing, medicine, radiotherapy, pharmacology and sociology was conducted to explore the potential relevance of the locatable evidence related to preceptorship. The literature search covered the period 2000-2010 and drew on a variety of data sources to identify references related to preceptorship in each of the above professions. The electronic databases accessed are shown below in table 1:

Table 1: List of the accessed electronic databases

Databases
All EBM reviews-
Cochrane Database of Systematic Reviews (DSR)
ACP Journal Club
Database of Abstracts of Reviews of Effects (DARE)
Cochrane Controlled Trial Register (CCTR)
Cochrane Methodology Register (CMR)
Health Technology Assessment (HTA)
NHS Economic Evaluation Database (NHS EED)
Allied and Complementary Medicine (AMED)
British Nursing Index & Archive
Excerpta Medica Database (EMBASE)
Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Global Health
Health and Psychosocial Instruments
Health Management Information Consortium (HMIC)
Wilson Humanities Index
International Pharmaceutical Abstracts
International Political Science Abstract
Maternity and Infant Care
Ovid MEDLINE® (The National Library of Medicine's Premier Bibliographic Database)
Ovid MEDLINE ® In-process & other Non-Indexed Citations
Ovid MEDLINE Daily Update
PsychINFO
American Bibliography of Salvic & East European Studies
International Bibliography of the Social Sciences
Google Scholar website

In addition, the content lists of the educationally focused electronic journals located on the John Ryland's University library web page were also searched. These were Nurse Education in Practice (2001 to present), Nurse Education Today (2000 to present), Nurse Educator (2000 to present), Nurse Practitioner (2001 to present), International Journal of Nursing Education (2000-2004, when the subscription ended), Nursing Administration Quarterly (2000 to present). Furthermore, a hand search of reference lists from all sourced papers was also undertaken to ensure that no important paper(s) or book(s) were missed. Moreover, books and reports listed in the University of Manchester John Ryland's library catalogue were also checked. This chosen method of literature searching provided an in-depth review of a large quantity of the data available via the University of Manchester library resources relevant to the chosen research topic.

The key words used to identify papers were: preceptorship, preceptor, mentorship, mentoring, mentors, newly hired, newly hired experienced preceptees, new nurses, clinical performance, clinical competence and clinical nursing care.

The terms mentorship, mentoring and mentors were used in most of the literature interchangeably with the terms preceptorship, preceptoring and preceptor. The terms mentorship, mentoring and mentors were therefore added to the key words to ensure that all studies related to preceptorship were included.

The initial search was conducted using the search term 'preceptorship' and 'preceptor'. A second search was then performed using the term 'preceptorship' combined with 'newly hired' 'newly hired experienced preceptees' and then 'new nurses' in order to target relevant literature. A third search was subsequently conducted using the term 'mentorship' 'mentoring' 'mentors' with the second search terms 'preceptorship' and 'new nurses'. To identify papers pertinent to preceptorship and its impact on clinical nursing care, a further search was carried out by combining the terms from the third search with the terms 'clinical performance', 'clinical competence', 'clinical nursing care'. Finally, any duplicate texts were removed from the list to generate one definitive list of potential literary sources for review.

2.2.5 Data management, assessment and data extraction

Details of the identified articles were entered into Reference Manager. The titles and abstracts of the articles were first examined to categorize each paper into the relevant themes. Copies of the papers were saved, retrieved and photocopied in full wherever possible. Each selected paper was reviewed and evaluated individually by comparing each paper's aim(s) and objective(s), data collection and analysis methods, sample (participants), methodological robustness, summary of the study findings and implications for practice with the proposed study inclusion and exclusion criteria. Methodological robustness of each included paper was critically appraised by following the guideline outlined in the Critical Appraisal of Environmental and Occupational Health Literature (Fowkes & Fulton 1991). The latter is a generic tool for critically appraising the quality and validity of all published literature (see appendix A, page 285).

2.2.6 Findings of the search

From the first search, 2885 papers related to preceptorship were identified. The second search identified no papers concerning preceptorship related to newly hired or newly hired experienced preceptees or new nurses. In the third search, 6700

papers related to preceptorship and mentorship of new nurses were founded, while 725 papers were identified from a further search that combined the terms preceptorship and mentorship of new nurses related to clinical nursing care. All 725 of these papers were accessed in full. Finally, after all duplications were removed and the search limited to studies published between 2000-2010, a list of 200 papers was identified. From this total, 97 papers matched the study inclusion criteria with the remaining 103 excluded because they did not meet the inclusion criteria as 98 were about preceptorship of undergraduate students and 5 were about clinical supervision. Table 2 below illustrates the search steps taken, key words used and the findings derived from each search.

Table 2: Search strategies and findings of the search

Search Strategies	Key words	Findings of the search
First search	Preceptorship And Preceptor	2885 papers
Second search	Preceptorship And Newly hired Or Newly hired experienced preceptee Or New nurses	Zero
Third search	Mentorship Or Mentoring And Preceptorship And New nurses	6700 papers
Fourth search	Mentorship Or Mentoring And Preceptorship And New nurses And Clinical performance Or Clinical nursing care Or Clinical competence	725 papers (note: all 725 were accessed in full)
Duplication removed and search limited to the period 2000 - 2010		200 papers
Based on the inclusion and exclusion criteria		97 papers
30 papers were empirical studies and 67 books & papers (non-empirical studies)		

All 97 papers that met the inclusion criteria have been used in this literature review. From the total number of papers (n=97), only thirty were based on empirical evidence generated from qualitative, quantitative and mixed methods studies, as shown in table 3 page 31. There were no systematic reviews or randomised controlled trials (RCTs). Of the 30 empirical studies sourced, only one related to a non-nursing health care field (radiotherapy). The remaining 67 texts were based on non empirical sources of data and were therefore used in this literature review to add

contextual and additional information to the study. In particular, the latter papers comprised literature reviews, expert opinions, government reports, NHS policy documents/reports, guidelines and programme descriptions.

In terms of a hierarchy of evidence, data cited in the 97 papers located as part of this review could be considered weak given that it tended to be exploratory or descriptive as opposed to the types of data it is possible to generate via systematic reviews or RCTs, both of which are considered the Gold Standard in the evidence hierarchy (Daly *et al* 2007, Evans 2003). However, although the current literature review was based on more descriptive evidence, which could be considered one of the study's limitations/weaknesses these were nevertheless the only sources available at the time of undertaking this study. Therefore, the evidence forming the basis of this review was the most robust available at the time. Furthermore, it was also considered the most appropriate evidence for answering the study questions.

Table 3: Previous methodological approaches used to study preceptorship

Research approach	Types of designs (as stated by the researchers)	Included studies
Quantitative	Descriptive Survey	Hancock 2002
		Kuroda <i>et al</i> 2009
		Leigh <i>et al</i> 2005
		Charleston & Happell 2004
	A longitudinal survey	Hardyman & Hickey 2001
	Non-experimental Survey	Giallonardo <i>et al</i> 2010
	Descriptive Correlational survey	Kim 2007
	Prospective comparative design	O'Connor <i>et al</i> 2001
A Quasi-experimental	Lee <i>et al</i> 2009	
Qualitative	Qualitative design	Harbottle 2006
		Turner 2007
		Bourbonnais & Kerr 2007
	Exploratory qualitative	Clynes 2008
		Clark & Holmes 2007
	Descriptive qualitative	Duffy 2009

	Longitudinal descriptive qualitative	Henderson <i>et al</i> 2006
	Qualitative evaluation	Allen 2002
		Kaviani & Stillwell 2000
	Qualitative summative evaluation	DeCicco 2008
	Grounded theory	Charleston & Happell 2005
		Myrick & Yonge 2004
	Case study	Carroll <i>et al</i> 2005
	Phenomenology	Ohrling & Hallberg 2001
Ohrling 2000		
Action research	Kelly <i>et al</i> 2002	
Mixed methods (Qualitative-Quantitative)	Hautala <i>et al</i> 2007	
	Farrell & Chakrabarti 2001	
	Almada <i>et al</i> 2004	
	Ross & Clifford 2002	
	Scells & Gill 2007	

The included literature drew from international sources although no literature relevant to preceptorship in Saudi Arabia was found indicating a gap in the literature related to the Saudi context. Table 4 below indicates the countries where the studies were conducted. Further detail of each of the studies can be found in the data extraction sheets contained in appendix B, page 290.

Table 4: Presentation the countries where the international studies were conducted

No of studies	Country where conducted	Authors	Date
13	United Kingdom	Allen C	2002
		Clark T & Holmes S	2007
		Clynes M	2008
		Duffy A	2009
		Farrell M & Chakrabarti A	2001
		Carroll M. <i>et al</i>	2005
		Hancock J	2002
		Harbottle M	2006
		Hardyman R & Hickey G	2001
		Kelly D, Simpson S & Brown	2002
		Leigh J <i>et al</i>	2005
		O'Connor S <i>et al</i>	2001
		Ross H & Clifford K	2002

No of studies	Country where conducted	Authors	Date
4	Canada	Bourbonnais F & Kerr E	2007
		DeCicco J	2008
		Giallonardo L, Wong C & Iwasiw C	2010
		Myrick F & Yonge O	2004
4	Australia	Charleston R & Happell B	2005
		Charleston R & Happell B	2004
		Henderson A, Fox R & Malko-Nyhan K	2006
		Scells M & Gill R	2007
3	USA	Hautala K, Saylor C & O'Leary-Kelly C	2007
		Almada P <i>et al</i>	2004
		Kim K	2007
2	Sweden	Ohrling K	2000
		Ohrling K & Hallberg I	2001
2	New Zealand	Kaviani N & Stillwell Y	2000
		Turner R	2000
1	Taiwan	Lee T <i>et al</i>	2009
1	Japan	Kuroda T <i>et al</i>	2009

As part of this review, it has been noted that the term 'newly hired' or 'new nurse' used in the studies meeting the inclusion criteria referred either to newly qualified preceptees or new graduate preceptees; particularly nurses. Preceptorship of newly hired experienced nurses, as in the case of the current study, has not been examined previously. Consequently, I returned to the literature and examined its content in more detail, but despite this, I still did not uncover any study that examined this latter group of nurses. Thus, it could be argued that the current study adds to the body of existing knowledge by examining the impact of preceptorship in a unique group of nursing personnel.

Accordingly, those studies located in the literature that related specifically to preceptorship of newly qualified preceptees and new graduates have been included in this review for the following reasons:

- 1- Although newly qualified preceptees and new graduates are considered competent and knowledgeable, it has been shown that they need the support and guidance of more experienced practitioners, in this case preceptors, in order to facilitate integration into their new role. The same or similar

principles may also be applied to newly hired experienced preceptees entering a new area of practice.

- 2- Similar to the newly qualified nurses who are new to the health care system, newly hired experienced nurses in this study were also new to the health care system and possibly also to the culture despite having had previous clinical experiences. Therefore, they had the potential to need more support than newly qualified nurses working in their native cultural domain.
- 3- The literature review aimed to provide a general overview of the phenomena forming the focus of the study in order to identify any gaps in our current knowledge of preceptorship. Consequently, including studies that explored preceptorship of newly qualified and new graduate nurses in this review helped to uncover their understanding of its meaning and accordingly what was already known about preceptorship.

Furthermore, a small number of papers published outside the selected search period have been included to provide conceptual understanding of the topic. This is because they are considered key papers and the building blocks on which previous studies of preceptorship have been based.

In the following sections, the meaning of the term preceptorship has been juxtaposed and compared with the terms mentorship and clinical supervision to highlight how the interchangeable use of the three terms adds to the overall confusion regarding what preceptorship constitutes. The latter is followed by the history of preceptorship programmes in clinical settings. An exploration of the terms preceptor and preceptee and other preceptorship related issues have also been examined in order to provide a general understanding of that which is already known about preceptorship. This action was taken to reinforce the rationale for the current study. The meaning of preceptorship in clinical settings is the first point to be discussed as indicated below.

2.3 What is preceptorship?

Charleston & Happell (2005), Ohrling & Hallberg (2001) and Kaviani & Stillwell (2000) have all investigated the meaning of preceptorship, yet despite this there is still a lack of clarity regarding the term in the literature (Kaviani & Stillwell 2000). As a result of the critical analysis of the included literature, I found considerable inconsistency in the definitions of the term preceptorship in the wider literature, which generates the potential for confusion between the term preceptorship and other related concepts such as mentorship and clinical supervision. A striking example of this notion of confusion, manifest in Ohrling's (2000) study, when the term clinical supervision was used to describe what was proffered as a preceptorship model. However, according to this definition, the new nurse could be supervised by more than one experienced nurse at the same time. Hence, the individual may not receive the one-to-one attention that would be prescribed as part of a preceptorship programme.

Moreover, international interpretations regarding the meaning and use of terms such as counselling, mentoring, and coaching to describe clinical teaching and preceptorship increase the confusion manifest between individuals when applying the terms preceptorship and mentorship to different forms of clinical education. There is no clear definition of what the term preceptorship means in the literature since each study appeared to adopt a definition appropriate to itself based on each organisation's interpretation and understanding of the meaning of preceptorship (Kaviani & Stillwell 2000). The lack of a standard definition of the term 'preceptorship' resulted in confusion for the reader regarding what preceptorship should be and its relative goals.

Discussions regarding the meaning of preceptorship, how it is perceived, and the inconsistent definition of preceptorship across the literature was an ongoing problem encountered whilst undertaking this research. As a result, previous researchers have tried to differentiate between the three concepts (Kuroda *et al* 2009, Hautala *et al* 2007, Billay & Yonge 2004). As an integral part of this review, it was deduced that clinical supervision, mentorship and preceptorship were somewhat fluid concepts when referred to in the literature. In particular the three terms were often used inappropriately. For example, people used preceptorship when they meant

mentorship and mentorship when they meant preceptorship, while clinical supervision was used to mean all three terms. This interchangeability in the use of each term made it difficult to know exactly what the authors were referring to. Despite this confusion and lack of a definitive definition for each term following analysis of the literature I deduced that each had its own distinctive features making preceptorship different from mentorship and clinical supervision different from the other two terms.

In order to clarify the term preceptorship for the purposes of this thesis each of the terms used in the literature will be briefly examined in turn with the major focus being on defining preceptorship. At the end of this section, a definition of the term *preceptorship* as it has been applied within the context of the current study will be presented. Furthermore a definitive definition of the terms preceptor and preceptee will also be established for the purposes of this study. The first term to be examined is that of clinical supervision.

2.3.1 Clinical Supervision

Clinical supervision is a more formalised, practice-focused professional relationship between two or more clinicians (Hanocx & Lynch 2002). It is an exchange between practicing professionals for the purpose of professional skills development (Ashurst 2008). The aim of the latter relationship is to encourage supervisees to think critically, as well as improve their skills, knowledge and practice through support and the inception of effective understanding. Furthermore, it enables skilled supervisors to reflect on practice, identify solutions to problems and improve standards of care by increasing their understanding of professional issues (NMC 2002).

Consequently, supervision is a more structured relationship than mentorship and lasts longer than preceptorship, although it is usually offered to Registered as opposed to student nurses (NMC 2002). Clearly, clinical supervision is more focused towards the development of professionalism. This means that the supervisor does not focus on the personal and/or social development of the supervisee. However, the current definition of clinical supervision is not dissimilar to the definition of mentorship outlined below, which only adds to the confusion when trying to

distinguish the difference between mentorship, clinical supervision and preceptorship. Nevertheless, clinical supervision was not the focus of this thesis.

2.3.2 Mentor and Mentorship

In this section, it is not intended to go into detail regarding mentorship. However, there appears to be more confusion and uncertainty between mentorship and preceptorship in the literature than between clinical supervision and preceptorship. In this section, the discussion will briefly focus on the main points of mentorship in terms of meaning, purpose, relationship, period and context in order to distinguish the differences between mentorship and preceptorship.

Following the review of the literature, no precise singular definition was found that clearly defined mentoring or mentorship programmes. For example, Mills' *et al* (2008) in their constructivist, grounded theory study defined mentorship as '*a teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials*' (p.600). Generally, however, most researchers' defined mentorship as a process conducted via a supportive, nurturing and respectful relationship between two practitioners (Cashin & Newman 2010, Block *et al* 2005, CNA 2004).

It focuses on all aspects of the mentee's life including personal and professional development (Mills *et al* 2008, Modic & Schoessler 2007, Block *et al* 2005, Oliver & Aggleton 2002) as it aims to improve the mentee's attitude, knowledge, clinical practice and leadership skills (Block *et al* 2005, CNA 2004). Implementation of a mentorship programme is thought to promote long-term growth and retention of the mentee through a structured support system that increases job satisfaction. Hence, mentorship is more than an orientation programme. It is considered an ongoing commitment to support and promote organisational success (Block *et al* 2005).

The word Mentor means 'one who thinks', and was derived from the Indian word mantar. However, the Latin meaning of mentor is 'to advise' and in Greek it represents 'an advisor, monitor' (Billay & Yonge 2004). However, more recently the term mentor has been defined as an experienced professional person who guides a mentee via a collegial, nurturing relationship (Ashurst 2008, Billay & Yonge 2004).

In the literature, researchers across the globe have examined the mentor role (Mills *et al* 2008, Kilcullen 2007, Carroll 2004, Greene & Puetzer 2002). In these studies, the mentor's role encompassed the giving of support; guidance, socialisation and well-being advice, career development and empowerment skills (Carroll 2004, Greene & Puetzer 2002).

Furthermore, mentors '*should be good listeners, approachable by other nursing staff, positive influencers on the unit, committed to the nursing profession, team players, able to face difficult situations with a positive attitude, and help to discover [mentees] talents and expand [their] thinking*' (Modic & Schoessler 2007, p.195). It is not required for the mentor to be selected from the same clinical unit as the mentee or to be available all the time. The mentee should ask for the mentor's help whenever it is needed. In addition, mentor may have a part in the practical work assessment in a formal or informal way based on the type of programme (Kilcullen 2007, Wilson 2000). Conversely, the mentee is one who is less experienced, a novice or student nurse (Cashin & Newman 2010).

In the case of mentorship, the mentor is chosen by the mentee, based on the mentor's knowledge and superior experience and their ability to guide the development and clinical performance of the less experienced professional (Oliver & Aggleton 2002). Modic & Schoessler (2007) proffered therefore that mentoring newly hired nurses begins when newly hired nurses have completed the requirements of their orientation programme in order to pursue further professional development and become expert in their particular clinical speciality.

The relationship between a mentor and mentee was described as a long-term process that takes place between a senior, more experienced and knowledgeable leader (mentor) and a junior, less experienced staff member with a potential for leadership (mentee). The relationship in this situation is built on mutual respect and compatible personalities (Cashin & Newman 2010). Such a relationship may therefore extend over several years for the purpose of professional development in order to increase staff retention and reduce staff turnover (Mills *et al* 2008; Beecroft *et al* 2006). Mentorship is therefore more of a partnership as opposed to a superior-subordinate relationship. In a study by Beecroft *et al* (2006) the relationship between mentor and

mentee lasted for six years, yet despite this protracted time frame the two parties still felt it was not long enough.

Regarding the context, mentorship is carried out both internal and external to the workplace. Yet the current lack of differentiation between the role of a mentor and preceptor is confusing. However, it is crucial to indicate that mentorship is not identical to preceptorship although they are both supportive processes (Greggs-McQuilkin 2004). Hence, mentorship lasts longer and does not simply address professional development. Instead, mentorship encompasses the professional, personal, cultural and environmental development of the mentee.

2.3.3 Preceptorship

The notion of preceptorship has been explored in numerous empirical studies as well as opinion and review papers in order to try to define the term more precisely (Dewolfe *et al* 2010, DOH 2009, Robinson & Griffiths 2009, Gleeson 2008, Nisbet 2008, Billay & Yonge 2004, CNA 2004, Ohrling & Hallberg 2001, Morton-Cooper & Palmer 2000). As part of the current review, multiple definitions of preceptorship were discovered. However, generally preceptorship was found to have been defined as a clinical education programme aimed at providing access to a competent, supportive role-model through a time-limited relationship between the preceptor and preceptee (Dewolfe *et al* 2010, DOH 2009, Robinson & Griffiths 2009, Gleeson 2008, Billay & Yonge 2004, CNA 2004, Ohrling & Hallberg 2001, Morton-Cooper & Palmer 2000). The time-limited nature of this relationship was viewed by Wilson (2000) as a transitional period, which lasted only until the novice practitioner had achieved some form of role transition. This type of supportive educational programme was generally found to be offered to new nurses by their employing organisation.

Findings drawn from the literature highlighted that preceptorship was originally developed to provide the learner (preceptee) with the necessary clinical training and education to perform and integrate into their new role more effectively. The training and education processes were carried out via one-to-one contact with the preceptor who was located in the same clinical area as the preceptee (Dewolfe *et al* 2010, Wood 2007, Harbottle 2006, Ridge 2005, Kaviani & Stillwell 2000). The Canadian Nurses

Association illustrated that the type of training and education deemed to be a necessary part of the preceptorship process involved providing preceptees' with the basic knowledge, skills and personal attributes for them to become integrated into the new profession (CNA 2004). This notion concurs with the ideas stated earlier in Bain's (1996) review, which concluded that preceptorship provided support for new nurses and eased their transition into professional practice by facilitating their socialisation into a new role.

Preceptorship is in essence '*a specified teaching and learning strategy performed by an experienced nurse who acts as a role model and resource [person]*' (Ashurst 2008, p.307). It aims to develop the preceptees' confidence and competence whilst simultaneously fostering their clinical practice (DOH 2009, NNRU 2009, Ashurst 2008) whether this is a student, newly qualified or newly hired experienced nurse (NMC 2002, Wilson 2000). For example, each nursing group still needs to enhance their ability to communicate, reflect on and receive feedback regarding their clinical practice. One of the main differences between the above concepts was found to be oriented towards the timing of the relationship, hence, preceptors are:

'Concerned with teaching and learning aspects of the relationship which are more closely linked to adult education principles and therefore [are] a more effective means of learning than those proposed through the mentorship approach. While the mentor, although also concerned with these aspects, aims for a closer and more personal relationship' (Kaviani & Stillwell 2000 p.219).

Across the literature, preceptorship was found to be used as a source of staff development given that it tended to be considered part of a new nurse's orientation process enabling them to become embedded into their new role and environment (Ashurst 2008, Ridge 2005, Diehl-Oplinger & Kaminski 2000). Consequently, Block *et al* (2005), in their review paper, described preceptorship as an orientation technique. Unlike mentorship, preceptorship focuses on orientation, skill acquisition and mastery in order to achieve the necessary competence to be ready for work. Hence, preceptees were expected to become more autonomous, independent, safe, confident practitioners able to deliver the quality of nursing care demanded by an organisation (Mills *et al* 2008).

In conclusion, preceptorship is considered to be situated, on the educational continuum, between the concepts of mentorship and clinical supervision as it

encompasses attributes from both of these concepts. The idea of preceptorship is to develop preceptees within the environment in order to be accommodated both by and within the environment. Thus, the focus is on developing the preceptees' clinical skills and proficiency to be fit to meet the demands of the environment. Therefore, preceptorship focuses predominantly on professional development, which is similar to the underpinning drivers for clinical supervision. Despite the latter, preceptorship also focuses on other more esoteric dimensions such as environmental and psychological factors; in particular, how confident and/or comfortable a preceptee feels within a given context.

Thus, preceptorship reflects some of the underlying principles synonymous with the notion of mentorship, particularly as it focus on the person rather than being purely oriented towards the professional. However, it is not a protracted process and does not look at all aspects of the person. Instead, preceptorship looks at development within a group-professional and social context rather than a personal-professional context.

As indicated in the discussion above, preceptorship is similar to clinical supervision and mentorship in that all are clearly a form of clinical education. However, it is not a requirement of clinical supervision or mentorship for these clinical educational processes to be conducted within the mentee's or supervisee's own clinical domain, whereas in preceptorship the preceptee should be trained in his/her assigned clinical area in order to be well integrated into the new clinical setting. Preceptorship is similar in purpose to clinical supervision in that both focus on the professional development of the preceptee or supervisee who is expected to be a registered, nurse. However, preceptorship unlike clinical supervision focuses on the preceptee's more personal aspects. Furthermore, preceptorship differs in that it is offered to registered nurses who are new to the clinical setting (be they newly qualified nurse or experienced nurse new to the setting).

Likewise, preceptorship is also similar in its focus to mentorship in that both are considered supportive clinical education programmes. However, mentorship tends to provide support for individuals or small groups of staff. Conversely, preceptorship provides one-to-one support, focusing on clinically based teaching. Mentorship

generally forms an integral part of a course, conducted in collaboration with the clinical setting and university or college, whereas preceptorship tends to be implemented via the employing organisation in the preceptee's designated clinical area.




Therefore, the main aim of the preceptorship programme is to develop independent, autonomous and clinically competent nurses who are able to provide complete patient care at the point of employment. The distinct feature of preceptorship is that it is a one-to-one teaching-learning strategy, adopting individualised adult learning principles. The preceptor should therefore, be selected from within the clinical area where the preceptee is based. Hence, the preceptor should be available from the outset and work with the preceptee throughout the preceptorship period in order to be able to observe and formally assess the preceptee's clinical performance and report this to the preceptee's manager. Thus, preceptorship has certain requirements, competencies and goals which preceptees need to achieve by the end of the programme. Nevertheless, preceptorship is usually shorter than both mentorship and clinical supervision, ranging from two weeks to six months duration. Table 5 located on page 43 presents the key differences between the three terms in tabular form to make the distinctions between these three terms even more discrete .




Thus in order to be able to study the effectiveness of preceptorship in detail Bain (1996) suggested that a clear definition of term was needed. More recently a similar empirically based recommendation was proffered by Harbottle (2006) who suggested that a clear definition of the term preceptorship should be considered before engaging in any study of the topic. Consequently, in the context of the current study, the term 'preceptorship' has been distilled and defined from the preceding discussion as constituting: an organised clinical education programme whereby an experienced, competent senior staff nurse facilitates the integration of a newly hired experienced nurse into her/his role and responsibilities in a new clinical setting. This integration into the new practice environment is thought to be achieved via the instigation of a professional, supportive, one-to-one relationship between the preceptor (senior staff nurse) and the preceptee (newly hired experienced nurse) over a flexible but limited time frame - in this case two weeks.

Table 5: Differences between Mentorship, Preceptorship and Clinical supervision



Items	Mentorship	Preceptorship	Clinical Supervision
Qualification Development	Less experienced nurse with leadership potential More effective mature nurse	Novice practitioner Competent practitioner	Competent practitioner Specialist nurse
Nature of the relationship	Supportive nurturing relationship between more experienced nurse and less experienced nurse (student or nurse who wishes to be more effective).	Self limited, professional relationship between an experienced nurse and the new hired nurse (newly qualified or new experienced nurse).	Professional/formal relationship between two clinical professional nurses focusing on practice- related issues
Nature of the programme	Integral part of a course, conducted in collaboration between the clinical setting and college/higher education institute.	Part of an orientation programme for new nurses. Conducted by the health care organisation at the end of a one week formal and/or general orientation programme.	Clinical development programme conducted in a specific clinical area in order to improve the practice of the clinical practitioner in a designated area.
Purpose of the programme	Promote personal, attitudinal, theoretical knowledge, leadership and clinical professional development.	Facilitate transition from newly qualified/newly experienced nurse to a competent, well- oriented, confidence practitioner	Develop the supervisee to provide the best quality patient care possible.

Items	Mentorship	Preceptorship	Clinical Supervision
Qualification Development	Less experienced nurse with leadership potential  More effective mature nurse	Novice practitioner  Competent practitioner	Competent practitioner  Specialist nurse
Supervisee	Nursing student still undergoing their initial training period or nurse who is willing to be more effective in her/his role	Probationer Nurse/newly qualified nurse	All remaining nurses, particularly experienced nurses.
Supervisee Qualification	Pre-registered student nurse or post-registered nurse.	Newly hired (newly registered and/or post-registered nurse.	Post-registered nurse.
Supervisor	Experienced nurse	Experienced nurse	Experienced/skilled nurse
Length of the programme	Throughout the training period inside or outside a practical placement, ranging from months-years.	Throughout the preceptees clinical placement. Pre-determined by the organisation, approximately two weeks to six months of adjustment	Throughout the career. From 12 months post-registration
Assessment Function	Mentor may have a part in the practical work assessment, could be formal or informal based on type of the programme (structured or unstructured)	Preceptor may report to the preceptees manager. Assessment and evaluation are formal.	No assessment or report unless there is unsafe or unethical practice.
Requirement for the supervisor role	Expert in the field, highly proficient professional, older and more senior than mentee, not necessary to be from the same clinical setting.	1 st level nurse, usually with a minimum of six months experience, attended preceptor-training workshop as a preparation for the role, from the same clinical setting.	No requirements, no standards set for training or competence.
Method of providing support	Working with individual or small group of individuals, providing education, role-modelling and direct feedback,	Working with individual, providing education, instruction, role-modelling, direct feedback, may organise and structure	Does not need to work with individual, work is reported and reflected upon rather than observed.

Items	Mentorship	Preceptorship	Clinical Supervision
Qualification Development	Less experienced nurse with leadership potential  More effective mature nurse	Novice practitioner  Competent practitioner	Competent practitioner  Specialist nurse
	meetings on a minimum three occasions per placement.	sessions to discuss, monitor progress.	
Key element	There are learning relationships provided by the more experienced or more skilled person. However, preceptorship is more instructional than mentorship, which aims to develop nursing skills by adopting individualised adult teaching, learning and assessment strategies. Mentorship could commence after preceptorship is completed.		
Main differences	Timing of the relationship, context, focus and purpose of each programme		

Created from: Gleeson 2008, Mills *et al* 2008, Guhde 2005, CNA 2004, NMC 2002, Kaviani & Stillwell 2000, Wilson 2000

In the subsequent section, the history of preceptorship has been examined in order to chronicle how preceptorship has developed over time. In addition, as a result of the literature analysis, three different models of preceptorship have also been discussed as an integral part of examining the historical features of preceptorship.

2.4 Historical development and implementation of preceptorship in clinical settings.

Formally, documented preceptorship programmes first emerged in North America during the 1970's after Kramer (1974) conducted a study to help newly qualified nurses make the transition from student to registered practitioner. Kramer noticed that new nurses faced considerable anxiety and a major culture shock on commencement of their independent clinical practice. Therefore, she recommended the development of a preceptorship programme to help new nurses' consolidate their clinical ability before engaging in independent clinical practice.

In the early 1980s, preceptorship was established in the UK as part of the post-registration education and practice project (PREPP) instigated with the introduction of the English National Board (ENB) Higher Award Scheme in 1991 (Wood 2007). Similar initiatives were developed in Canada around the same time (Myrick & Yonge 2005). Furthermore, preceptorship programmes were progressively introduced in Sweden, along with other models of clinical and educational support, where practitioners supervised student nurses (Ohrling & Hallberg 2001).

Currently, preceptorship is used by health care organisations all over the world as an integral part of new nurses' formal orientation to the setting to enhance their integration into an organisation (Hardyman & Hickey 2001) and facilitate professional development (Ashurst 2008, Allen 2002, Allen & Simpson 2000). Therefore, the empirical evidence identified that inclusion of a preceptorship programme within an organisation's orientation package is thought to be helpful since newly qualified nurses have been found to require detailed comprehensive guidance, assurance and daily feedback about their clinical performance and progress (Giallonardo *et al* 2010, Lee *et al* 2009, Kim 2007, Roman 2001).

Furthermore, Block *et al* (2005) stated that new employees might not stay long enough to fit into an organisation if they do not feel connected to the people within

it. For example, Uhlman (2002) in his national survey study discovered that 4.7 % of both male and female nurses left their career within 4-years of graduation because they felt overloaded, unwelcome and unable to fit into the clinical setting. Other empirical studies have given support to the significance of preceptorship concerning the orientation of new nurses as well as helping organisations retain staff (Lee *et al* 2009, Guhde 2005).

Hence, it is now generally accepted that the following topic areas: teaching and learning strategies, educational theories - including the principles of adult education; communication skills, values and role clarification, conflict resolution, the assessment of individual learning needs and the evaluation of performance - are important components to include in a preceptorship programme (Burns *et al* 2006, O'Malley *et al* 2000). Furthermore, standardisation of the preceptorship programme, development of preceptorship guidelines, preceptor selection and training and supporting services for preceptors and preceptees are necessary elements for effective implementation of preceptorship programmes in any healthcare setting (O'Malley *et al* 2000).

Consequently, implementation of a preceptorship programme for orienting and supporting newly hired nurses into a large tertiary-care teaching hospital is not only recommended but also expected by both newly hired nurses and organisational bodies (NNRU 2009, Robinson & Griffiths 2009). For instance, in the United Kingdom, development of preceptorship programmes in clinical settings were recommended by the United Kingdom Central Council (UKCC) and subsequently supported by the Nursing and Midwifery Council (NMC). Although preceptorship is not a mandatory requirement, as the NMC has no power to enforce the system (NMC 2008), it is still considered to be an element of best practice in UK hospitals. However, it is not known how many hospitals or Trusts have implemented it.

Thus, several preceptorship programmes were established in the UK for both adult (Bick 2000, Gerrish 2000) and paediatric nurses (Hancock 2002, Farrell & Chakrabarti 2001). Findings from the UK studies included, verified that the majority of newly hired nurses requested that preceptorship was offered to them as it was viewed as playing a key role in enabling them to gain/increase their confidence and

competence (NNRU 2009, Robinson & Griffiths 2009, Robinson 2008, Farrell & Chakrabarti 2001).

2.4.1 Preceptorship period

Based on an analysis of the included literature no agreement has been found regarding the optimum preceptorship period. In the empirical literature, the preceptorship period has varied from one programme to another worldwide, ranging for example, from two days (Kaviani & Stillwell 2000); one to two months (Bourbonnais & Kerr 2007, Griffin *et al* 2002); to four or five to six months (Kuroda *et al* 2009, NNRU 2009). Thus, it could be assumed that the reason for this variation emanated from each organisation wanting to set its own time, based on the skills, competencies and procedures preceptees were expected to achieve by the end of the preceptorship period.

The duration of preceptorship programmes has been criticised by preceptors and preceptees alike. In one context, the duration of preceptorship was described as insufficient and was one of the factors identified as having a negative impact on the success of the preceptor role (Kaviani & Stillwell 2000). While in another study; the period was expected to be sufficient for preceptees to fulfil the preceptorship requirements (Griffin *et al* 2002).

Setting a specific duration for completing the preceptorship process so that preceptees' are empowered to deliver independent nursing care to the assigned patients could be useful for an organisation, particularly when considered from an administrative perspective. This is because one of the main reasons for organisations instigating preceptorship programmes is to solve the problem of staff shortages and high attrition rates. However, when examined from an educational perspective, this may not produce an independent, competent, skilful nurse able to deliver the required quality of nursing care to the assigned patient, which is often the stated goal of preceptorship. This is because each preceptee takes to the respective clinical arena his/her own clinical capability and distinctive background.

Hence, not all preceptees are able to attain the required skills and competencies within a pre-determined period. For example, one preceptee could come to the new

setting with the skills and competencies, which enable her/him to finish before the expected time, and therefore, s/he feels the period is too long. While another, may have no idea about the skills required or what is going on in the new setting and need extra help/time to complete their preceptorship requirements.

Therefore, there is no optimum duration for preceptorship. Instead, the period should be based on each preceptee's needs if the organisation wants to produce confident, competent, independent nurses. In the UK, a formal period of preceptorship was determined by the UKCC as comprising a minimum of four and a maximum of six months (NNRU 2009). This time-period for the duration of preceptorship was based on a continuum focusing equally on the preceptees individual needs and local circumstance. Hence, the findings of the empirical studies revealed that the majority of preceptors and preceptees perceived that six months or longer was more appropriate as the confidence of some nurses only began to emerge or became more enhanced at the four-month time point (NNRU 2009, Robinson & Griffiths 2009, Robinson 2008, Farrell & Chakrabarti 2001).

In summary, the preceptorship literature drawn on as part of this study identified a general agreement that the development and implementation of a preceptorship programme in clinical settings was crucial for the enhancement of novice practitioners' practice, in order to facilitate their learning and integration into a new role. Furthermore, success of a preceptorship programme was predicated on having sufficient time, resources and commitment from programme stakeholders to make it work (DeCicco 2008, Harbottle 2006, Guhde 2005, Farrell & Chakrabarti 2001, Kaviani & Stillwell 2000).

Thus, in order to run a successful preceptorship programme, it should last for a minimum of four months with no clearly defined end-point. Despite the latter however, it has still not been possible to establish a definitive time-period over which a preceptorship programme should take place as it has not been possible to determine when it should end as this is dependent on each preceptees' unique needs. However, lack of time for the preceptorship process to take effect has been highlighted across several empirical studies particularly when the preceptorship

process lasted from a few days up to two months (DeCicco 2008, Harbottle 2006, Guhde 2005, Farrell & Chakrabarti 2001, Kaviani & Stillwell 2000).

2.4.2 Models of Preceptorship

Following analysis of the literature, it has been possible to discern three models of preceptorship. Although the three models were not always given a name in the literature it was clear that what was being described was that, each approach adopted a slightly different focus to the way preceptorship was implemented. For the purpose of this text the first model encountered has been named by me as the “learner-practitioner transitional model” as this was designed to support and teach nursing students who were not fully registered but in the final year of their programme (Ohrling & Hallberg 2001, Kaviani & Stillwell 2000). It aimed to build on the students’ clinical learning experiences by encouraging them to apply theory to practice and ease their transition from learner to practitioner, thus limiting the reality shock faced when entering practice as new registrants (CNA 2004, Lambert & Glacken 2004, Ohrling & Hallberg 2001).

However, this model did not reflect the preceptorship model concerned with the developmental needs of newly hired nurses. Instead, in this latter context the preceptorship process described was more akin to the notion of an internship programme. Internship is a formal, one-to-one teaching, and supportive programme offered to undergraduate, pre-registration nurses who have not completed their bachelor degree programme. In effect, the internship programme is designed to ease the intern’s transition into paid work and *‘specific position within the health care setting. [A process that] takes several months to a year, depending on the setting in which interns work and the level [of experience] of the participant’* (CNA 2004, p.23). This “preceptorship model” is common in the US, Saudi Arabia and Canada (CNA 2004). Nevertheless, this model of preceptorship was not the primary focus of the current study.

The second model was called ‘team preceptorship’ (Beecroft *et al* 2008, Scells & Gill 2007). This model was based on the notion that a small group of people (namely programme stakeholders including preceptees, preceptors, nurse managers and/or nurse educators) worked together in a dynamic manner drawing on the principles of adult learning and professional development. This model was created due to the

complexity of the preceptor role and shortages of experienced nurses who could work as preceptors.

Although the studies used the term ‘team preceptorship’, each had a different approach to its implementation. In fact, it seemed that each approach depended on which key stakeholders were included in the process. For example, in one context, the programme stakeholders included preceptees, nurse managers and two preceptors: one was a novice preceptor who had little or no precepting experience and the second has longstanding precepting experience. Here, the experienced preceptor was “teamed” with the novice preceptor to facilitate the preceptees integration into their new role (Beecroft *et al* 2008). In a second study, programme stakeholders consisted of preceptees, preceptors, nurse managers and nurse educators. Hence, the team preceptorship programme was built on the teamwork of the nurse educator in association with the preceptor in order to facilitate the integration of the preceptee (Scells & Gill 2007).

The third model of preceptorship identified from the literature tended to be implemented by many health care organisations for newly hired nurses (including newly qualified nurses, new graduates, newly hired experienced nurses or nurses transferring from one setting or practice domain to another). This third model represents what had been termed ‘the singular/one-on-one preceptorship model’ and takes place between preceptee and preceptor’ (Beecroft *et al* 2008, Scells & Gill 2007). Hence, organisations use this model of preceptorship to facilitate the nurses’ transition into their new clinical setting and/or orient them to new clinical practices, standards, policies and procedures (O’Malley *et al* 2000). Here, the role of preceptor and quality of preceptor-preceptee relationship is thought to play a vital role in the success of the programme and is the model that formed the focus of the current study.

In the literature, there was no evidence to recommend one model of preceptorship over another. All preceptorship programmes, regardless of the model or focus, were considered best practice for clinical education as each had its own benefits for the preceptees, preceptors and the organisation. The present study focused exclusively on the last model of preceptorship, namely that designed for newly hired experienced

nurses. Although the programme examined as part of this study appeared similar to ‘team preceptorship’ as preceptors, clinical resource nurses, nurse educators and nurse managers were responsible for facilitating the integration of the preceptee into his/her new role and situation. The focus of the preceptorship programme in the clinical setting was and indeed still is on the preceptor's role and quality of the preceptee-preceptor relationship rather than any other role, which will be detailed later in this chapter.

Given that preceptors and preceptees are considered the foundations on which an effective preceptorship programme can be built. In the next section, the definition of preceptor and preceptee has been identified to make it clear what is meant by these two terms in the context of this thesis. This was achieved by examining the meaning of the terms preceptee and preceptor firstly as general concepts and then by examining what they both meant for this study in particular.

2.5 Definition of the Preceptor and Preceptee

A preceptor has been defined in the literature as “*a nurse who has the ability to integrate educational and work values so that realistic strategies for resolving conflict may be developed. Such a relationship allows for the trainee to work and identify with a competent role model*” (Kaviani & Stillwell 2000, p.219). Although several authors have previously tried to define the term *preceptor*, it seems that their definitions were mainly based on the qualities of the preceptor. Perhaps what was most striking was the fact that all authors agreed preceptors should be experienced, registered and/or competent clinically based nurses capable of providing clinical support and guidance for new learners (preceptees) on a one to-one basis by engaging in teaching and/or role modelling (Carlson *et al* 2009, Bourbonnais & Kerr 2007, Turner 2007, Burns *et al* 2006, Charleston & Happell 2004, Feldt *et al* 2002, Wright 2002, Bick 2000). Thus, a preceptor should be a teacher or instructor (Kuroda *et al* 2009, Ashurst 2008, Nisbet 2008). To reinforce the above, Billay’s & Yonge’s (2004) review highlighted preceptors should be registered nurses who provided clinical teaching, supervision and instruction through a one-to-one time-limited relationship.

Conversely, preceptees tended to be defined as new registered nurses who needed to be orientated, guided and taught by a preceptor to enable them to engage in their

new work and/or role (Turner 2007, Ohrling 2000). More specifically, it was possible to distil from the literature that preceptees in the UK tended to comprise newly hired nurses including newly qualified nurses (DOH 2009, NNRU 2009, NMC 2002); while in Canada preceptorship tended to focus on developing nurses who had moved to a new practice domain or clinical setting (CNA 2004). However, in Saudi - the site of the current study – preceptorship tends to be oriented toward developing newly hired experienced nurses. However, no matter how the term preceptor or preceptee is defined; it is clear that there is consensus within the literature that preceptors and preceptees are essential components of the preceptorship programme (DOH 2009, Nisbet 2008, Ivey 2006, CNA 2004, Billay & Yonge 2004, O'Malley *et al* 2000).

For the purposes of this study, the term *preceptor* was defined as an experienced registered nurse (RN) who acts as a role model, guide, counsellor, teacher and resource person to assist newly hired experienced nurses adjust and adapt to a new clinical setting during the preceptorship period. Equally, the term *preceptee* has been defined as a newly hired experienced nurse who needs to be adjusted to the clinical area, and learn the necessary skills and procedures to practice independently and competently in order to provide the required quality of nursing care to patients.

Each party involved in the preceptorship process forming the basis of this study needed to know the exact nature of the role that s/he was going to play in order for the preceptorship goal to be fully achieved. In the next section, I will clarify the role and responsibilities of the preceptor and preceptee during the preceptorship period by returning to an analysis of the literature. The reason for undertaking the latter is that having a clear definition of the role of the preceptor and preceptee during preceptorship has enabled me to build a conceptual understanding of how to prepare and select the preceptors.

2.6 Preceptor and preceptee roles and responsibilities

Role clarification is essential if an organisation is to describe exactly what it expects from preceptees and preceptors. This could help both parties (preceptors and preceptees) to work effectively in order to fulfil their expected roles and responsibilities during the preceptorship period (Shermont & Krepcio 2006). The preceptee is expected to be an active learner and professional by being committed to

his/her role and acting safely by adhering to ethical and hospital standards of care (Myrick & Yonge 2005). The preceptee should interact respectfully and proactively with the preceptor, patients, colleagues and other health teams and should be accountable for his/her own actions (Myrick & Yonge 2005). Furthermore, s/he should engage in self-evaluation in order to identify his/her strengths and weaknesses and be able to work towards improving performance (Myrick & Yonge 2005). Finally, the preceptee needs to become involved in the clinical setting and be seen as helpful (Burns *et al* 2006) in order to enhance his/her clinical learning and share some of the preceptor's workload.

In contrast, the preceptor role is to provide day-to-day clinical teaching for the preceptee (Gleeson 2008, Burns *et al* 2006, Hardyman & Hickey 2001). However, as Gleeson (2008) clarified, the first priority for preceptors is patient care in addition to teaching the preceptee how to deliver safe care within their scope of practice. Despite their having to put patients first, preceptors still play a major role in reducing preceptee stress, helping them overcome their fear of the unknown, and changing their attitudes and perceptions of nursing practice from those they started out with (Charleston & Happell 2005). Thus, an expert preceptor is one who thinks ahead about the type of activities that will help the preceptee progress (Ridge 2005). Furthermore, the preceptor has to develop a daily plan during the preceptorship period, by identifying appropriate patients for the preceptee to deal with. In addition it is imperative that preceptors communicate with the preceptee to meet his/her expectations regardless of the number, type and complexity of patients that need to be managed, in order to help the preceptee reflect on his/her difficulties and identify how clinical performance might be improved (Elmers 2010, Burns *et al* 2006)

In a review paper by Burns *et al* (2006) they concluded that communication between the preceptor and preceptee needs to be open in order to be able to discuss and cover most unit related topics and thus fulfil preceptees' needs. Myrick & Yonge (2005), in their nursing preceptorship book, also asserted that even in the face of potential problematic situations, the preceptor needs to maintain the status of role model and deliver the standards of teaching and learning required to provide preceptees with unit specific as opposed to general information. Hence, Ashurst (2008) and Diehl-Oplinger & Kaminski (2000), in their opinion papers illustrating

how their preceptorship programmes were developed and implemented in their clinical settings, described the preceptor role as that of a clinical instructor, role model, counsellor and resource person.

Furthermore, Ridge (2005) added that preceptors were responsible for helping the preceptee apply his/her theoretical knowledge to practice and identify the preceptee's needs by demonstrating sufficient knowledge of their nursing programme. In addition, the preceptor should comprehend how the preceptee accommodates to the new clinical setting, works collaboratively with others and provides continuous feedback to the preceptee.

Within both the empirical and non-empirical based literature, there was general agreement that the preceptor role included orientation of the preceptee to the clinical setting, clinical routine and work-related policies and procedures. However, the preceptor was not accountable for the preceptee's performance or actions (Ashurst 2008, Ivey 2006, Guhde 2005, Bain 1996). In addition, the preceptor should provide the preceptee with support and clinical expertise (Charleston & Happell 2004, Kaviani & Stillwell 2000). Similarly, Nisbet (2008) and O'Malley *et al* (2000) added the preceptor should be committed to the role by observing, assessing and evaluating the preceptee's clinical development. Regarding the latter issue, Ridge (2005), in his opinion paper, indicates that the preceptor needs to collaborate with the nurse educator and nurse manager in order to evaluate the preceptee's performance, address any further needs and provide a formal written evaluation at the end of the preceptorship programme.

Although most of the literature is concerned with highlighting the preceptor's role as vital for the success of a nurse's development as well as the preceptorship programme *per se* (Finkel 2003), Diehl-Oplinger & Kaminski (2000) added that the nurse manager role was complementary to this process. Hence, Diehl-Oplinger & Kaminski (2000), in their opinion paper, expected nurse managers to: be available during the preceptorship period for consultation; provide preceptees and preceptors with the necessary written material and teaching aids; act as a resource, assist with problem-solving, meet regularly, evaluate the preceptee and provide feedback to the preceptor on his/her performance.

Kemper (2007) added a further responsibility for the nurse manager: that of assessing the preceptor's readiness for the role. Despite the importance of the manager's role in the preceptorship process, only DeCicco (2008) and Allen (2002) looked at managers' perceptions of preceptorship effectiveness for new nurses. The following section however, examines the factors that impact, directly or indirectly, negatively and positively, on the success or failure of the preceptorship programme.

2.7 Factors associated with the success or failure of preceptorship programmes

Analysis of the empirical studies highlighted a series of direct and indirect factors that had the potential to contribute to the success or failure of a preceptorship programme in the clinical setting. Direct factors were revealed as being the most common constraints influencing the effectiveness of preceptorship programmes (NNRU 2009) and as such, must be taken into consideration if the development of a preceptorship programme is to be successful (CNA 2004).

These factors included preceptor selection and preparation, the preceptor-preceptee relationship and support services (Gleeson 2008, Kemper 2007, Guhde 2005 Bashford 2002, Kelly *et al* 2002, Kaviani & Stillwell 2000, O'Malley *et al* 2000). Thus, each of the above aspects can be viewed as key drivers influencing the failure or success of the preceptorship process *per se* because each is essential for the effective development and implementation of a preceptorship programme. However, analysis of the literature revealed other factors, such as workload and nursing shortages, had the potential to indirectly result in failure of the preceptorship programme. In this section, the impact of workload and nursing shortages on the preceptor's role, and the quality of the preceptor-preceptee relationship will be discussed first. The debate will then move to examining the reciprocal relationship between direct and indirect factors and the impact they are able to exert on the preceptorship process.

Preceptorship as a form of clinical education is not problem-free either for the preceptor or for the preceptee. For example, there are times when the preceptor has a workload that prevents him/her providing the expected care or supervision for the preceptee, which affects the continuity and status of the preceptorship process, especially during busy work periods (Gleeson 2008, Burns *et al* 2006, Allen 2002, Kelly *et al* 2002).

Accordingly, preceptees may find the type of one-to-one clinical teaching and learning being offered is not effective because it does not fulfil their needs; the learning style is not collaborative and there is no time for reflection because her/his preceptor was always busy (NNRU 2009, Gleeson 2008, Kemper 2007, Burns *et al*, 2006, Kelly *et al* 2002). Thus, if preceptors are to be effective in their role, and teaching and learning in the clinical setting rendered less stressful, the research based findings' suggested that preceptors need to have their workload reduced (Henderson *et al* 2006, Allen 2002, Kaviani & Stillwell 2000). In that way they can identify the preceptee's learning needs and their own leadership style, and have the time and energy, they need to engage in effective learning and teaching (Carlson *et al* 2009, DOH 2009, Charleston & Happell 2005, CNA 2004).

As stated earlier, the findings of the empirical studies have found that nursing shortages and insufficient time to spend with preceptees are also factors, which negatively influence the efficacy of the preceptor role and the subsequent success of the preceptorship programme (Gleeson 2008, Hautala *et al* 2007, Harbottle 2006, CNA 2004, Allen 2002, Kelly *et al* 2002, Ross & Clifford 2002, Whitehead 2001, Kaviani & Stillwell 2000). These factors were found to be significant reasons for preceptors having increased workloads.

In addition, in their qualitative evaluation study Kaviani & Stillwell (2000) championed the view that the personal characteristics of the preceptor, such as self-confidence, knowledge and expertise, motivation and the ability to update her/his knowledge and skills, also contributed to the development of an effective preceptorship programme; a view more recently reinforced by Charleston & Happell (2005). Similarly, the type of educational strategies adopted by those running preceptorship programmes also contribute to its success or failure (DOH 2009, Beecroft *et al* 2008, Gleeson 2008, Kemper 2007, CNA 2004, Allen 2002). The latter factor encompasses preceptor selection and preparation, which is the first direct factor to be discussed below.

2.7.1 Preceptor selection and preparation

Several studies have discussed preceptor selection and preparation (Beecroft *et al* 2008, Gleeson 2008, Licqurish & Seibold 2008, Ivey 2006, Smith & Chalker 2005,

Feldt *et al* 2002, Wright 2002, Agnew 2000, Bick 2000, Kaviani & Stillwell 2000). Although, there is no consensus in the literature about how or on which basis the preceptor should be selected, this aspect tended to be orientated specifically towards the characteristics of the preceptor. For example, a good preceptor had to be warm, empathetic, respectful, flexible, fair, dependable and humorous, able to work with the beginner and adjust their teaching style based on the preceptee's learning and development needs (Hayes 1994). Furthermore, s/he should be able to provide constructive feedback (Beecroft *et al* 2008, Burns *et al* 2006).

However, despite this lack of consensus regarding precisely what basis the selection process should be founded on, it was clear that it should be based on some form of specific criteria. Thus, some have argued that such criteria should encompass the preceptors' willingness to undertake the role, engage in some form of training and demonstrate commitment to the role (Elmers 2010, Kaviani & Stillwell 2000, O'Malley *et al* 2000). In addition to the above, in 2001, the UKCC recommended that preceptors must be first-level registered nurses with at least 12-months experience and located within the same or an associated clinical setting as the preceptee requiring support (Ashurst 2008, UKCC 2001). Moreover, nurses must be willing to share their knowledge and skills with the preceptees. They should understand and support the notion of preceptorship, be aware of the additional responsibilities they would be expected to handle and demonstrate an ability to teach and develop a learning relationship with the preceptee (NMC 2004). It was also recommended that preceptor selection should be based on the nurse's knowledge and clinical competence (CNA 2004, NMC 2004).

Careful selection of the preceptor was also considered essential if the preceptorship goals⁵ were to be achieved. Therefore, Ivey (2006) recommended conducting a workshop for experienced nurses to discuss ways in which they could improve their teaching skills by exposing them to a variety of teaching strategies, offering free access to journals or library resources, or conducting continuous education sessions as a way of recruiting and supporting potential and/or actual preceptors.

⁵ The goal of preceptorship is to facilitate integration, socialisation of the preceptees into their new role in order to independently, and competently provide the required quality of nursing care to patients within the boundaries of the organisation's standards of care.

Although there are no formal requirements associated with being a preceptor in the UK, the Nursing and Midwifery Council (2002) recommend a period of preparation should be undertaken for nurses taking on the preceptor role. As part of the preceptor preparation, it has been shown in more recent studies that it is important for preceptors to have some knowledge about adult learning principles (Burns *et al* 2006, NMC 2002). Possession of this knowledge was thought to enable preceptors to help preceptees develop and utilise critical thinking skills and strengthen their clinical competence (Thompson *et al* 2001). Hence, as part of this preparation, preceptors need to have been shown how to judge which teaching approach to adapt when instructing the preceptees within the clinical context (Burns *et al* 2006).

Consequently, when preparing preceptors, such a programme of preparation needs to include learning styles so that preceptors are able to take this into consideration when attempting to impart knowledge to preceptees (Carlson *et al* 2009, Burns *et al* 2006). In this way, it is possible for the preceptors to develop clinically oriented teaching, which is evolutionary and participatory, repetitive and reinforced in order to strengthen and enhance learning (Burns *et al* 2006). Hence, by using a range of learning activities, it has been shown that a participants' interest and readiness to learn increases. Therefore, the immediate use of new information and/or skills has the potential to enhance the retention of information (Burns *et al* 2006).

Furthermore, during their preparation stage, preceptors should be exposed to the most common teaching methods in clinical practice in order to develop their own teaching skills and confidence (Burns *et al* (2006). For example, the '*sink or swim*' and '*manipulated structure*' approaches. In the '*sink or swim*' approach, preceptors expose preceptees to a variety of patients with no visible support. Here the preceptor is only responsible for important decisions, but is available as "back-up" at all times while providing minimal pre-clinical interventional teaching. However, in the '*manipulated structure*' approach, preceptors choose clinical cases based on a preceptee's previous experience and skills. The pre-clinical interventional teaching is greater in this case and achieved via a process of preceptor consultation (Burns *et al* 2006). In this latter context, the preceptors increase the number and complexity of cases alongside the preceptee's clinical skills development (Burns *et al* 2006).

Modelling is another effective learning strategy that preceptors should be prepared to use as part of their preceptorship training and subsequent teaching (Irby *et al* 2004). In this approach, the preceptor demonstrates his/her clinical skills during patient interactions while the preceptee observes. This approach enables preceptors to help new nurses apply nursing theory to the actual patient and observe patient interactions (Irby *et al* 2004). Furthermore, modelling and observation create opportunities for the preceptor and preceptee to share their thoughts and impressions of the case by allowing the preceptee to challenge the preceptor to answer the ‘why?’ behind what they are doing (Burns *et al* 2006). However, modelling and observation are passive processes since the learner tends to focus on the application of clinical skills rather than achieving mastery (Burns *et al* 2006).

Recognition of the importance of nurses’ preparation for the preceptor role before being engaged in the preceptorship process resulted in all organisations running preceptorship programmes to conduct workshops in order to build preceptor skills. Sometimes called a ‘preceptor preparation course or programme’, the duration of such programmes ranged from one day to one week (Beecroft *et al* 2008).

However, inconsistent preceptor preparation for their role was noted in most of the empirical studies (Duffy 2009, Beecroft *et al* 2008, DeCicco 2008, Henderson *et al* 2006, Kaviani & Stillwell 200). The reason for this seemed to be based on what preceptorship was meant to be and the role and responsibilities of the preceptor in each organisation. Preceptor preparation programmes were criticised by most of the preceptors, as the important points of how the role should be performed were not covered. Therefore, the research-based findings highlighted that preceptors appeared inadequately prepared for the role (Gleeson 2008, Allen 2002, Ross & Clifford 2002). Hence, it was concluded that specific selection criteria were not implemented in organisations as some nurses were selected without any prior training and others were unwilling or felt they were not ready to precept (Duffy 2009).

The latter issues undoubtedly influence the preceptors’ ability to guide preceptees and the preceptees’ ability to fulfil the expected preceptorship requirements as they often appeared incompetent and lacked the necessary knowledge skills and confidence to enable them to work independently (Duffy 2009, Charleston &

Happell 2005, Allen 2002). Conversely, preceptors who had absolute clarity in relation to their role as a preceptor together with a well developed vision of the attributes, skills and knowledge base necessary to fulfil the role and were aware of their limitations, were more committed to the role. Thus, they were concerned with building constructive preceptor-preceptee relationships, which contributed to the success of the preceptorship programme.

2.7.2 The preceptor- preceptee relationship

In a preceptorship programme, building an effective relationship between the preceptor and preceptee is significant (Myrick & Yonge 2005). “*The nature of the relationship between a preceptee and preceptor will be dependent on the previous experience of each, the practice setting and the nature of the care to be given*” (Kaviani & Stillwell 2000 p.219).

Bain (1996) claimed the relationship between preceptor and preceptee during the preceptorship programme is ‘short’ and ‘functional’. In contrast, Turner (2007) argued that the preceptor-preceptee relationship is a peer relationship in which both parties work as equals. The preceptorship relationship classically comprises three stages: the initial, maintenance, and termination stages (Myrick & Yonge 2005). The initial stage begins with the primary meeting between preceptor and preceptee in which mutual familiarisation occurs, and the preceptor assesses the preceptee’s needs. At this point, the preceptor, in collaboration with the preceptee, decides which method of training and evaluation is appropriate to meet the preceptee’s teaching and learning needs (Myrick & Yonge 2005).

During the maintenance stage of the preceptorship programme, daily feedback forms a fundamental part of the relationship. Feedback should therefore be structured and include both negative and positive points regarding the preceptee’s clinical performance to help the individual feel more secure in their clinical role (Myrick & Yonge 2005). The termination stage of the preceptorship relationship is usually characterised by formal evaluation of the preceptee’s clinical performance (Myrick & Yonge 2005).

However, the preceptor-preceptee relationship can be affected by many different indirect factors: preceptor workload (as stated earlier), the number of preceptees in

the clinical setting, duty rosters, the nature of managerial support, and preceptee-preceptor motivation (Kaviani & Stillwell 2000). The latter is particularly important because, if the preceptee is motivated to learn, s/he will (under normal circumstances) by default motivate the preceptor to teach (Kaviani & Stillwell 2000).

Furthermore, the stress of the preceptorship experience may also negatively affect the preceptee's clinical performance as well as her/his relationship with the preceptor (Yonge *et al* 2002). This would therefore contribute negatively to the success of the preceptorship programme. For a successful relationship to flourish, both preceptor and preceptee should know the expectations of the relationship and its outcomes (NMC 2002). Myrick & Yonge (2005) concluded that, regardless of the quality of the preceptor-preceptee relationship, the preceptorship experience should finish with dignity and a critical appraisal of the individual's clinical performance. Hence, administrative support also plays a key role in enhancing an effective preceptor-preceptee relationship as outlined below.

2.7.3 Role of support in a preceptorship programme

There is only scant empirical evidence to demonstrate how support impacts on preceptorship programmes (Bourbonnais & Kerr 2007, Hautala *et al* 2007, Allen 2002, Kelly *et al* 2002). However, from the data available it was possible to discern that support was not always evident, or was not delivered adequately or properly to preceptors and/or preceptees. However, Hautala *et al* (2007) in their mixed method study suggested that support from nursing administration and the education department, together with adequate resources and dedicated time allocated to facilitate preceptor-preceptee interactions all need to be in place if a preceptorship programme's goals are to be achieved.

Myrick & Yonge (2005) argue administrators play a pivotal role in the promotion, support and success of a preceptorship programme, although nurses involved in such programmes are often unaware of the importance of such roles. In addition, educational support for preceptees and preceptors during the preceptor process is also a vital element of such programmes. For example, Ivey (2006) emphasised that educators need to stay in contact with and direct preceptors, especially those who are new to the role. In addition, educators should also ask preceptees about their

relationship with the preceptor, as many preceptees are unwilling to disclose their feelings about the relationship particularly when the preceptorship process is not going well (Ivey 2006).

Furthermore, Finkel (2003), in her opinion paper, claimed that ongoing peer support for the preceptor is required during preceptorship in order to help the preceptor perform his/her dual role effectively especially as preceptorship is a time-consuming, complex activity. The qualitative study of Kaviani & Stillwell (2000) derived similar conclusions to Finkel's (2003) views during their study examining the effectiveness of a preceptorship programme from preceptors' perspectives. In particular, while member checking their data to increase study the rigour, all participants emphasized the need for on-going support from nursing colleagues, administrators and educators and the contribution each could make to the development of an effective preceptor-preceptee relationship (Kaviani & Stillwell 2000).

The more opinion based articles reflected similar themes in that they indicated nurse educators in particular, need to be available within the clinical setting to provide the preceptor/preceptee with the necessary clinical learning resources (Finkel 2003, Diehl-Oplinger & Kaminski 2000). Additionally, recognition from nurse managers was found to encourage preceptors develop their theoretical and practical knowledge, enhancing their commitment to the preceptor role and its associated responsibilities. Support from peers also helps stop preceptors feeling overloaded (Myrick & Yonge 2005). Likewise, support for the preceptee from a nurse manager and/or educator ensures the preceptee feels clinically more secure and welcomed (Myrick & Yonge 2005).

Recognition of the preceptor role was discussed by most authors in the context of how support from peers and managers could impact positively on the nurses' willingness to be a preceptor, increase their job satisfaction and commitment to the role (Giallonardo *et al* 2010, Henderson *et al* 2006, CNA 2004, Finkel 2003, O'Malley *et al* 2000). The empirical as well as the opinion based studies demonstrated that recognition of the preceptor role was considered critical in a preceptorship programme where extra efforts are required to teach and train the newly hired nurses (preceptees) in addition to providing patient care (Giallonardo *et al* 2010, Henderson

et al 2006, Finkel 2003, O'Malley *et al* 2000). Therefore, ongoing support to the preceptors, in the form of assistance with workload, and nominating them for awards at employee events, were considered part of the recognition process for the preceptor role as well as preceptorship programme.

In conclusion, proper selection and preparation of nurses for the preceptor role may contribute to building effective trusting preceptor-preceptee relationships, especially if this is integrated with appropriate forms of support from colleagues, managers, educators and recognised by administrative personnel. Thus the latter has been demonstrated by research to enhance preceptees' job satisfaction by increasing both clinical competence and performance (Lee *et al* 2009, Kim 2007, Leigh *et al* 2005), expanding their experience of real life practice situations (Myrick and Yonge 2005, Ohrling & Hallberg 2000) and accordingly enabling them to work independently and integrate effectively into the new role.

In addition, the empirical evidence illustrated that appropriate preceptor selection and preparation was also found to enhance preceptors' self-confidence and esteem, as well as boost their personal and professional satisfaction particularly when it resulted in enhancement of the preceptors' leadership skills (DeCicco 2008, Green & Puetzer 2002). Hence, the latter resulted in increased recruitment and retention rates within the clinical setting (Charleston & Happell 2005, Leigh *et al* 2005, Myrick & Yonge 2005) helping to resolve nursing shortages and reduce workload (Block *et al* 2005, Lambert & Glacken 2004, Griffin *et al* 2002, Lofmark & Wikblad 2001).

However, it could be suggested that where the above were not effectively achieved, implementation of a preceptorship programme would not be considered appropriate. This can have a negative effect on the new nurse's clinical ability and his/her willingness to remain in the clinical setting, leading to nurses leaving the organisation unexpectedly, increasing staff turnover, and augmenting financial burdens for an organisation. Hence, job satisfaction for the remaining ward staff will also be negatively influenced due to staff shortages and increased patient workloads (Hautala *et al* 2007, Kemper 2007, Guhde 2005). Nevertheless the latter is a factor that may overtly contribute to a reduction in the quality of clinical nursing care due to further

loss of staff and an associated spiral of declining standards (Leigh *et al* 2005, Hancock 2002, O'Malley *et al* 2000).

2.8 Preceptorship and Clinical Nursing Care

The effect of preceptorship on the clinical performance and competence of newly qualified nurses were found to have been examined across a small number of research studies (Lee *et al* 2009, Clark & Homes 2007, O'Connor *et al* 2001). More importantly, in this case, no study was found that examined the effect of preceptorship on the clinical nursing care of the newly hired experienced nurses.

Analysis of the literature also revealed that the effective implementation of preceptorship in the clinical setting through the facilitation of effective preceptor-preceptee relationships improved the standard of care received by patients because preceptorship enhanced the newly qualified nurses' skills and knowledge and, by default, their clinical competence (O'Malley *et al* 2000). Clark & Holmes (2007) concurred with this notion by suggesting that effective preceptorship was central to the enhancement of competent practice. Thus, the quality of preceptorship is directly linked to the preceptee's learning and development such that the more knowledge and clinical skill the preceptee gains the more competent s/he becomes (Clark & Holmes 2007). Moreover, in an opinion paper, Finkel (2003) states that preceptor effort impacts significantly on the quality of patient care, reduces the duration of the preceptorship period and influences preceptees' performance.

Synthesizing the findings from a series of empirical studies examining the impact of preceptorship on clinical performance there is a growing body of evidence to suggest that preceptorship may have a positive outcome on competence and clinical performance. For example, Kim (2007) reported that 90% of senior nursing students perceived their overall level of competence increased after the preceptorship programme, while 10% of students perceived there to be no change in competency. Furthermore, Kim's (2007) data also indicated a significant correlation between perceived levels of competency and the preceptee-preceptor relationship suggesting that there is a need to create an environment conducive to clinical learning.

Lee *et al* (2009) evaluated the impact of preceptorship on staff turnover, cost, quality and professional development of the preceptees using a quasi-experimental research design. 24 female preceptors and 34 new nurses were included in the study. Findings from this study revealed that on completion of the preceptorship period, medication errors had reduced from 50% to 0% as did the overall incidence of adverse events. Thus, Lee *et al* (2009) concluded that preceptorship enhanced the quality of nursing care. However, the study did not state how long these effects lasted.

Research examining the impact of preceptorship on clinical practice, although growing, is still limited in its scope. The reasons for this might include the fact that organisations expect newly qualified nurses and newly experienced nurses to be equipped with the necessary knowledge and skills to enable them to be competent to practice their new role independently without direct supervision (Clark & Holmes 2007). However, it is still not clear whether new nurses are truly equipped with the knowledge, skills and confidence they require to be competent practitioners (Clark & Holmes 2007, O'Connor *et al* 2001). This is due to lack of standardisation across nursing education programmes during the pre-registration period (Clark & Holmes 2007). Secondly, the lack of objective methods to measure the clinical competence of new nurses in the clinical setting leads to the questioning of unreliable evidence or tentative conclusions concerning the competence of new nurses (O'Connor *et al* 2001).

In conclusion, if preceptorship is to be in any way meaningful and relevant it must have a positive impact on clinical nursing care. However, it could be questioned whether it does indeed have a positive impact. Although the previous empirical studies have indicated that it does have a positive impact on clinical nursing care, this evidence by itself is insufficient, thus the converse could be true. For example, if the preceptor has not received the support s/he needs to manage patient care, ward and preceptee demands, the quality of nursing care could be diminished.

Conversely, if the preceptor receives support from, for example, a colleague or one of the team, the result could be a reduced workload. This would allow the preceptor to utilise the time saved to focus on preceptee development. However if the preceptor does not receive the necessary support, workload will increase and time

available for supporting preceptees will be reduced which, in turn, means that preceptees become independent at a slower rate. Once preceptees are equipped with the necessary skills to work effectively in the clinical environment, the workload will decrease as it is spread between the preceptor and preceptee. Collective care will be increased because the preceptee is now trained to work at the same level as other colleagues. Therefore, the quality of clinical nursing care may increase. This is, however, dependent on the cooperation of other nursing team members and the ward manager's sensitivity at picking up on such issues. Consequently, further research to study the efficacy of preceptorship and its ability to secure quality improvement of the new nurses' performance by ensuring they are adequately trained and prepared for their new role is increasingly recommended (Leigh *et al* 2005).

2.9 Previous methodological approaches to the study of preceptorship and how this has shaped the design of the proposed study

Preceptorship has been repeatedly investigated since the early 1960's using quantitative, qualitative and mixed methods approaches as illustrated previously in table 3, page 31. Each methodological approach has its own strengths and limitations given that each has a unique and valuable contribution to make to the examination and detailed investigation of a research topic (Ritchie & Lewis 2003) – in this case preceptorship. Nevertheless, selection of the most appropriate methodological approach is key to the success of any investigation (Burns & Grove 2007), which is why the following discussion explores the methods used by other researchers and why particular approaches to undertaking research have been rejected in favour of the proposed methodology, which will be explored in detail in chapter three.

As illustrated in table 3, page 31, when studying preceptorship researchers have adopted various quantitative designs; one used the quasi-experimental design (Lee *et al* 2009). While most used a survey design (Giallonardo *et al* 2010, Kuroda *et al* 2009, Kim 2007, Leigh *et al* 2005, Charleston & Happell 2004, Hancock 2002, Hardyman & Hickey 2001, O'Connor *et al* 2001). Although diverse authors used different terms for the notion of their survey study, my analysis of these studies revealed that all were based on the general standards of survey design but each referred to a specific method used for conducting the survey research. For example, descriptive (Giallonardo *et al* 2010, Kuroda *et al* 2009, Leigh *et al* 2005, Charleston & Happell 2004, Hancock 2002), correlational (Kim 2007), longitudinal (Hardyman & Hickey

2001) and prospective comparative (O'Connor *et al* 2001). These terms are stated in table 3 and the data extraction sheet (Appendix B, page 290) as have been used by the authors. Further details regarding each of the studies can be found in the data extraction sheets located in appendix B, page 290.

In general, the strengths of these quantitative studies are that each of the latter designs were considered appropriate as they described the examined phenomena in natural situations and examined the relationship among or between variables (Topping 2010, Burns & Grove 2007). Thus, the chosen designs enabled the authors to obtain new information on preceptorship and identify the relationships between preceptorship and other variables, such as competence, job description and satisfaction, staff turnover, anxiety, quality and professional development, which had the potential to change nursing practice in the respective study settings. In the studies, logical deductive reasoning was the form of logic used to draw conclusions from the data. Hence, each study's purposes were clearly stated.

Nevertheless, a weakness of such studies was that they had low response rates, ranging from 39-58%, due to their use of postal surveys, leading to a lack of generalisability. This lack of generalisability was then compounded by the work having taken place in one study setting with no detailed description of the characteristics of the setting or the sample (Giallonardo *et al* 2010, Kim 2007, Leigh *et al* 2005, Hardyman & Hickey 2001, O'Connor *et al* 2001). Equally, there was the potential for non-responder bias as non-respondents may have differed from respondents in some way (Jones & Rattray 2010). However, the potential for response bias in these studies may have been reduced as they used postal surveys (Jones & Rattray 2010). Selection bias was possible due to the sample being non-randomly selected: some participants may have contributed because a ward manager asked them to do so (Kuroda *et al* 2009, Lee *et al* 2009, O'Conner *et al* 2001). All of these factors have also been seen as weaknesses of this form of study.

Another weakness was that there was a greater risk of missing data as a result of using a self-reported tool, as in the Giallonardo *et al* (2010), Charleston & Happell (2004) and O'Connor *et al* (2001) studies. In addition, the Quasi-experimental methodological approach, adopted in the Lee *et al* (2009) study, lacked a clear

definition of the concept under investigation. This factor also limits the theoretical generalisation of the findings making them difficult to assimilate into practice (Burns & Grove 2007). Furthermore, lack of a random sample was a more significant criticism that could be levied at this and other such studies, as the latter impacts on the internal validity of the findings (Bryman 2008, Burns & Grove 2007). Finally, replication of such quantitative studies can also be difficult particularly when authors do not outline the procedures used in the research in detail, as was the case with the studies drawn on as part of this review.

Other researchers have adopted qualitative approaches to studying preceptorship in nursing with most having used a generic qualitative research design (Bourbonnais & Kerr 2007, Turner 2007, Harbottle 2006, Allen 2002). However, some authors used different terms for describing their qualitative design, which may indicate the purpose for adopting such an approach. These terms were: an exploratory qualitative design (Clynes 2008, Clark & Holmes 2007), descriptive qualitative design (Duffy 2009); longitudinal descriptive design (Henderson *et al* 2006), evaluative qualitative design (Allen 2002, Kaviani & Stillwell 2000) and a qualitative summative evaluation design (DeCicco 2008). These terms are also stated as used by the respective researchers in table 3 pages 31 and the data extraction sheets located in Appendix B page 290 even though in essence they each refer to a generic qualitative approach.

Nevertheless, some researchers did apply specific qualitative methods underpinned by the philosophies of Phenomenology or Grounded Theory. Of those using Grounded Theory, (Charleston & Happell 2005, Myrick & Yonge 2004); Charleston & Happell (2005) explored nurses' perceptions about their experiences of preceptorship. While Myrick & Yonge (2004) examined the impact preceptorship had on improving graduate nursing students' critical thinking skills. This methodology was considered appropriate as all studies offered valuable insight into preceptorship, the way it enhanced the critical thinking skills of both preceptors and preceptees in real world clinical practice and how it facilitated the participants' transition to the role.

The Grounded Theory approach enabled authors of the latter studies to generate theories related to preceptorship practice. The latter analysis was ostensibly achieved

by looking at preceptor and preceptee' perceptions based on both parties experiences' of preceptorship. However, study rigor was questioned as insufficient detail was given regarding the methods of data analysis and interpretation. Hence, this latter deficiency affected the confirmability and credibility of the findings (Speziale & Carpenter 2007, Ritchie & Lewis 2003).

Conversely, a hermeneutic-phenomenological interpretive methodology was applied by Ohrling & Hallberg (2001) and Ohrling (2000) studies. Carroll *et al* (2005) used case study design. Finally, Kelly *et al* (2002) adopted an action research approach to evaluating the contribution preceptors made to the development of preceptees. However, in general, the weaknesses of the included qualitative studies are that they failed to provide sufficient detail regarding the demographic characteristics of their sample and/or the setting, which ultimately impacted on my ability to decide if the study could be transferred to my own research setting (Ritchie & Lewis 2003). Furthermore, it was difficult to decide on the dependability of most of the studies as they lacked detail and clear documented information about the research process (Bryman 2008, Speziale & Carpenter 2007). Few of the evaluative studies included the perspectives of all programme stakeholders. No study examined newly hired experienced nurses' perceptions of preceptorship.

However, the general strengths of these studies are that each intended to provide new insights, meanings and descriptions of preceptorship in order to illustrate, understand and interpret the day-to-day experiences of nurses who had been involved in the preceptorship process. As a result, the studies highlighted different and valuable perspectives related to preceptorship and revealed the experiences of new nurses across a variety of natural settings, such as critical care, community and mental health, via rich descriptions of the preceptorship phenomenon. In addition, data were interpreted either by two researchers or confirmed by the participants themselves after having been interpreted by the researcher in order to ensure the credibility of the findings, uncover any bias and enhance theoretical sensitivity (Speziale & Carpenter 2007). Consequently, the meaning of preceptorship as an holistic concept was created, which helped to guide the participants' clinical practice.

In contrast, the Hautala *et al* (2007), Scells & Gill's (2007), Almada *et al* (2004), Ross & Clifford (2002), and Farrell & Chakrabarti (2001) studies all adopted a mixed qualitative and quantitative design. Scells & Gill (2007) used a two-phase process to evaluate a team preceptorship model and the impact this had on clinical and professional development of nurses working in an orthopaedic unit: the initial phase was interpretive while the second phase followed a survey methodology. A more detailed analysis of all the papers reviewed as part of this study can be found in the data extraction sheets located in appendix B, page 290.

However, a major strength of mixed methods studies is that greater validity and/or credibility for such study findings can be achieved as the qualitative and quantitative data are combined to enhance study rigor. In this design, qualitative findings reinforce the quantitative results by providing additional information and views that help to illustrate and clarify the participants' understandings in order to generate a more comprehensive picture of the study topic – in this case - preceptorship (Simons & Lathlean 2010, Bryman 2008). Additionally, findings generated from the qualitative element can be tested and/or compared with the quantitative elements of such studies (Bryman 2008).

However, the weaknesses of the mixed method approach are similar to the previous quantitative and qualitative approaches but doubled in that now you have two sets of methodological flaws that can potentially compromise the rigour or validity of a study. Of the studies that adopted the latter approach, generalisability of the findings to all the participant populations was difficult to achieve as most studies were conducted in only one setting with small and non-representative samples. Similarly, transferability of the study findings to other settings was also impossible as some studies lacked an adequate description of the demographic characteristics of the participants and/or the settings. Thus, it was difficult to establish the reliability and/or dependability of the studies as there was no complete audit trail outlining each of the research phases (Bryman 2008).

It is clear from the diversity of methods used, that preceptorship is a complex topic. For this reason, any number of research designs could be used to study the topic. However, factors such as study aims and objectives are important aspects to be

borne in mind when selecting the most appropriate methodology to help elicit the type of data needed to answer a particular research question. For this reason, it was vital to choose only the method(s) that could help me answer the questions stated at the outset of this thesis but before I do so, it is crucial to state in the following section how the literature review has helped me to develop the study's aims and select the appropriate methodological approach.

2.10 How the literature has informed the development of the thesis aim and the subsequent methodological approach

Following analysis of the literature, the study's aim did not fundamentally change from that which I set out to achieve. Reviewing the literature, in fact, reinforced the aim identified at the outset as being appropriate due to a lack of prior research into this particular area.

Furthermore, when considering what methodology to adopt, a review of the literature made me realise that it was not appropriate to undertake a quantitative study due to the fact that there was no available data about the study phenomena in a Saudi Arabian context thus preventing any type of comparison or control research between my study and others. There were no data regarding the impact preceptorship had on clinical nursing care or how it enabled nurses to be fit to practice in Saudi Arabia. Therefore, as my concern was to elicit participants' perceptions, based on the types of methodologies previous researchers had used, it was clear that a qualitative study was the only approach, which could be adopted in order to actually examine this phenomenon in a Saudi Arabian context. This was because choosing a descriptive survey method would only enable me to access very limited data related to participants' perceptions. However, in order to look at participants' perceptions in more depth, a qualitative method seemed to be the most appropriate design to adopt. The latter approach provided the freedom to explore the phenomena without constraints.

However, in terms of adopting a particular qualitative framework such as phenomenology or grounded theory, analysing the literature also enabled me to examine the use of particular qualitative approaches in relation to preceptorship as presented in method chapter section 3.3.2.1 page 83. Thus, I concluded that a generic qualitative design was the most suitable methodology to use. Reasons for adopting a

generic qualitative design as an appropriate methodology for this study are presented in more detail in section 3.3.2.2 page 84 of the next chapter.

In essence, the purpose of qualitative research is to examine perceptions and experiences of human beings in order to generate deeper insights and understanding of the topic under study. This choice of methodology thereby facilitated the collection and analysis of the study data in a naturalistic setting, which allowed me to focus on the study participants and their experiences of the preceptorship format in question (Duffy 2009). The reason for choosing a generic qualitative approach is discussed in more detail in the methodology chapter.

2.11 Aim of the study

The aim of the study was to elicit nursing staff perceptions of the preceptorship programme within one hospital in Saudi Arabia and the impact they perceived it had on clinical nursing care.

2.12 Objectives of the study

The objectives of the study were therefore designed to:

1. Elicit nurses' understandings of preceptorship.
2. Identify nurses' expectations of preceptorship.
3. Explore nurses' perceptions of the impact of preceptorship on their clinical nursing practice.
4. Highlight any problems associated with preceptorship.
5. Identify factors related to the success of preceptorship.
6. Use the findings to develop recommendations for programme improvements.

2.13 Why the study is needed

Following the literature review, it was found that previous studies usually examined preceptorship from either one or a range of perspectives. For example, that of the preceptors, teachers, managers or preceptees (undergraduate or newly qualified or new graduate nurses). Thus far, however, no study has explored the meaning of preceptorship and its role in improving clinical nursing care from the perspective of newly hired experienced nurses. More importantly, no one to date seems to have

examined this concept from the perspective of all parties involved in the preceptorship programme, that is: preceptor, preceptee, educational facilitators and managers, to generate a more complete picture of what preceptorship means and involves for all parties.

To date no study has examined the effect of preceptorship on clinical nursing care in a Saudi Arabian hospital. Therefore, this study explored the experiences of all those involved in a preceptorship programme in operation at one Saudi Hospital in order to explore to what extent it facilitated the new nurses' ability to develop clinical practice.

The study's significance lies in the pioneering nature of its approach, where service consumers (in this case the preceptee) and providers (preceptors, nurse managers, clinical resource nurses and nurse educators) were each invited to express their perceptions of preceptorship and its impact on clinical nursing care. Thus, it was possible to fill a gap in the current literature relating to how nurses working in Saudi Arabia felt about preceptorship. Furthermore, the study also has the potential to provide data on how clinical education could be improved.

2.14 Summary

Preceptorship is an important clinical learning and educational programme, which helps develop new nurses' knowledge, skills and attitudes via direct contact with an expert role model to ease their transition into a new role (Kramer 1974). The benefits of preceptorship have been shown to include enhanced staff retention, decreased turnover and a reduction in nursing shortages, as well as improved clinical competence (Kaviani & Stillwell 2000, O'Malley *et al* 2000). Furthermore, factors contributing to the success or failure of preceptorship programmes have also been identified across a number of studies.

Despite the latter, there is no clear definition of what is meant by the term preceptorship. The impact of preceptorship on clinical nursing care has also not been sufficiently examined by nursing researchers. More importantly, what preceptorship meant to the newly hired experienced nurses, what type of support they received, needed or expected in order to integrate effectively into the new

setting and what impact preceptorship had on such nurses' abilities to deliver quality nursing care have not previously been explored globally or locally in Saudi Arabia. These factors alone strongly indicate that a gap in the literature exists in this respect. Furthermore, the methodological approaches previously used to study preceptorship and how this has shaped the design of the current study has been examined.

In the included studies, the strengths and weaknesses of the research that has been conducted to date have been examined. The most common strength of these studies was their value in providing new insights into the preceptorship phenomenon, which could be considered as having important implications for clinical practice. However, it is impossible to generalise their findings or truly replicate them. Finally, how the literature review informed the development of my study's aim and the subsequent methodology as well as the rationale for conducting this study has also been presented as part of this chapter. In the following chapter, a detailed description and discussion of the methodology and methods chosen for conducting the current research are presented.

Chapter III

Methodology and Study Method

3.1 Introduction

At the end of the previous chapter, methodological approaches to the study of preceptorship adopted by other researchers were examined. In addition, how these ideas have shaped the design of the current study was highlighted. Consequently, the present chapter discusses in detail both the methodology and research methods selected for implementation in the current study. Hence, this chapter is divided into two sections as follows:

The first section covers the methodology, which includes exploration of the research design used for this study. In this section, the distinction between quantitative and qualitative approaches is illustrated. In addition, how this exploration of approaches influenced my choice of a qualitative design drawing on ideas taken from the naturalistic paradigm, as a means of approaching this study are revealed. The reasons for using the latter design, based on the current study's aim and objectives have also been outlined. The theoretical perspective of using the naturalistic inquiry paradigm that informs the chosen methodology is also examined.

The second section presents the methods that were chosen for implementation as part of this research. It discusses in detail how the study has been conducted. This element describes the study setting and discusses how the process of gaining access to and selecting participants for the study was achieved. Data collection and analysis tools and how they were implemented are also examined. At the end of this section, ethical issues and how these were addressed as well as reflexivity are illustrated. However, before examining the methodological issues the purpose of the study is outlined as stated below.

3.2 Purpose of the study

The purpose of this study was to examine how preceptorship was perceived by, and how it affected newly hired but experienced nurses in a Saudi Arabian context. The study aimed to describe the nature of preceptorship and its impact on clinical nursing care in Saudi Arabia. In order to achieve this, the study looked at preceptorship from multiple perspectives instead of examining only the perspectives of preceptees and/or preceptors, as previous studies had done. The latter action was felt to be particularly important, in order to understand what it was like for participants to

come to a new environment. More especially, it was felt to be essential to explore what it was like for newly hired experienced nurses to undergo preceptorship in Saudi Arabia; to discover how they learned to engage with other staff, and be effective in their new role, given that the culture was very different for those who came from diverse parts of the world.

Furthermore, the study aimed to explore what preceptorship meant to participants and whether they perceived that the preceptorship programme met their needs and/or produced effective nurses who were able to fit into the team and deliver high quality nursing care. The study also looked at commonalities between participants in terms of the major issues they identified as affecting their respective role(s) and/or how successful the preceptorship programme was in helping them develop a shared view and common meaning of the term preceptorship and thus generate a comprehensive summary of what preceptorship actually consisted of in Saudi. Finally, the purpose of the study was to explore the personal perceptions of all stakeholders⁶ involved in the preceptorship programme, to provide an in-depth, holistic understanding of the study phenomenon (Lincoln & Guba 1985), enabling me to present a thick description of the nature of preceptorship and its impact on the newly hired experienced nurses' ability to deliver effective clinical nursing care.

3.3 The methodology

The term methodology essentially refers to a strategy through which research is structured to answer the research question(s) (Mason 2002). Selection of the most appropriate methodological approach is key to the success of any investigation (Burns & Grove 2007). In a broader context, qualitative and quantitative approaches are the two main methodologies used in scientific research. As established in the previous chapter, preceptorship can be examined using quantitative and/or qualitative methodologies.

However, the study aims and objectives are important factors to take into consideration when choosing the most suitable methodology to help generate the data required to answer particular research questions. For this reason, it was vital to examine the two methodological paradigms in order to be able to choose only the

⁶ The term key stakeholders when used in this context equate to preceptees, preceptors, nurses managers, clinical resource nurses and nurse educators.

method(s) that would answer the questions stated at the outset. The following discussion therefore explores a series of quantitative and qualitative approaches to undertaking research that were rejected as part of this study in favour of adopting the proposed methodology. In addition, why the proposed qualitative design was adopted is also outlined. The quantitative approach and the reasons why it was considered an inappropriate methodology for the present study are the first to be discussed below.

3.3.1 The quantitative approach

Quantitative research is '*a formal, objective, systematic process in which numerical data are used to obtain information about the world*' (Burns & Grove 2007, p.17). It is a scientific process that operates on logical rules and truths, which is often referred to as *logical positivism* (Bryman 2008, Ritchie & Lewis 2003). Quantitative researchers believe that each phenomenon has a single reality, which is an absolute truth that can be investigated using statistical empirical measurement and a process of deduction. Hence, the researcher starts with a general principle to reduce the complexity of a phenomenon and test theory. In addition, personal values, beliefs and perceptions are factors that are not considered when reality is measured in this context (Burns & Grove 2007). This is because the latter factors are human responses, which are difficult to quantify or measure (Burns & Groves 2007, Flick 2006).

Quantitative methods are used when researchers want to describe specific variables, or study a cause and effect relationship between or among variables. Therefore, a blueprint for action or a pre-determined structure regarding the data collection and analysis is determined (Bryman 2008, Burns & Groves 2007, Flick 2006). In quantitative research, the researcher is not an integral part of the study and does not interact directly with the study participants (Burns & Grove 2007, Flick 2006, Ritchie & Lewis 2003). Nevertheless, an advantage of quantitative research is that large amounts of information can be collected within a short period of time (Bryman 2008, Burns & Groves 2007). However, applying a quantitative design to the proposed study was not felt to be appropriate as discussed below.

3.3.1.1 Reasons for rejecting quantitative designs as part of this study

Quantitative methods were considered inappropriate to be adopted for the present study as it did not match the study's aim, objectives and research questions for the following reasons:

1. The study did not intend to test the relationship between variables or statistically test effectiveness as in the case of quantitative methods (Burns & Grove 2007). It aimed to elicit the meaning of preceptorship and its impact as perceived by nurses who had participated in a preceptorship programme. Perceptions, understandings, philosophies and interpretations are human responses and subjective data, which are difficult to measure or quantify accurately. The quantitative method does not allow for the exploration of these issues in any depth or with sufficient clarity because it is a structured, restrictive approach based on a specific, objective framework, following a standardised and structured format using predominantly closed ended questions (Bryman 2008, Burns & Groves 2007).
2. Preceptorship is an important phenomenon in nursing. It was applied in the study setting as part of an orientation programme. Moreover, it was mandatory in that all newly hired nurses had to attend the preceptorship programme. As a result, it was not possible to have a control group, which would lead to selection bias and render the results less valid (Burns & Grove 2007, Greenhalgh 2006, Khan *et al* 2003).
3. The study was conducted in a naturalistic setting, hence manipulation or control of the setting would be difficult, which would increase the probability of a type I and type II error occurring, leading to inaccurate findings (Burns & Grove 2007).
4. The preceptorship programme in Saudi Arabia is a new concept. Therefore, it has been implemented only in the largest hospitals. The lack of standardisation between the programmes could have made it almost impossible to conduct a comparative study, as the comparison would take place by focusing on dissimilar programme content.

5. A power calculation in any quantitative study is important in order to reach a representative sample if the study is to be generalisable. In order to have a representative sample of nurses who attended preceptorship in Saudi Arabia would be difficult to achieve due to the lack of related accurate documentation in each of the hospitals, which was a methodological limitation that would have influenced the credibility of any findings (Burns & Grove 2007).
6. Lack of clarity regarding the definition of preceptorship also impacted on my ability to develop a conceptual framework, which was a further theoretical limitation (Burns & Grove 2007).

The qualitative approach and the reasons why a generic qualitative design was considered an appropriate methodology for the present study are discussed below.

3.3.2 The qualitative approach

In contrast, a qualitative approach was considered a more suitable approach for this study because qualitative research looks at the personal experiences and philosophies of participants in order to examine them in a systematic way and give them meaning (Burns & Grove 2007). Qualitative designs are systematic, subjective approaches to research, aimed at understanding and interpreting the nature/meaning of a phenomenon from an individuals' perspective. Unlike quantitative approaches, qualitative research is usually located in the natural setting and tends to target small groups, rather than trying to explore the world by inference and deduction using manipulated, changed or controlled settings. Therefore, qualitative philosophies are based on the naturalistic, humanistic and interpretive sciences (Speziale & Carpenter 2007, Ritchie & Lewis 2003).

Qualitative researchers believe that phenomena are complex and dynamic, which need to be fully understood if researchers are to accurately interpret them as perceived by individuals within a particular socio-historical context. For this reason, qualitative approaches use a process of induction in data analysis. In this process, the researcher moves from specific details in order to develop a general, broad, in-depth understanding of the phenomena under investigation, which often aims to generate

theory (Burns & Grove 2007). Thus by combining previous personal beliefs, perceptions and values of a phenomena with participants' personal experiences the qualitative researcher explores the meaning of the phenomena under investigation (Ritchie & Lewis 2003).

Moreover, qualitative approaches are suitable for answering questions that require explanation, understanding and/or interpretation related to complex social phenomena and their contexts (Ritchie & Lewis 2003). Furthermore, qualitative methods appear to be more appropriate for examining emotional responses and humanistic concepts as opposed to quantitative methods, simply because human emotions and behaviours are difficult to quantify accurately (Burns & Grove 2007, Flick *et al* 2004). Thus, as indicated above, qualitative methods examine phenomena from a naturalistic stance rather than by manipulating or controlling the setting (Creswell 2009, Denzin & Lincoln 2000). Consequently, qualitative research is more flexible because data collection procedures and study plans often change as the study progresses in response to the data collected from study participants, which might point to a new research direction (Burns & Grove 2007, Flick *et al* 2004). However, this does not mean that any approach can be applied, as the most appropriate method to adopt will depend on the research question needing to be answered and study aims and objectives requiring to be achieved.

Nevertheless, quantitative researchers have often criticized the subjectivity and small sample sizes used in qualitative research as they provide low significance in relation to the findings and so cannot be generalised to the whole population. In other words, the findings of qualitative research are often perceived to be less credible than quantitative research results because data are subjective rather than objective. According to Ritchie & Lewis (2003), using more than one data-collection method and comparing multiple perspectives regarding a phenomenon increases the credibility and accuracy of the study findings thereby reducing the subjectivity of the results. Speziale & Carpenter (2007) who emphasized the validity and reliability of data in qualitative research can be improved by applying different approaches to the same investigation, similarly support this notion.

Ritchie & Lewis (2003) also discussed sample size and stated that samples in qualitative studies are chosen not to be statistically representative, but rather to make theoretical inferences. Hence, analysis of data derived from small samples often generates new evidence in a limited timeframe yet “*increasing the sample size [may] no longer contribute [any] new evidence*” (Ritchie & Lewis 2003, p.83). Furthermore, qualitative studies may yield rich information, so that choosing a small sample is a reasonable approach to adopt if large quantities of data are to be handled effectively (Denzin & Lincoln 2008, 2005, 2000, Ritchie & Lewis 2003).

3.3.2.1 Reasons for rejecting specific qualitative designs for this study

Although the decision was made to adopt a qualitative research approach in this study, the diversity of qualitative designs (i.e. grounded theory, ethnography, phenomenology) and their particular underpinning philosophies encouraged me to examine each of these in terms of their suitability for addressing the current research aim, objectives and fundamental question in order to find the most suitable method to adopt. Hence, the most appropriate qualitative design needed to be able to elicit the type of data required to answer the research question comprehensively. For example, *grounded theory* explores and describes social phenomena in a natural setting with the goal of developing theory or generating concepts (Speziale & Carpenter 2007, Glaser & Strauss 1967).

Consequently, grounded theory involves using both inductive and deductive reasoning. In the case of inductive reasoning, theory is derived from specific data in order to generate theory that is more general; while in deductive reasoning, theory is tested empirically “*to develop predictions from general principles*” (Speziale & Carpenter 2007, p. 137). In this study, the idea of using a grounded theory approach was rejected because it was not intended to generate theory from the study findings but to explore participants' philosophies and perceptions of preceptorship to generate an understanding of what preceptorship meant within the Saudi context.

Likewise, ethnography is designed to study culture, by focusing on describing the nature of life and knowledge embedded in a particular culture via participant observation and/or participants' experiences (Hammersley 1990, Hammersley & Atkinson 1983). However, this design was also rejected, as the intention of the study

was not to explore culture *per se* but rather to examine personal philosophies and individual views of a particular phenomenon.

Similarly, phenomenology was not considered a suitable methodology for this study as it aims to study human phenomena in an effort to illustrate the lived experiences and give them meaning from a single perspective (Holroyd 2007, Lavery 2003, Van Maanen 1990). In essence, the current study did not look at the lived experience simply from one perspective. In fact, the study focused on exploring what it was like to be involved in and an integral part of a preceptorship programme from diverse perspectives, thereby highlighting multiple personal philosophies or lived experiences.

3.3.2.2 Reasons for adopting a generic qualitative approach as an appropriate methodology for this study

Since grounded theory, ethnography and phenomenology were each considered unsuitable designs to adopt in the present study, the search for an appropriate qualitative methodology continued. As a result, four different purposes for conducting qualitative research within the world of scientific research were found: evaluation, description, exploration and explanation. The evaluation method was excluded, as the intention was not to make a judgment regarding the quality of the current preceptorship programme, or to decide its effectiveness, or even whether it should be stopped or continued (DeCicco 2008, Scells & Gill 2007). Instead, the study looked at whether preceptorship was 'fit for practice and purpose' from an exploratory and descriptive perspective.

Moreover, it was apparent that all qualitative research requires description and all description needs interpretation. Accordingly, as this study proposed to explore the perspectives of all staff involved in the preceptorship process in one Saudi Arabian hospital in order to describe and interpret the meaning of preceptorship and illuminate its impact on clinical nursing care, a generic qualitative design was considered to be the most suitable to adopt. The reasons for this are as follow:

1. There was no prior information regarding preceptorship and its impact on clinical nursing care within the Saudi context. More specifically, although there is considerable information regarding preceptorship in nursing globally, no literature related to this phenomenon exists specific to the Saudi context.

A qualitative approach was therefore felt to be the best method to select, as little was known about the investigational phenomena (Polit *et al* 2001, Sandelowski 2000, Lincoln & Guba 1985). A qualitative design aims to generate a rich understanding of the world from the participants' own perspective (Lincoln & Guba 1985) to produce thick descriptive meaning regarding the phenomenon under investigation. In other words, in the context of this study I wanted to generate in-depth understanding of preceptorship from the perspective of all those involved in the process in one Saudi Arabian hospital (Erlandson *et al* 1993, Lincoln & Guba 1985).

Hence, a qualitative design was chosen as it facilitated the collection of as much data as possible from those who experienced and/or were involved in the preceptorship programme. In adopting such an approach, it was possible to capture what participants perceived preceptorship to be, and the influence they felt it was able to exert on clinical nursing care in order to offer a comprehensive summary of preceptorship in an everyday context (Burns & Grove 2007, Sandelowski 2000).

2. The study looked at people in their natural setting to discover what it was like to be part of the preceptorship process from multiple perspectives in order to reveal any similarities, differences or issues important to the participants and accordingly generate a deeper understanding of preceptorship in Saudi Arabia. A qualitative approach is concerned with studying particular phenomena in their natural setting to understand and describe individual and group experiences via collecting and listening to their subjective narratives in order to generate an holistic understanding of what the phenomena meant to those involved (Denzin & Lincoln 2008, Gillis & Jackson 2002, Sandelowski 2000, Guba 1978). In essence, this subjective narrative represents participants' perceptions as they manifest as part of their everyday lives (Speziale & Carpenter 2007, Polit *et al* 2001).

The natural setting is the context within which social interactions between people occur. Thus, the meaning of a phenomenon for a person arises following his/her interaction with others (Lincoln & Guba 1985, Blumer

1969). Therefore, it was important to examine preceptorship in the study's natural setting in order to uncover what preceptorship meant to each participant as it appeared to him/her because each person's way of interpreting how a person acted towards him/her was different (Erlandson *et al* 1993, Lincoln & Guba 1985, Blumer 1969).

3. In qualitative research, the researcher is both an integral part of the research and a research instrument, a factor that can enhance and support the study findings by helping to enrich the data via a process of active reflexivity (Topping 2006, Denzin & Lincoln 2005). Thus, in such cases, researchers need to *constantly take stock of their actions and their role in the research process, and subject these to the same critical scrutiny as the rest of their 'data'* (Mason 2002, p.7).

In view of the above, a researcher's ability to influence the selection and reporting of data in a biased manner across all stages of the research are to be expected in qualitative research, which needs to be acknowledged. Hence, to minimise the latter limitation of this approach researchers *per se* need to utilize different techniques such as 'triangulation' or 'respondents validation' to assure the reader that the research is trustworthy (Bryman 2008, Topping 2006). Thus, as the researcher in this context, I had considerable experience of preceptorship across multiple roles. Consequently, I was by default an integral part of the research and become a research instrument in my own right, as a direct result of having reflected on my experiences of preceptorship. Nevertheless, it was still necessary to control my bias by consulting with a co-researcher and my thesis supervisors to ensure that the data generated reflected participants' perspectives rather than the ideas presented being an extension of my own views or beliefs.

4. A qualitative approach to research depends on the researcher adopting a *'patient, careful and imaginative life study, not quick shortcuts or technical instruments'* (Athens 2010, p.88). It requires researchers to be in continuous contact with the natural context where they must remain close to the people they are studying, in order to facilitate understanding and interpretation of their actions and provide a comprehensive summary of the phenomena under

study (Athens 2010, Denzin & Lincoln 2008, Erlandson *et al* 1993). As the fieldwork for the present study, took place in the actual setting this helped me to understand the participants' language more effectively, particularly as I also lived and had worked in the selected environment for many years and therefore understood the cultural nuances of the setting. Furthermore, this facilitated my interaction with the participants and the building of a trusting relationship, particularly as I already knew most of the participants with the exception of the preceptees (Lincoln & Guba 1985, Guba 1978).

5. Furthermore, a qualitative approach is fluid and flexible in nature and does not adhere to a rigid framework (Mason 2002). This meant that as the study progressed my plans and procedures for carrying out the study could be changed in response to the participants' expressed ideas that had the potential to highlight new and important directions for the research (Mason 2002). The flexibility of a qualitative approach allows unpredicted or new themes related to the topic of preceptorship to emerge (Sandelowski 2000, Lincoln & Guba 1985). For example, the use of a semi-structured interview guide allowed participants to talk freely about their experiences whilst enabling me as the researcher to simultaneously clarify their ideas or follow up new avenues that I had not considered when shaping the interview guide.

Qualitative methodology therefore facilitated the use of qualitative interviews that permitted participants to express what they thought were important facets or ideas regarding the topic - namely preceptorship, rather than limiting them to specific questions or answers. This action/process enabled me to generate data that might not have arisen had a structured interview process been strictly adhered to. As a result of the flexibility and fluidity of a qualitative methodology, ideas not previously considered by me as a researcher were raised by participants which subsequently become important elements for consideration by those planning or developing preceptorship programmes particularly in a global healthcare market (Bryman 2008, Sandelowski 2000).

As a result, a generic qualitative design was the approach utilised by this study to explore preceptorship in the Saudi context. Denzin & Lincoln (2000) and Lancy (1993) point out that in order for researchers to conduct a qualitative study, the philosophical base and the strategy or method of inquiry used to collect and analyse data should be discussed to illustrate how the chosen approach and its philosophical underpinning have been applied to the study context.

Before I discuss the theoretical or philosophical perspectives of the chosen approach, it is important to highlight that there is no specific methodology (i.e. phenomenology, grounded theory, or ethnography) has been applied in this study. The study does not describe the examined phenomenon in terms of a conceptual, philosophical, or other highly abstract framework or system. It provides a comprehensive summary of an event in everyday life. Sandelowski (2000) stated that *'researchers conducting such [generic qualitative] studies seek descriptive validity, or an accurate accounting of events that most people, including researchers and participants, observing the same event would agree is accurate, and interpretively valid, or is an accurate accounting of the meanings participants attributed to those events that those participants would agree is accurate'* (p.336).

However, qualitative studies may possibly have, for example, grounded theory or phenomenological overtones, by employing one or more techniques related to these methodologies without producing theory - as in grounded theory - or phenomenological renderings of the examined phenomenon - as in phenomenology - (Sandelowski 2000). In this qualitative study, a constant comparison technique was used to compare and contrast the findings with no intention of creating a theory regarding the preceptorship phenomenon.

Nevertheless, this does not mean that a qualitative approach has no theoretical or philosophical basis. A qualitative approach draws from the general principles of naturalistic inquiry paradigm (Sandelowski 2000, Guba & Lincoln 2005, Lincoln & Guba 1985), which this study adheres to.

3.3.3 The theoretical perspective of Naturalistic Inquiry

Naturalistic inquiry was born out of the work of Blumer (1969) as an alternative to positivism. Although Blumer died before the work was completed, an attempt to

finish the work that he left behind has since been made by other researchers such as Athens (2010), in an effort to make naturalistic inquiry clearer and more accessible for others, particularly novice researchers.

Furthermore, the underlying philosophy of naturalistic inquiry is symbolic interactionism, which aims to make people's words, comments or behaviour understandable and meaningful by describing and interpreting them in order to generate meaning from the underlying symbolism of their talk actions or behaviours. Symbolic interactionism aims to make what the researcher heard, read and/or observed meaningful by interpreting the interaction processes that take place between the researcher and others and/or documents (Athens 2010, Blumer 1969). The theoretical perspective of symbolic interactionism focuses on examining the phenomenon from collective perspectives rather than an individual standpoint (Blumer 1969). This is because in symbolism, society consists of human individuals fitting their lines of action to one another as group members, which helps identify each aspect in relation to a particular phenomenon. Thus, by interpreting each person's perspective and combining the meaning of these perspectives together it is possible to provide a comprehensive understanding about what is actually going on in the natural context (Athens 2010, Blumer 1969).

According to Sandelowski (2000), naturalistic inquiry, represents a generic form of qualitative inquiry. Hence, naturalistic inquiry in terms of its underpinning principles and characteristics was the theoretical perspective informing the qualitative data generation and analytical processes adopted as part of this study. Details of how this qualitative research approach was applied to the current study are outlined in the subsequent section.

As my research progressed, and in particular at the stage of writing the discussion chapter, I felt that the principles of symbolic interactionism and naturalistic enquiry did not offer meaningful explanations for the study findings. The application of an explanatory framework was necessary to obtain a more meaningful explanation of participants' behaviours during the preceptorship process and to draw significant conclusions from the data. Hence, social learning theory has been used which enabled me to better understand the study findings and discuss their wider

significance. Social learning theory was, therefore, not used from the outset as the theoretical framework for this study but subsequently allowed me to establish the potential impact of this study within a wider theoretical and more importantly in this case, educational context. My choice of social learning theory as the most appropriate explanatory framework for the study findings are discussed in more detail in section 6.1 of the discussion chapter. Additionally, in order to situate social learning theory more appropriately within the text, to demonstrate its relevance to this research, this aspect of the study process is fully explored within the discussion section in chapter six.

3.3.3.1 The principles of the naturalistic inquiry

Although social learning theory has been used to examine and situate the findings of this study as part of the analytical process, the principles of naturalistic inquiry reflect my ideological stance in respect to how data should be generated and analysed in the first instance. Hence, five overarching principles were invoked during the execution of this study in order to ensure that the data generated were robust and ethically derived (Erlandson *et al* 1993, Lincoln & Guba 1985). These five principles are considered the basic beliefs or building blocks of the theoretical and conceptual assumptions of naturalistic inquiry (Lincoln & Guba 1985). Therefore, it is important to discuss these principles and to identify how the principles were applied to this study.

3.3.3.1.1 Principle one: The nature of reality (ontology)

Naturalistic ontology is grounded in the belief that each phenomenon has multiple, interrelated realities that cannot be isolated from their context and can only be examined holistically (Lincoln & Guba 1985). These realities represent the meanings that are constructed in each person's (the research participant's) mind about particular phenomena based on his/her experience and interaction with others. His/her own individual perspective or philosophy toward the phenomenon is then displayed by words (verbal language) and/or behaviours (non-verbal language) during his/her interaction with others. However, the naturalistic paradigm assumes that there are divergences among these realities as people are not the same; each person creates his/her own meaning (reality) based on his/her way of interpreting information. Thus, it is crucial to explore these differences between individuals

(research participants) in order to understand each aspect of the examined phenomenon and create an holistic and detailed understanding of what the topic of inquiry consists of and how it manifests (Erlandson *et al* 1993, Lincoln & Guba 1985, Guba 1978).

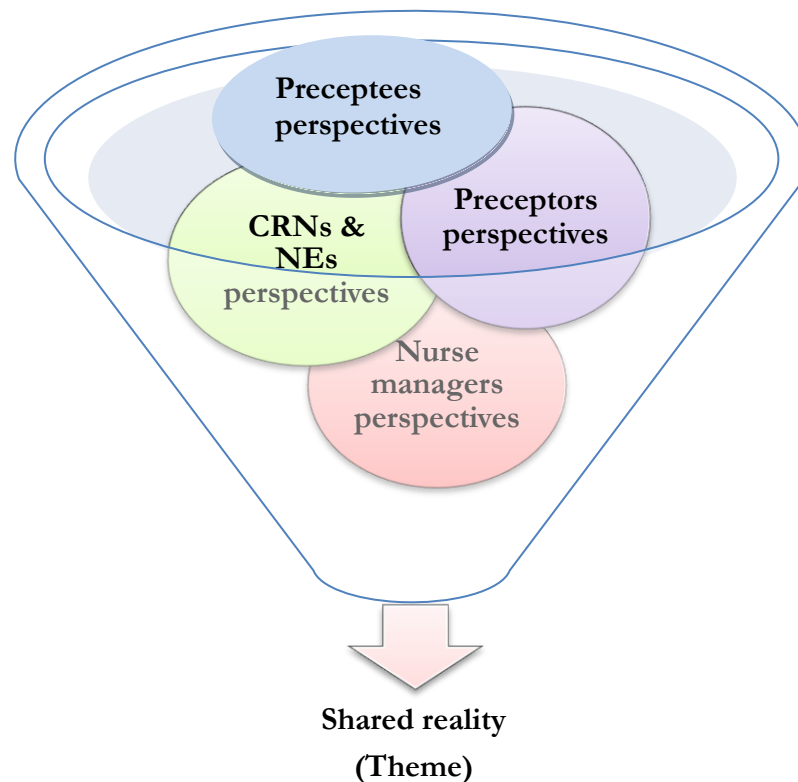
In the current study, the clinical setting provided the natural context where preceptorship took place, given the environment was not created or manipulated for the purpose of research. The meaning of preceptorship was examined from the perspectives of all nurses involved in the preceptorship programme. The latter included newly hired experienced nurses (preceptees) and other programme stakeholders (preceptees, preceptors, nurse managers, clinical resource nurses (CRNs) and nurse educators (NEs). Thus, it was possible to uncover the meaning of preceptorship from multiple perspectives based on participants' interactions with each other (Erlandson *et al* 1993, Lincoln & Guba 1985).

In this situation, each participant's perspective reflected how preceptorship in the Saudi context was perceived. For example, preceptees' perceptions reflected their understanding of what preceptorship should constitute in the clinical setting according to what information they received from nurse educators during nursing orientation week. These perceptions had the potential to differ from one participant to another based on the way that each one interpreted the received information during their interaction. Therefore, any divergent meanings within each group as well as between groups of participants could be highlighted regarding preceptorship in Saudi context.

Describing and making sense of each person's interpretation between and across the stakeholder group had the potential to uncover the dimensions of preceptorship as experienced in Saudi. Thus, by comparing and contrasting these divergences it was possible to identify similarities and differences between them to develop a fuller picture of what preceptorship meant in the Saudi context. However, to generate a deeper understanding about what preceptorship actually meant for the participants, it was necessary to look at the concept from a collective perspective by combining each of the meanings provided by participants in order to generate a shared reality and common meaning of preceptorship as demonstrated in figure 1, page 92.

However, the meaning of preceptorship - in this context - is not considered an absolute reality rather, it constitutes how preceptorship was experienced, understood and interpreted by the participants, and subsequently constructed in their minds as they perceived what actually happened (Burns & Grove 2007, Flick 2006, Lincoln & Guba 1985). Such realities are created as a result of the knower's interaction with others and his/her environment (Von Glasersfeld 1995), the latter are then presented as an holistic construct based on participants general agreement or collective experiences regarding the phenomena (Erlandson *et al* 1993). In this ontological situation, Lincoln & Guba (1985) argue that realities describe multiple constructive meanings for individuals regarding a particular phenomenon, which must present as a whole rather than as a single reality.

Figure (1): The current study's relationship with naturalistic ontology (Principle one)



3.3.3.1.2 Principle two: The relationship of the knower to the known (epistemology)

This principle involves an exploration of the way in which knowledge relates to truth, beliefs and justification (Munhall 2001). As mentioned above, my preceptorship experience inspired me to undertake this research. However, before

the study began I considered different questions such as what I expected the participants to say about preceptorship, whether they had a sufficiently clear idea or perception about preceptorship that they could share with me. Furthermore, I needed to examine how I was going to deal with the information received. More importantly, my own perception or constructed philosophy of preceptorship in the chosen setting needed to be clearly understood if I was to avoid influencing the participants' perceptions or, in turn, being influenced by theirs.

During the study, the exact nature of the researcher's and participants' roles needed to be carefully considered, especially since perceptions and philosophies are human characteristics and the examination of another's perceptions and philosophies is not an easy task (Denzin & Lincoln 2008, Burns & Grove 2007). More importantly, participants needed to be prepared to talk in order to obtain the required data. Thus, it was necessary first to know the participants and be known by them, by interacting with them positively in order to build mutual trust and facilitate their willingness to narrate their experience. Researchers drawn towards naturalistic inquiry believe that the knower and the known are closely connected (Erlandson *et al* 1993, Lincoln & Guba 1985). In other words, there is an inseparable relationship between the researcher and the study participants in which both interact to influence each other. In this case, the researcher and participants were both considered study instruments as each party had his/her own perceptions and philosophies of preceptorship that would collectively help to generate a more complete picture of the meaning of preceptorship based on what participants stated (Lincoln & Guba 1985).

Thus, it was recognized that researcher-participant interactions were at the heart of this qualitative study (Erlandson *et al* 1993). Building trusting relationships and ensuring researcher engagement in the research process was crucial if I were to conduct a rigorous qualitative research investigation (Erlandson *et al* 1993, Lincoln & Guba 1985). In this context, study data needed to be created through the interaction of both me (the researcher) and my study participants (Lincoln & Guba 1985). However, the potential risk of engaging in reporting bias was high (Flick 2006, Denzin & Lincoln 2000, Erlandson *et al* 1993). Therefore, it was important to control this form of bias, but without inhibiting the stream of relevant information, by being neutral during the interviews. Hence, I interacted with the participants as an

active listener. This was done by looking at their behaviours, listening to their narrative and showing interest in what they were saying in order to elicit what they knew about preceptorship (Munhall 2001).

Language was a vital element of communication during the study as interaction was necessary if I were to describe accurately participants' experiences when reporting my findings (Erlandson *et al* 1993). Participant interactions via the use of verbal and non verbal language facilitated the development of ideas and personal philosophies to be constructed and expressed (Erlandson *et al* 1993). Methods compatible with naturalistic inquiry in particular qualitative focus group interviews were chosen as one of the data collection techniques to enhance researcher-participant interaction (Flick 2006, Lincoln & Guba 1985). Thus, the interviews provided participants with a chance to communicate and share their constructed perceptions with me as the researcher. However, during the interviews there was the potential for participants' ideas to change or be influenced by others (Erlandson *et al* 1993). This is discussed in more detail in the focus group and analysis sections of this thesis on pages 120 and 137 respectively.

3.3.3.1.3 Principle three: The possibility of generalisation

Generalisation in quantitative research is '*the extension of the implications of the research findings from the sample to a larger population*' (Burns & Grove 2007, p.37). However, naturalistic investigators believe that this type of generalisation is impossible to achieve because of the subjectivity of data, its non-representativeness, the small sample sizes and context-bound characteristics of the qualitative naturalistic approach (Speziale & Carpenter 2007, Flick 2006, Lincoln & Guba 1985). Naturalistic inquiry depends on context. It assumes that each context is unique and participants in a naturalistic inquiry are linked together through this unique context. Hence, perspectives that are revealed regarding the investigated phenomenon are related to the context and time in which the phenomenon was experienced. Therefore, total replication of the findings in another context is impossible because no two contexts are identical. Therefore, naturalistic inquiry aims '*to develop an idiographic body of knowledge in the form of 'working hypotheses' that describe the individual case*' (Lincoln & Guba 1985, p.38).

Alternatively, 'naturalistic generalisation' is a concept considered by Stake & Trumbull (1982) as an alternative to nomic generalisation, which is based on representative data (Denzin & Lincoln 2008, Ritchie & Lewis 2003, Lincoln & Guba 1985). Stake & Trumbull (1982) indicated that generalisation is evidence of the usefulness of the research. Naturalistic generalisation is therefore a way of extending understanding whereby researchers provide their readers with information about the study in the form of a natural experience report (Stake & Trumbull 1982). This report has the potential to extend the readers' perception and awareness of what is happening or modify or reinforce the readers' understanding of a particular phenomenon (Denzin & Lincoln 2008, Lincoln & Guba 1985).

Erlandson *et al* (1993) pointed out that full generalisability to other contexts is impractical because each setting is considered unique. However, data could be transferred from its natural context to another if the study context was described fully so that the reader could decide whether the new context was similar to that, in which the research was conducted. The latter is called 'transferability' or the degree of 'fittingness', which is the degree of similarity between two contexts (Lincoln & Guba 1985). In this study, a thick description of the study context has been presented in detail, and an audit trail outlined to identify everything readers need to know in order to understand the findings and assess their transferability to other contexts.

3.3.3.1.4 Principle four: The possibility of causal linkage

In naturalistic inquiry, it is impossible to differentiate causes from effects because all aspects of the examined phenomenon are in a state of '*mutual simultaneous shaping*' (Lincoln & Guba 1985). The concept of mutual simultaneous shaping has been used by naturalistic inquirers as an alternative to the concept of causality (cause-effect relationship) in order for the researcher to clearly explain what is happening in the natural setting (Erlandson *et al* 1993, Lincoln & Guba 1985). This means that all aspects of the phenomenon – in this case preceptorship - are interconnected, including the interaction and influence which the researcher and participants have on each other to the extent that their ideas may be mutually shaped by one or the others' resulting in something that an outside observer could regard as an outcome or effect (Lincoln & Guba 1985). This mutual relationship means that the cause-

effect relationship is difficult to distinguish within the investigated phenomenon's entities.

However this interaction has no directionality and need not produce a particular outcome, indeed, the outcome may be totally unpredictable, something that simply 'happened' as a product of the interaction. Therefore, the naturalistic inquirer's concern is not to determine the actual or 'true' cause-effect relationship of the phenomenon under investigation but to provide a comprehensive description of the phenomenon through which issues related to the phenomena, in this case preceptorship, could be explained (Lincoln & Guba 1985). Understanding is achieved by appreciating aspects of the phenomenon and revealing their mutual relationship in order to meet the study aim and objectives (Lincoln & Guba 1985).

This principle is consistent with other naturalistic principles, in particular the notion of constructed realities (principle one) which is compatible with the concept of mutual shaping as it allows the researcher to develop purposeful imputations. These imputations could be changed if other constructs are uncovered. Hence, researchers seek a clear explanation through interaction between the context and the participants and the researcher's purposes (principle two). Mutual shaping also addresses principle three, as transferability could be appropriate if the results were applied to similar contexts. As part of the general shaping process, participant and context values should be recognised as well as the investigator's values, which should clearly exist in the choice of methodology, as illustrated below in principle five. Therefore, the qualitative research design chosen for this study is itself a demonstration of compatibility with these principles.

3.3.3.1.5 Principle five: The role of value in inquiry

Naturalistic inquiry is value-bound, influenced by the values of researcher, paradigm and methodology that guide the inquiry and the values of the setting in which the study is carried out (Lincoln & Guba 1985). For example, the inquiry – in this case the nature of preceptorship and its impact on clinical nursing care - was influenced by:

1. Researcher values as expressed in the selection and focusing of the study problem;

2. Participants' values inherent to the context.
3. Choice of paradigm to guide exploration of the problem and
4. Choice of strategies to guide the collection, analysis and interpretation of the study data.

The above values must, at some point, converge and exhibit congruence to constitute value resonance in order for the study to produce meaningful findings as illustrated in figure 2, page 97.

Accordingly, it could be argued that the focus of the current study, which was to generate a shared meaning and greater understanding of preceptorship and its impact on clinical nursing care as perceived by programme stakeholders in the natural context is well suited to a qualitative design underpinned by the theoretical perspectives of naturalistic inquiry. Thus, this study demonstrates values that are resonant with the researcher's personal values, while focusing on the context and research paradigm and methodology exhibit compatibility. Table 6 page 98 demonstrates the above principles.

Figure (2): Relationship of the study to the role of value in naturalistic inquiry (Principle five)

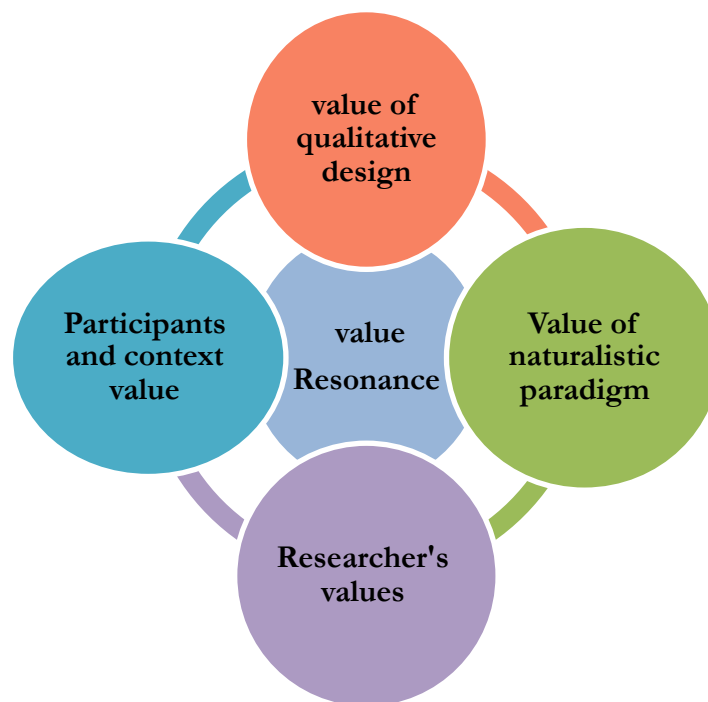


Table 6: The five principles of the naturalistic inquiry and their relationship to the current study

Principle	Relationship of the current study to the five principles
The nature of reality: realities are multiple, constructed and holistic	<ul style="list-style-type: none"> - The preceptorship programme was carried out in a natural context-rich setting; it was not manipulated or controlled for the thesis purposes. - Preceptorship concept was examined from multiple perspectives to which the researcher contributed as a data source - Several forms of data were collected to capture multiple perceptions and philosophies of the participants. - Participants narratives collected from the interviews were used to support the emerging findings. - The qualitative method of inquiry helped to generate a collective understanding regarding the nature of preceptorship and its impact on clinical nursing care.
The relationship of the knower to the known.	<ul style="list-style-type: none"> - The researcher interacted with the participants as a research instrument. - Participants shared their philosophies and views about preceptorship with the researcher. - The researcher interacted with the participants during the interviews as an active listener.
The possibility of generalisation	<ul style="list-style-type: none"> - Thick description of the study context is presented. - The study audit trail outlined. - Demographic characteristics of the participants are discussed in detail. - This study is part of a PhD thesis, discussing the findings with the supervisors and examiners considered working hypotheses.
The possibility of causal linkage	<ul style="list-style-type: none"> - All aspects of preceptorship take the form of mutual simultaneous shaping. It is impossible to distinguish causes from effects as all parts simultaneously interacted, having reciprocal effects.
The role of values in inquiry.	<ul style="list-style-type: none"> - The study focus, context, and the naturalistic theoretical perspective as well as the study design demonstrate value-resonance.

3.3.3.2 Operationalising the Naturalistic Inquiry Paradigm

Lincoln & Guba (1985) stated that conducting research by adopting a naturalistic inquiry approach needs to consider more than the five principles outlined above if the researcher is to be adequately guided through the process of using such an approach. Hence, Lincoln & Guba (1985) illustrate how the naturalistic paradigm can be applied to the actual research process by proposing the operationalisation of fourteen characteristics when adopting naturalistic inquiry.

These characteristics are considered important aspects of the naturalistic paradigm that need to be addressed when undertaking such research. They include the: natural setting, human instrument, utilization of tacit knowledge, qualitative methods, purposive sampling, inductive data analysis, grounded theory, emergent design, negotiated outcomes, case study reporting mode, idiographic interpretation, tentative application, focus-determined boundaries and special criteria for trustworthiness (Lincoln & Guba 1985, p.39). These characteristics were used as guidance for conducting this qualitative study to ensure that the naturalistic inquiry paradigm was actually applied to the research process. An overview of how these characteristics have been applied to the current study is presented in Table 7.

Table 7: Application the characteristics of naturalistic inquiry to the current study

Characteristics	Application to the study
Natural setting	Data were collected in the hospital where the preceptorship programme was conducted.
Human data collection instrument	Researcher was the primary collector of data.
Utilisation of tacit knowledge	Study data were based on the participants' perceptions/philosophies.
Qualitative methods	Focus groups and individual interviews as well as a review of preceptorship documents were used to collect data.
Purposive sampling	Preceptees and other programme stakeholders were invited to participate in the study because they were parts of the preceptorship programme. The participants were purposively and convenience sampled to obtain rich data and enhance the researcher's ability to generate emerging themes.
Inductive data analysis	Interview (narrative) data were analysed to identify themes and sub-themes that represented the collective/shared realities of preceptorship.
Emergent design	Concurrent analysis of data was used to pilot test the interview schedule and clarify the nature of questions asked by the researcher as well as the nature of the study.
Negotiated outcome	Participant involvement was negotiated via informed consent and initial information-giving meetings. Meanings of the data were confirmed and verified by the participants during and after each interview.
Idiographic interpretation	Data were tape recorded on an individual basis and transcribed verbatim including verbal and non-verbal languages, using symbols for the non-recordable participants' behaviours to represent the situation exactly as it happened at the time of the interviews for

	the purpose of interpretation.
Tentative application	Interpretation of the data resulted in a description of the meaning of preceptorship, factors affecting the success or failure of preceptorship, and the impact of preceptorship on clinical nursing care. From this information, hypotheses were generated about the nature of preceptorship and its impact on clinical nursing care in this group of people.
Focus-determined boundaries	The nature of preceptorship and its impact on clinical nursing in a selected group of nurses who had been involved in preceptorship either as preceptee or other programme stakeholder was examined. No other aspect of preceptorship was studied and no other people were involved.
Special criteria for assessment of trustworthiness	In this context, the data generated from participants together with checking and verification of my interpretation using myself as a researcher, co-researcher and thesis supervisor followed by comparison of findings with related literature were each used as criteria for establishing how the data collected and analysed is rigorous and trustworthy. Credibility, transferability, dependability and confirmability were each applied to the assessment of this study in order to verify the trustworthiness.
Grounded theory	For the purpose of this study, this characteristic has not been applied because it was not intended to develop theory.
Case study reporting mode	Although case study as a design was not adopted in this study, I have examined preceptorship in one single hospital in order to provide a thick descriptive report of what preceptorship meant to the participants in a Saudi context.

3.4 The study setting

Auditability of qualitative research can be achieved by providing a clear decision trail about the study (Bryman 2008, Sandelowski 2000). Describing the study setting and how it was accessed should be explained as part of an audit trail (Bryman 2008, Erlandson *et al* 1993). Therefore, I intend to describe below the setting where the study took place whilst also maintaining anonymity to provide others with an understanding of the study context, something that is essential if others are to be in a position to decide about the transferability of the method and data to alternative study settings (Lincoln & Guba 1985). Hence, what follows is a brief explanation of the preceptorship programme as presented in the study setting.

The study was conducted on a single hospital site. The hospital is one of the largest and most modern health care organisations in Saudi Arabia with approximately 477 in-patient beds. The hospital provides services focused around 12 areas such as general medicine and surgery, paediatrics, maternity and children's services, specialist surgery, critical care services and oncology. Additionally, there is an active outpatients' department functioning 5 days a week. The hospital offers academic and training opportunities for national nursing and medical students, encourages research and participates in industry and community service programmes related to health.

The hospital is a multi-cultural workplace, combining approximately 911 national and international nurses from around the world including England, America, Canada, Malaysia, Australia, South Africa, Philippines, Finland, India and the Middle East. Although no hospital areas were chosen *per se* for inclusion in the study, nurses were drawn from as many clinical areas as possible to access a wide spread of views and experiences of preceptorship. Arabic and English are the two official languages in the hospital. However, English is the communication language spoken between health care workers particularly, nurses.

Having worked in the hospital for approximately nine years, I have become familiar with the hospital routine, policies and procedures. In essence, this prior experience of the hospital facilitated my access to the setting, which also enhanced my ability to understand and interpret the collected data when interacting with the study participants (Denzin & Lincoln 2008, Erlandson *et al* 1993, Lincoln & Guba 1985). My experience in the hospital as a paediatric staff nurse and then as a clinical resource nurse for paediatrics provided me with the opportunity to practice and observe the day-to-day operations of the hospital environment generally and more specifically the preceptorship process. The latter experience subsequently helped me to analyse, interpret and understand the participants' daily experiences of preceptorship (Erlandson *et al* 1993).

3.5 Preceptorship programme in the study setting

Preceptorship in the study setting was established approximately ten years ago for all grades of newly hired nurses. Newly hired nurses include newly qualified nurses and newly hired experienced nurses who have worked in another hospital either inside or

outside Saudi Arabia and have gained at least one-year's clinical nursing experience. Preceptorship in the study setting is an organized educational programme, aimed at facilitating the integration of newly hired nurses into their role in the work setting through a time-limited preceptor-preceptee relationship. The preceptorship programme in the study setting was managed by an approved written policy, which directs all nursing staff involved in the programme and guides them as to their roles and responsibilities during the preceptorship period.

Before the period of preceptorship begins, preceptees spend 4 days with the nurse educators; this is called the general nursing orientation week. During this period, preceptees are introduced to the hospital's nursing philosophy, goals, general nursing policies and procedures, role expectations, facilities and services. Hence, preceptees attend organised educational sessions and workshops regarding nursing procedures and competencies such as IV cannulation, IV fluid administration and colour blind testing. Throughout this period, nurse educators are responsible for meeting the preceptees' needs namely their emotional, educational and learning needs and assessing and evaluating the preceptees' general behaviour as well as focusing on basic competencies including blood glucose and urine reagent testing. Once the orientation period is complete, the preceptorship period begins. On the first day of the preceptorship period preceptees enter their assigned clinical area to engage in eight shifts/ten days of supervised practice. During the eight shifts/ten days the preceptee works with his/her assigned preceptor in a one-to-one relationship, sharing the patient workload.

Throughout the eight-shift/ten day preceptorship period, each preceptee was expected to demonstrate competency across a pre-determined number of clinical nursing skills/tasks before they were allowed to work independently with patients. These basic requirements included generic competencies as well as a list of nursing skills and procedures relevant to the respective clinical area. Generic competencies included physical assessment, IV cannulation, urine reagent testing, blood glucose monitoring, drug administration, phlebotomy and blood transfusion. These requirements were standard and mandatory for all preceptees to demonstrate competency in, regardless of the unit, they were working on and needed to be completed by the end of the preceptorship period. The physical assessment

competency needed to be assessed and signed off by a clinical resource nurse, while the remaining skills and procedures could be assessed and signed off by preceptors.

The content of the preceptorship programme was laid down within the official curriculum documents produced by the nursing education department. However, although curriculum documents are supposed to be interpreted in the same manner across whole organisations there are times when these ideals vary in accord with an individual's personal philosophy regarding preceptorship and how they feel it should be implemented.

3.6 Sampling framework for selecting the study' participants

Sampling represents the decision making process that researchers engage in to select appropriate participants to help answer the study question and achieve the study aims (Speziale & carpenter 2007). Therefore, prior to data collection, it was decided to select a cohort of nurses who were involved in the preceptorship programme which would include newly hired nurses (preceptees) together with other preceptorship programme stakeholders (preceptors, nurse managers, clinical resource nurses and nurse educators) who had preceptorship experience and were responsible for orienting and evaluating preceptee progress.

The reason for including all those involved in the preceptorship process was to ensure that the perspectives and views of all parties involved were accessed and explored in order to reveal different or similar ideas and/or experiences across the sample; identify the full range of factors associated with the success or failure of the preceptorship programme, add richness to the study and gain greater understanding of the meaning of preceptorship and its impact on the preceptees' clinical care, (Lambert & Loiselle 2008, Flick 2006, Silverman 2006, Ritchie & Lewis 2003, Erlandson *et al* 1993, Lincoln & Guba 1985).

In order to select the study participants, two sampling strategies were used based on the study aim: purposive and convenience sampling. Purposive sampling is a criterion-based approach (Harbottle 2006), which aims to select a sample with the experience and/or information a researcher wants to target during an investigation (Kilcullen 2007, Erlandson *et al* 1993, Lincoln & Guba 1985). Convenience sampling

is used to select participants who are available in the right place at the right time when conducting the study (Burns & Grove 2007). The difference between purposive and convenience sampling is that purposive sampling is done systematically and rigorously (Procter *et al* 2010).

Purposive and convenience sampling were considered the only sampling methods that could be used in this study. In the first instance, participants were chosen purposively on the basis that they had particular knowledge, experiences and views to share related to the phenomenon namely preceptorship. Hence, each group of participants were chosen on the basis that they were able to contribute to the study by providing extensive and rich information about preceptorship from both their own and a collective experience (Sandelowski 2000). In the second instance, participants were selected using convenience sampling because they were readily available during the fieldwork and willing to participate in the study (Burns & Grove 2007).

More explicitly, purposive sampling was the initial strategy chosen to recruit the five groups of participants: preceptees, preceptors, nurse managers, clinical resource nurses and nurse educators. Based on the inclusion criteria stated in page 105, nurse educators were purposefully selected as they had experience of coordinating the preceptorship workshops and nursing orientation week for the participating preceptees. These participants were chosen in order to elicit their perceptions of the preceptorship programme in the study setting, particularly in terms of the preceptorship workshop and nursing orientation week, and subsequently to explore similarities and differences in their views by comparing them with those of other groups.

The remaining four participant groups (preceptees, preceptors, clinical resource nurses and nurse managers) were also purposefully selected at the outset of the study. A key factor for choosing the four groups outlined above at the outset was that I had decided to specifically recruit the preceptor, nurse manager and clinical resource nurse assigned to each preceptee because I wanted to generate a complete picture of each participants preceptorship experiences and the impact preceptorship was felt by

participants to exert on the preceptees clinical nursing care, by identifying the similarities and differences between each of their respective views.

However, in some cases not all parties were willing to consent to participate in the study. Consequently, those preceptees who had signed a consent form and whose preceptor (or other member of the preceptorship team) had not agreed to participate had to be excluded. Therefore, as I wanted to include participants from all four groups for each preceptee and as I did not want to compromise this ideal, I had to resort to a different form of sampling, furthermore as I did not know which clinical area potential preceptees has been allocated to at the outset of the study convenience sampling had to be resorted to as the final form of sampling. The reason for wanting to specifically include all five members of the preceptorship team in the research was to gain insight into each participant's diverse experiences of preceptorship as it took place in each of the eight clinical domains to which preceptees were allocated. Hence, by engaging in this form of sampling I was able to examine the concept from a range of clinical, organisational, managerial, and educational perspectives.

3.6.1 Inclusion criteria for selecting the study participants

The criteria for inclusion in the study were:

1. Newly hired nurses about to participate in the preceptorship programme and whose preceptors had also agreed to participate in the study.
2. Preceptors, clinical resource nurses, and nurse managers who were assigned to the participating preceptees for the duration of the preceptorship process.
3. Nurse educators coordinating the preceptorship workshops and nursing orientation week for the participating preceptees.

3.6.2 Exclusion criteria for selecting the study participants

Any new or senior nurses who did not fit the above criteria were excluded.

3.6.3 Recruitment of the study participants

Before the fieldwork began an initial meeting was held with the Director of Nursing Services, who in turn introduced me to the nurse managers and Director of Nursing Education as part of their annual meeting. Clear information regarding the study aim, its scope, data sources, data collection and modes of analysis, the type of information

needed for the study and where and how the results would be used were presented during the meeting. Any questions that arose at the end of the presentation were answered by me. Following the meeting, agreement from the nurse managers and Director of Nursing Education to access their clinical units was obtained.

Prior to commencing the fieldwork, the sample size for the study was determined by taking into consideration the inclusion criteria and those factors beyond my control as outlined above, in order to select not only the preceptorship team namely: preceptees, preceptors, nurse managers and clinical resource nurses but to decide how many teams I might include in the data collection process. Accordingly, I sought a minimum sample size of 32 nurses which included eight newly-hired nurses (preceptees) from eight hospital units to cover as broad a spectrum as possible from the hospital's specialist areas. However, the sample size was not set as an exact number because it was not possible to predict exactly how many new nurses would arrive for induction or how many participants would sign a consent form and agree to take part in the study.

Nevertheless a sample size of no less than 32 was considered appropriate, as in qualitative research the quality of data generated from participants is considered more important rather than focusing solely on the number of participants, which tends to be the focus of quantitative research (Burns & Groves 2007). More specifically a sample size of 32 nurses was also considered a manageable number for a single person undertaking a PhD that utilised individual and focus group interviews approaches to data generation. Therefore, participants were chosen for their specific ability to discuss their perceptions of preceptorship and to facilitate the generation of a more complete picture of what preceptorship meant to each of the participants both as individuals and as a collective group.

At the beginning of the fieldwork, a list of sixteen (16) newly-hired nurses attending the orientation week was obtained from the secretary of the nursing education department; however, only fifteen (15) nurses met the inclusion criteria. The sixteenth new nurse was excluded because he was assigned to an area outside of the study setting. A meeting with the remaining 15 nurses took place during the induction week prior to commencement of the nursing orientation week, which

included a discussion of the study's aims and objectives, my role as a researcher and their potential role during the study as participants. In addition, confidentiality and data anonymity were also discussed. Participant information sheets reinforcing this information and consent forms were also given to all potential participants who were asked to think about participating in the study (see Appendix D, p. 365). By the end of the week, 11 signed consent forms were received from the preceptees indicating their willingness to participate.

Subsequently, 11 preceptors, 6 nurse managers and 6 clinical resource nurses (CRN) from the same ward as the preceptees and who were responsible for precepting, training, supporting and evaluating the 11 consenting preceptees were approached to participate in the study. Time for discussion in order to answer any queries was also offered. Information sheets and consent forms were distributed to this second group of participants and they were asked to indicate whether they were willing to participate in the study within seven days (Appendix D, p. 370 & 373).

Likewise, the two nurse educators who had been informed about the study by the Director of Nursing Education were invited to participate because they were responsible for coordinating the preceptorship programme and nursing orientation week as well as delivering the preceptors' and preceptees' education and training. In the same way as with the other groups I met with both nurse educators to answer their questions (see Appendix D, p. 370). Similarly, this nurse educators also had one week to decide whether or not to participate.

At the outset of the study 11 preceptees agreed to take part, which if their respective preceptors, nurse managers, clinical resource nurses and nurse educators, had consented to participating I expected to have a potential sample of 36 participants taking part in the study. However, at the end of first week, it was clear that some preceptors were unwilling to participate resulting in a total sample size of 30 participants (8 preceptees; 8 preceptors; 6 nurse managers; 6 clinical resource nurses and 2 nurse educators). Hence, three preceptees had to be excluded because their preceptors chose not to participate in the study. The reason why only six nurse managers and six CRNs were included was because two members of these respective nursing groups were responsible for more than one ward included in the study. For

example, one nurse manager and one CRN managed ICU and CCU. Similarly, one nurse manager and one CRN respectively managed the female and male medical wards.

The sample size of 30 participants in this case was considered adequate to address the current research questions. This was because during the collection and analysis of the data provided by the 30 participants in three focus groups and 22 individual interviews, I noticed that there was considerable repetition in the data and there were no new themes or perspectives reported: a phenomenon known as data saturation (Gerrish & Lacey 2010). This indicated that all the components of preceptorship and its impact on clinical nursing care were captured and that the sample size of 30 participants was sufficient.

In order to further confirm that a diverse range of participants with multiple clinical experiences educational and nationality were accessed during the study it was important to establish the demographic characteristics of the participants. Hence, at the outset of each interview I asked participants to indicate details regarding their age; gender; educational qualification(s); length of clinical experience; assigned ward and nationality. These latter factors were chosen in order to provide detailed information and an explanation of whom the participants were, to allow readers and/or other researchers to decide whether the study findings could be applied to similar clinical settings (Lincoln & Guba 1985). This demographic data is presented in the following subsection and will be referred to again later in this thesis as part of the analysis of the findings in order to gain greater insight into the phenomenon under study.

3.7 Demographic characteristics of the study participants

Thirty participants including nine male and twenty-one female nurses from the education department and eight clinical areas took part in the study based on the inclusion and exclusion criteria stated on page 105 of this chapter. The eight wards included in the study were ICU⁷; CCU⁸; female and male medical; female surgical; staff health clinic; outpatient department (OPD); and emergency room (ER). The eight wards were included based on where the preceptees who agreed to participate

⁷ ICU: Intensive Care Unit

⁸ CCU: Cardiac Care Unit

in the study were allocated during their nursing orientation week. The remaining participants, that is, the preceptors, ward managers and clinical resource nurses (CRN) were located on the same wards as the preceptees to obtain multiple perspectives regarding the preceptorship process and thereby generate a richer understanding of phenomenon. Nurses were drawn from as many clinical areas as possible to access the widest spread of views that could represent how nurses in the clinical setting viewed the preceptorship programme and what it meant to them.

Participants consisted of five discreet groups: eight preceptees, eight preceptors, six nurse managers, six CRNs and two nurse educators. However, the latter two nursing roles were amalgamated and considered as one group for the purpose of analysis under the heading, clinical educators. The reason for the latter decision was that this group were responsible for the educational/clinical training and development of the selected preceptees and preceptors (IPP2 2009). Table 8, page 110 presents distribution of the study's sample based on their assigned wards and role within the clinical setting.

Table 8: Distribution of study's sample by assigned wards and role within one study's setting.

Assigned Ward	Preceptees	Preceptors	Clinical Resource Nurses	Nurse Educators	Nurse Managers
ICU	1	1	1	X	1
CCU	1	1			1
F. Medical	1	1	1		1
M. Medical	1	1			1
F. Surgical	1	1	1		1
Staff Health	1	1	1		1
OPD	1	1	1		1
ER	1	1	1		1
Education Department	-	-	-	2	-
Total	8	8	6	2	6
9	Over all total: 30 Participants				

Table 9 shows the demographic characteristics of the preceptee group. The age of preceptees ranged from 23 to 37 years. Most were female (N = 5) with only three males. The preceptees' basic educational qualifications varied from a nursing diploma to a Bachelor of Science in Nursing (BSN) degree. Length of time in clinical practice ranged from 2 to 12 years. All preceptees were assigned to wards matching their previous clinical experience with the exception of two, who had both previously worked as dialysis nurses; one of which was assigned to OPD and the other to staff health. The preceptees were all multi-nationals with no Saudi nurses amongst them. Instead, the personnel were drawn from British, Canadian, Filipino, and Indian nationals.

Table 9 - Demographic Characteristics of Preceptees

No	Participant Selected Initial	Age	Gender	Educational Qualification	Length of clinical Experience	Previous Occupation	Assigned ward	Nationality
1	VI	25	M	BSN	2 yrs : 9 m	Dialysis Nurse	OPD	Filipino
2	SH	23	F	BSN	3 yrs	Dialysis Nurse	Staff Health	Filipino
3	AK	28	F	BSN	6 yrs: 6 m	Med/ Surg.	F. Medical	Canadian
4	SU	29	F	BSN	5 yrs	ICU	CCU	Indian
5	Mi	37	F	Nursing Diploma	12 yrs	ICU	ICU	Indian
6	RE	33	F	Nursing Diploma	2 yrs	Med/ Surg.	F. Surgical	British
7	AE	35	M	BSN	8 yrs	Medical	M. Medical	Filipino
8	RR	34	M	Nursing Diploma	4 1/2 yrs	ER	ER	British
Range	-	23 – 37 yrs	-	-	2 – 12 yrs	-	-	-

The demographic characteristic of the preceptor group are presented in Table 10. Preceptors ranged in age from 28 to 53 years. Six were female while only two were male. Most preceptors were Bachelor of Science in Nursing graduates whereas two held a Nursing Diploma. The total length of the preceptors' clinical experience ranged from 5 to 32 years. Similar to the preceptees, preceptors were also multi-national in that they were Filipino, Indian, Jordanian and South African.

Table 10 - Demographic Characteristics of Preceptors

No	Participant Selected Initial	Age	Gender	Educational Qualification	Length of clinical Experience	Assigned ward	Nationality
1	DT	51 yrs	F	BSN	11 yrs	Staff Health	South African
2	EP	53 yrs	F	Nursing Diploma	32 yrs	Female surgical	Filipino
3	CS	33 yrs	F	BSN	9 yrs	OPD	Filipino
4	JT	28 yrs	F	BSN	5 yrs	CCU	Indian
5	BP	36 yrs	F	Nursing Diploma	14 yrs	ICU	Indian
6	TS	30 yrs	M	BSN	8 yrs	ER	Jordanian
7	CH	52 yrs	F	BSN	27 yrs	Female Medical	Filipino
8	IA	50 yrs	M	BSN	28 yrs	Male Medical	Filipino
Range	-	28 – 53 yrs	-	-	5 – 32 yrs	-	-

Table 11 shows the Clinical Educators' demographic characteristics. Their ages ranged from 33 to 50 years old, with six females and two males amongst the recruited group. Four had a BSN degree; three were qualified to Diploma level and one held both a BSN and Critical Care Diploma. Their clinical experience ranged from 10 to 27 years. Similar to the other participants, the CRNs and Nurse Educators were multi-national drawn from Australia, Jordan and New Zealand; of the remaining 3 were Saudi Arabian, and 2 South African.

Table 11 - Demographic Characteristics of Clinical Educators*

No	Participant Selected Initial	Age	Gender	Educational Qualification	Length of clinical Experience	Assigned ward	Nationality
1	MB	37 yrs	F	BSN, Critical D	13 yrs	ICU & CCU	Saudi
2	GW	38 yrs	M	N. Diploma	19 yrs	Staff health	Australian
3	SM	40 yrs	F	BSN	16 yrs	OPD	Saudi
4	AB	36 yrs	F	BSN	10 yrs	Medical Units	Saudi
5	RD	43 yrs	M	BSN	20 yrs	ER	Jordanian
6	NG	33 Yrs	F	N. Diploma	17 yrs	Surgical Units	South African
7	SG	50 yrs	F	N. Diploma	25 yrs	Education	New Zealand
8	SE	50 yrs	F	BSN	27 yrs	Education	South African
Range	-	33 – 50	-	-	10 – 27 yrs	-	-

* Clinical Educators: Clinical resource Nurses and Nurse Educators.

The demographic characteristics of the nurse managers are shown in Table 12. Their ages ranged from 34 to 65 years, four of whom were female and two males. Each manager held one of various educational qualifications including: BSN, Nursing Diploma, RGN, RMN and BMSC (Board of Medical Speciality Coding). The length of clinical experience gained by these nurses varied from 10–36 years from the point of qualification. Three managers were South African, while the remaining three were a Malaysian, New Zealander and Saudi Arabian.

Table 12 - Demographic Characteristics of Nurse Managers

No	Participant Selected Initial	Age	Gender	Educational Qualification	Length of clinical Experience	Assigned ward	Nationality
1	SM	65 yrs	F	N. Diploma	36 yrs	Staff Health	South African
2	BE	46 yrs	F	BSN	25 yrs	OPD	South African
3	SA	58 yrs	F	N. Diploma	36 yrs	F. Surgical	South African
4	AM	34 yrs	M	MSN	14 yrs	ER	Saudi
5	An	53 yrs	F	RGN, RMN	35 yrs	ICU & CCU	Malaysian
6	LI	refused	M	BMSC- Nursing	10 yrs	Medical Units	New Zealand
Range	-	34 – 65 yr	-	-	10 – 36 yrs	-	-

These demographic characteristics provided me with additional information about the nature of the participants. Understanding the demographic nature of the study participants facilitated the process of data analysis and interpretation as well as contributing to a clearer understanding of preceptorship in Saudi Arabia. Furthermore, it provided me with greater insight into the clarity and meaning of preceptorship as perceived by the participants. For example, the diversity in nationality and experiences of participants helped me to explore the importance of preceptorship for newly hired experienced nurses and enabled me to understand exactly what those nurses meant when they talked about their needs during preceptorship.

In addition, demographic characteristics such as previous occupation and assigned ward aided my analysis in terms of the relationship between the preceptorship programme and the recruitment process. Demographic characteristics in general, helped me to compare and understand the similarities and differences between the groups. Consequently, this study was not like others, which examined only the perspectives of Saudi nationals, instead, participants were both Saudi and non-Saudi nurses. Thus, the sample selected reflected the skill mix of the environment and facilitated the acquisition of more diverse data.

3.8 Data collection

Selecting an appropriate method to collect study data is considered a challenging task in the research process (Polit *et al* 2001). The main aim of gathering data in naturalistic inquiry is to be able to construct reality in ways consistent and compatible with the perceptions of a setting's inhabitants (Erlandson *et al* 1993). In the literature, there are different types of data collection methods that can be used by naturalistic researchers. These include: the semi-structured individual interview, focus group interview, document analysis, observation, field notes, diaries and reflective journals (Denzin & Lincoln 2008, Burns & Groves 2007, Speziale & Carpenter 2007, Sandelowski 2000). Since the study focus was to explore preceptorship in Saudi Arabia from multiple perspectives, semi-structured, focus group and individual interviews as well as a review of hospital documents were chosen as the methods of data collection.

The semi-structured interview was chosen, as it is flexible despite its focus being determined by the researcher; the sequence of questions could be changed during the interview based on participants' responses and/or insights gained from previous interviews. Furthermore, semi-structured interviews enabled me to add new questions in response to the direction in which interviewees took the interview (Speziale & Carpenter 2007).

In semi-structured qualitative interviews, naturalistic researchers are advised to use a list of relatively fixed questions or fairly specific topics to be covered; this is called an 'interview schedule' or 'interview guide'. In this case, the researcher may choose not to use the questions exactly as scheduled in the interview guide, but all questions are asked and new questions might be added (Mason 2002). In this study, I wanted to explore more specifically the views of the newly hired nurses and other programme stakeholders regarding preceptorship. Semi-structured qualitative interviews were used to uncover more specific issues regarding preceptorship. These are proffered as being high-quality strategies to use when researchers have a clear view of the phenomenon at the outset of a study, rather than starting with a very general idea, namely wanting to conduct research on an ill-defined topic (Silverman 2006). Semi-structured qualitative interviews can take the form of one-to-one interviews, larger group interviews or focus groups (Mason 2002).

In this study, I decided to use both semi-structured focus group and individual interviews as the methods of data collection in order to access directly what happened to participants during the preceptorship programme (Silverman 2006). Focus group interviews aimed to gain a broad range of data about the investigated phenomenon through the group members dynamic interaction while the individual interviews focused on the interviewees' own perspectives in order to uncover personal philosophies more openly (Sandelowski 2000, Erlandson *et al* 1993). Using both types of data collection helped to generate rich, detailed answers (Bryman 2008, Flick 2006). In the following section, the theoretical description of each tool and the rationale for its use in the study are discussed.

3.8.1 Focus group

Focus group interviews consist of a purposively selected group of individuals who have similar interests and characteristics (Speziale & Carpenter 2007) in order to explore their perceptions of a specific phenomenon in a comfortable and non-threatening environment (Bryman 2008, Burns & Grove 2007). Focus groups build on the idea of dynamic interaction between group members as this interaction stimulates members to raise more points related to the topic - namely preceptorship. At the same time it helps them clarify their views more easily than in individual interviews which may lead to further exploration and/or unexpected perceptions (realities) (Goodman & Evans 2010, Bryman 2008) of the phenomenon, in this case, preceptorship in the Saudi context.

The main advantages of focus groups are that they help study participants reflect on their experiences as part of a group discussion (Bryman 2008, Sandelowski 2000). The dynamic interaction of the focus group is a component for analyzing and interpreting the data (Goodman & Evans 2010). Being in a focus group may provide participants with a sense of safety particularly for those who may be anxious or wary of a researcher (Burns & Groves (2007), especially if participants know each other as was the case in the current study. Focus groups were considered useful in this study as it aimed to explore multiple perspectives of preceptorship (Litoselliti 2003). Moreover, the focus group data could also be triangulated with other data sources used in this study to obtain a more comprehensive view of the phenomena. Furthermore, focus groups can be used to explore participants' shared meaning of everyday life, use of language and culture of specific groups, and for checking the validity of any findings (Litoselliti 2003).

Despite the above however, focus groups are of limited use when exploring a phenomenon participants are unfamiliar with or if there is inconsistency between the researcher, the topic and the participants' ability to reflect on the topic. More importantly, focus groups should not be conducted when there is a lack of time or resources (Litoselliti 2003). Nevertheless, limitations of the focus group tool include, reacting to a '*false consensus*' because a dominant member of the group may do all the talking while others keep silent. A further weakness of this approach that may arise is: leading question bias and manipulation particularly if the interviewer leads

participants to say what s/he wants to hear. A further limitation could be *difficulty in distinguishing between the individual and group view* because of group influence and the inability of some members to express their disagreement and/or discuss this within a group context. Finally, there may be *difficulty making generalizations* because of the limited sample size and difficulty in obtaining a representative sample (Litoselliti 2003, p.21).

In this study, the above limitations were managed by trying to remain neutral during the interview, by intending to be a good listener without providing any comments or discussing my own views to help reduce researcher bias. Additionally, I tried to avoid using yes, no or leading questions. Dominant participants were dealt with, via the use of the interview guide to keep the interview on track and by asking participants not to talk when another participant was talking. Questions such as: *what do you think about what has been said?* were directed to quiet participants to encourage them to participate and comment on the discussed issue to uncover their views and ensure that every participant had chance to speak.

Thus, focus group interviews are considered compatible with naturalistic inquiry and have previously been used in qualitative research (Kilcullen 2007, Clark & Holmes 2006, Harbottle 2006, Sandelowski 2000) to enhance discussion and open up new perspectives regarding the examined topics. This helps to provide in-depth understanding of the investigated phenomenon (Litoselliti 2003) and therefore gain a broad range of data about, in this case, preceptorship.

In this study, as group members knew each other, the dynamic interaction stimulated them to make sense of their own views regarding preceptorship whilst also challenging each other's understanding of what preceptorship really meant for each of them (Kilcullen 2007). Thus, the group interaction between participants gave them more time to think and elaborate their point of view and recall ideas whilst another participant was talking, which enhanced the debate between members and helped them explore the topic in more detail (Lambert & Loiselle 2008, Ritchie & Lewis 2003).

Hence, data generated from the focus group interview added richness to the study findings, especially when compared and contrasted with the data generated from individual interviews. In essence, the group dynamics and interactions within focus groups helps generate richer data than it is possible to achieve via individual interviews, so as to obtain multiple perspectives between groups of individuals and more importantly about the topic (Rabiee 2004).

3.8.2 Semi-structured individual interview

In this naturalistic study, semi-structured individual interviews facilitated the construction of a relatively flexible, one-to-one conversation between the researcher (interviewer) and the participant (interviewee). Semi-structured individual interviews were used to ensure that the relevant context was brought into focus through interaction between the researcher and participant (Mason 2002) in order to obtain detailed descriptions of the participant's thoughts about the preceptorship event (Speziale & Carpenter 2007). The semi-structured individual interview was considered suitable for this study as it can explore the personal philosophy of each participant regarding preceptorship and its impact on clinical nursing care without the influence of other participants (Bryman 2008). Each personal philosophy provided additional insight into preceptorship as it represented another aspect of the preceptorship experience. Based on these philosophies and perceptions, it was felt that a shared reality of preceptorship could be then generated (Erlandson *et al* 1993).

Although some researchers argue that individual perspectives cannot be expected to provide a 'true' picture of the phenomenon (Burns & Groves 2007), the current study aimed to explore personal views and philosophies as the participants chose to describe them. These philosophies or views were considered by the participants to be real and true as they emanated from their own individual and personal experiences. Analysis and interpretation of these views revealed that preceptorship was characterised by multiple realities.

Hence, the findings chapters present a shared view, which represented the meaning of preceptorship for my respective study participants. It must be noted however, that individual interviews are subjective in nature as they rely on the researcher's and participants' honesty when reporting the findings (Rubin & Rubin 2004). In order to

achieve this notion of honesty, I as the researcher had to be close to the data through continuous reading and re-reading of the interview texts (Bryman 2008, Lincoln & Guba 1985). In addition, I also needed to avoid the potential for reporting bias by checking my data independently with my co-researchers and presenting the data as it had been collectively agreed by both me as the researcher and my co-researcher (Sandelowski 2000, Erlandson *et al* 1993, Lincoln & Guba 1985).

In this study, semi-structured individual interviews enriched the whole process so that any problems encountered with the focus group interviews could be overcome by semi-structured individual interview (Rubin & Rubin 2004). Moreover, individual interviews encouraged participants to spontaneously provide their own description of preceptorship (Silverman 2006). Nevertheless, semi-structured individual interviews require the researcher to be skilful, for example being a good listener, communicator and asking open-ended questions, when conducting the interviews so as to interact with the interviewees effectively and thereby understand the interviewee's perceptions or experiences (Silverman 2006). During individual interviews, the interviewee and interviewer are both active participants, which means the interview text is collaboratively produced as the interviewee focuses on answering the questions, while the interviewer takes on the role of active listener (i.e. concentrating on the questions to be asked and the answers provided), by having control over the whole interview process and deciding when to close or open topics (Silverman 2006).

Nevertheless, during individual interviews participants may choose to withhold specific information or ideas or may try to amplify their explanations and description of the phenomenon, particularly if the truth is contrary to that person's perceptions and beliefs, or the participant wishes to impress the interviewer (Lambert & Loiselle 2008). This limitation was managed in this study by using the focus group interview, to achieve greater understanding of the study phenomenon (Lambert & Loiselle 2008). Furthermore, participants may become anxious during individual interviews, which may impact on the researcher's ability to accurately interpret the data (Rubin & Rubin 2004). This potential limitation was managed here by meeting the potential participants many times before the actual date of the interview. During these preliminary meetings, I introduced myself to the participants, provided them with a

clear idea of the study and nature of their participation and interacted with them in a friendly and informal way in order to minimise any feelings of anxiety.

Individual interviews are often chosen as one of the most suitable data collection techniques for use in naturalistic inquiry based qualitative studies. Individual interviews have been applied either singly or in combination with focus groups to examine the preceptorship phenomenon in previous qualitative descriptive research projects (Duffy 2009, Clynes 2008, Clarks & Holmes 2006, Evans *et al* 2004) as well as in the current study

In conclusion, the semi-structured individual interview was chosen to elicit participants' understanding of the nature of preceptorship and its impact on their clinical nursing care. Individual interviews were considered suitable here as the study aimed to explore participants' views rather than make generalisations (Mason 2002). Moreover, individual interviews were thought to reveal each participant's perception of preceptorship more openly and freely by using the open ended questions listed in the interview guide (see Appendix D, page 382). These allowed me to obtain richer and deeper comments from participants than it might not otherwise have been possible to achieve in a focus group (Rubin & Rubin 2004). As this study sought to find answers from multiple perspectives, semi-structured individual interviews could also be considered suitable tools to explore each personal perception and help elicit collective perceptions through the cross-comparability structure of thematic analysis.

The rationale for combining individual and focus group interviews as part of a data generation process is outlined below, followed by pilot testing the interview guides.

3.8.3 The rationale for using both individual and focus group interviews in the study

Despite the differences between individual and focus group interviews, combining the data generated from them can help researchers achieve a broader understanding of the examined phenomenon as data generated from individual interviews can complement that generated from focus group interviews. In so doing, more general overviews of the phenomenon may be generated (Lambert & Loisel 2008). Individual and focus group interviews are most effective when they are combined for three major reasons: 1- pragmatic or practical reasons (as a substitute) to reduce

withdrawal rates by providing participants with a chance to choose the most convenient method of participation, 2- to compare and contrast participants perceptions, 3- to complete and/or confirm data (Lambert & Loiselle 2008, Burns & Groves 2007, Flick 2006, Taylor 2005, Ritchie & Lewis 2003).

In this study, the main purpose of using both individual and focus group interviews was to complement each other, to gain a broader more holistic understanding of the preceptorship phenomena and to help ensure that the generated findings could be confirmed, were complete and helped to enhance rigour (Speziale & Carpenter 2007). Furthermore, combining the two data sources contributed to enhancing study rigor (Speziale & Carpenter 2007). The latter issue will be discussed in more detail in section 6.6 page 250 in the discussion chapter.

Combining these data sources helped to offset limitations of using a single method and facilitated confirmation of the study's findings (Breitmayer *et al* 1993) by comparing and contrasting different points of view and uncovering common and shared views (Speziale & Carpenter 2007).

The second purpose was that individual interviews were used as an alternative to focus groups in order to capture views of those participants who could not attend the focus group because of work or family commitments (Lambert & Loiselle 2008) in an effort to reduce withdrawal rates and to help add a diversity of views regarding preceptorship in the study setting. Furthermore, individual interviews were also used to complete participants' views of preceptorship in the study.

3.8.4 Pilot testing the interview guides

In this study, focus groups and semi-structured individual interviews were conducted using an interview guide (Appendix D, pages 378 & 382) to guide the exploration of participants' understanding of preceptorship and its impact on their clinical nursing care. The interview guide was based on the study's aim and objectives and ideas generated from the literature review. The questions listed were open ended to obtain in-depth data exploring participants' perceptions of preceptorship in order to answer the research questions and achieve the study aim and objectives (Ritchie & Lewis 2003). The interview questions were checked and approved by my supervisors to

ensure that they were not simply focused towards generating ideas or responses they reflected my own philosophies regarding preceptorship.

In qualitative research, the scope of the interview guide can be piloted in the initial interviews (Ritchie & Lewis 2003). In this study, the interview guide was pilot tested in the first individual and focus group interview by assessing how well the interview guide was working according to the type(s) of data I was able to generate and whether these data met the study objectives. In focus groups, the nature of the questions, the characteristics of the participants and the interaction between the participants were considered during the pilot testing of the interview guide. Furthermore, as part of this process was I also able to identify the sort of direction that successive interviews might take. Hence, appropriate changes could occur in order to ensure the interview guide enabled me to conduct any subsequent interviews more effectively (Ritchie & Lewis 2003). In this study, the interviews were conducted and recorded as described below.

Following the pilot interviews, as with those undertaken as part of the main study, data were transcribed verbatim and then analysed using a thematic analysis technique. Based on an initial analysis of the pilot data, the questions were examined in terms of whether they reflected each theme in the interview guide. Thus, it was possible to uncover unexpected (unlisted) issues related to preceptorship, while also allowing participants to speak freely and express their perceptions and raise issues related to the preceptorship process that they themselves felt were important (Ritchie & Lewis 2003). Moreover, the interview guide was reviewed further by discussing the content of the data collected with my supervisor after each interview to identify the direction of the interviews and to check that the research questions were being answered.

Following these interviews one open ended question was added to clarify issues regarding the preceptorship period. The same questions were then asked in all subsequent individual and focus group interviews to ensure the same data were generated from each group of participants enabling me to explore similarities and differences in respect of within and across group perceptions (Flick 2006, Ritchie & Lewis 2003). Data generated from these individual and focus group pilot interviews have been included in the findings because no major changes were made to the

interview guides and the data collected reflected the interview guide themes generated in other interviews in that they uncovered participants' perceptions and generated in-depth data (Ritchie & Lewis 2003).

Ritchie & Lewis (2003) stated that data collected in pilot interviews can contribute to the research findings even when or if the emphasis changes slightly. Consequently during the interviews the same questions were used for both the individuals and focus group interviews although they were sometimes presented in different sequences based on the participants' response to a previous question to facilitate flexibility and increase the depth of data attained (Flick 2006, Ritchie & Lewis 2003).

Using an interview guide helped me to focus on the research topics and ensure that the same types of data were generated from each party (Ritchie & Lewis 2003). Pilot testing the interview guides also helped me to be more familiar with the interview process. As interviews proceeded, I became less dependent on the interview guides as familiarity with the topics discussed increased.

3.8.5 How the individual and focus group interviews were conducted

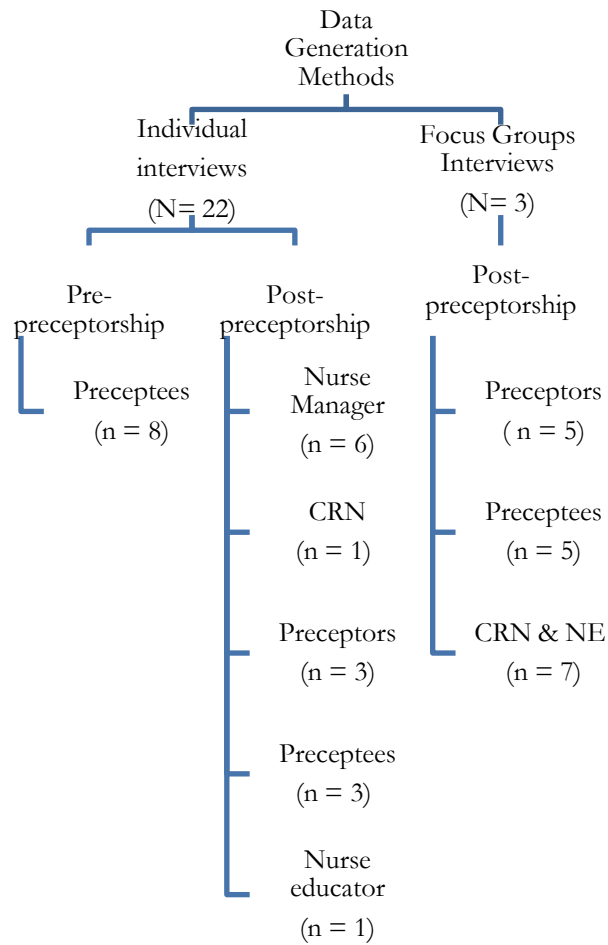
Data were collected in two stages: pre-preceptorship and following the two weeks of preceptorship. During the two stages, 22 semi-structured individual interviews were held. In the first stage, eight individual interviews were conducted with each preceptee to explore their understanding and initial expectations of preceptorship before they engaged in the preceptorship experience. The interviews during this stage lasted from 15 to 22 minutes.

In the second stage, six individual interviews were held for nurse managers and eight individual interviews were held as an alternative data collection tools for participants who agreed to take part in a focus group interview but were subsequently unable to attend on the dates and times scheduled due to unexpected work or family commitments. The eight individual interviews included three preceptors, three preceptees, one CRN and one nurse educator. Individual interviews during this stage lasted from 38 to 87 minutes.

In addition, a total of three semi-structured focus groups involving five preceptors (n=5), five preceptees (n=5), and seven participants which included both the CRNs and nurse educators (n=7) were conducted at this second data collection stage to explore their perceptions of preceptorship and what impact preceptorship had on the preceptees' clinical care. Each group was homogeneous in that participants shared a similar grade, role responsibilities and experience of preceptorship around which the discussion was constructed (Lucasey 2000). Homogeneity of the group helped to let group members feel comfortable so they could reflect on preceptorship issues that concerned them or affected their preceptorship role (Krueger & Casey 2000).

Although 5 participants were considered less than ideal, given a range of participants from (6 -10) had been noted in the literature as appropriate for effective discussion and eliciting variety of ideas (Burns & Grove 2007, Clark & Holmes 2006). Nevertheless 5 was considered an acceptable number as in other studies by Strong *et al.* (1994) and Benner *et al.* (1992) 4-6 focus group participants were used. The focus group interviews in this study lasted from 86 to 120 minutes. Figure 3, page 129 shows an overview of the methods used to collect study data, stages of data collection, type and number of participants targeted for each data collection method used, and at which stage.

Figure (3): Sample of participants contributing to each data collection method pre- and post- preceptorship.



Semi-structured individual and focus group interviews were conducted at a time and in a place appropriate to both the participants and the interviewer. A conference room was located for these events to ensure interviews ran without disruption and clear recording of the conversation was facilitated. Before the interviews took place, an invitation letter stating the date, time and venue of the interview was sent to each participant, followed by a telephone call one day before the interview date as a reminder and to confirm attendance. The focus group participants, moderator and I were all seated at a round table to assist communication and observation (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003). The moderator attended the focus group interviews to observe, assess and note non-verbal communication without overtly disturbing the participants.

At the beginning of each individual and focus group interview, I welcomed the participants, provided a brief overview of the study aim and objectives and presented

an outline of the interview process. Participants were reminded of the ethical considerations outlined earlier. The purpose of the moderator's role was also explained to those taking part in the focus groups to express my respect to the participants and let them feel relaxed and able to talk openly. In addition, it was to ensure confidentiality of the discussion (data) (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003). In order to be able to transcribe the data in a way that helped distinguish between the statements of several speakers and to identify them during the discussion, nicknames provided by the participants were used during the interview to ensure confidentiality and anonymity (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003). Finally, verbal consent was also obtained at the beginning of the interviews to re-confirm earlier written consent and to make sure participants were still willing to take part and answer queries.

All individual or focus group interviewees were asked to introduce themselves to the interviewer as well as the moderator and each other for those taking part in the focus group. At the same time, demographic data for each participant, such as age, nationality, number of years experience as a registered nurse were also ascertained. In the case of the focus group participants, a short demographic questionnaire was distributed and filled-in by each participant at the start of the session to save time and ensure confidentiality.

The individual and focus group interviews both took the form of moving from a general towards a more in-depth exploration of the participants' perceptions of preceptorship using open-ended questions. Hence, participants were first asked, "*What does preceptorship mean to you?*" to access a general overview of their views. The latter was then followed up by a more specific question such as "*What are/were your expectations of the preceptorship programme?*" For consistency, these two questions were used at the beginning of each individual and focus group interview both before and after the preceptorship programme. Other questions drawn on as part of the semi-structured interview process are shown in full in appendix D, p. 378 & 382. Questions followed on naturally from one to the next based on either the participants' answers, or the interview schedule itself to avoid prolonged silences. Additionally, new questions were also generated as a result of the participants' own reflections on the preceptorship experience. These facilitated greater clarification of

the topic being discussed and generation of sufficient data to obtain a richer understanding of the phenomenon (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003).

During the focus group interviews, participants were encouraged to speak freely and express their views and feelings even if these were not compatible with those of others because it was felt that *'everything the respondent might wish to discuss would be of interest to [me] the researcher'* (Bechhofer & Paterson 2000, p.69). When a participant raised a point that was unclear, I would ask them to clarify it by asking *'What do you mean by this?'* or *'Could you make it clearer?'* in order to make the point explicit, clarify any misinterpretation and obtain a richer understanding of what was being said (Rubin & Rubin 2004). The latter process was adopted for both the focus group and individual interviews until no new data were elicited.

During both types of interview, participants would sometimes raise issues that neither answered my question nor addressed my study aims. In this case, I tried to manage the situation either by asking another question or by redirecting them to the issue that had not been fully discussed or they had avoided answering. During the conversations, I listened to the participants, demonstrated my interest by maintaining eye contact and providing signals that conveyed I was paying attention and encouraged participants to talk openly about their perceptions (Flick 2006, Ritchie & Lewis 2003). Although participants sometimes began discussing what appeared on the surface to be an unrelated issue, when clarified it highlighted an unexpected area that was in fact tangentially related to preceptorship, an example of this was recruitment services. In this way, the participants themselves added further richness to the study data as such comments revealed information that inadvertently provided answers to the research questions and additional unexpected depth to the research objectives (Erlandson *et al* 1993, Lincoln & Guba 1985).

Furthermore, I made myself aware not only of my own but others speech tone and body language, as these two factors are important signals for obtaining in-depth information, as non-verbal communication can confirm or refute verbal expressions (Ritchie & Lewis 2003). Hence, this latter action helped to clarify and/or generate additional data. For example, there were times when participants reacted emotionally

and appeared frustrated, which I explored by saying '*you talked about this point while you looked disappointed, why?*' This information was recorded in the moderator notes because it was not possible to record or reveal such information on the audio-tape and was considered to be particularly useful for clarifying and generating a richer understanding of the study phenomenon. Furthermore, I tried to provide time for participants to think about the points raised to allow them time to formulate their responses and reflect more deeply on their experiences (Burns & Grove 2007). In this way I was furnished with more detail regarding the participants own personal philosophies concerning the meaning and value of the preceptorship programme.

Towards the end of the focus group interview process, both the moderator and I conferred to check whether any non-verbal expressions needed further exploration (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003). Prior to closing the individual and focus group interviews, participants were asked if they would like to add any points or talk about any issues not discussed during the interview but which they felt may be of benefit to the study. At the end of the interview, participants were thanked for their participation and willingness to share their knowledge and experience with others (Flick 2006, Rubin & Rubin 2004, Ritchie & Lewis 2003). This latter action is particularly important as it indicates that the researcher values the participants' contributions (Bryman 2008, Speziale & Carpenter 2007).

Finally, each focus group and individual interview was transcribed *verbatim*, into written texts in a question and answer format, considering the dynamic interaction between the participants in transcribing the focus groups interviews. I transcribed the first three individual interviews and an external professional transcriber was employed to transcribe the remaining interview data. However, to ensure confidentiality of the recorded data, the transcriber signed a declaration letter stating that all the information she had heard and transcribed would be kept confidential and whatever was discussed in the interviews would not be disclosed. Furthermore, she declared that she has no right to use any of this information for any reason, and discs containing transcriptions were returned to me. I subsequently verified accuracy of the transcribed texts by listening to the tapes and comparing the typed content with the audio-recordings to ensure the integrity of the text (Burnard *et al* 2008, Silverman 2006).

Simplified transcription symbols were adopted from Silverman (2006), which indicated the participants' elapsed time in silence, laughter, in breaths, and out breaths, which were added to the texts (see appendix E, p. 388). Non-verbal communications from the moderator notes were also added into the transcribed texts of the focus groups interviews (Burnard *et al* 2008, Silverman 2006). The final validated texts were then saved in a Microsoft file format. The transcript of each individual interview was also saved in a Microsoft file with a distinguishing name to ensure that there was a back up copy in case of emergency.

3.8.6 Review of preceptorship documents

Documentary analysis is another data generation method that can be used in qualitative research drawn from naturalistic inquiry paradigm (Mason 2002, Sandelowski 2000) and represents one particular form of reality built for a specific purpose. Thus, documents can be used to complement other data collection methods, such as interviews (Flick 2006). Official documents can take many forms such as case reports, remarks, diaries, statistics, annual reports, expert opinions (Bryman 2008), and can be text and/or non-text based (Mason 2002).

The practice of analysing documents is considered by many qualitative, naturalistic researchers as an appropriate method to gain insight into the document's content and for examining consistency inside and even across documents as in this case (Bryman 2008, Erlandson *et al* 1993). This latter data source can also be compared with participants' interview data, in order to obtain a deeper understanding of the phenomena under study and to check for consistency of interpretation, meaning and understanding (Mason 2002, Lincoln & Guba 1985).

In this study, documents were text-based, policy and procedural statements regarding preceptorship, plus the nursing orientation and probationary period requirements for new staff. These documents were prepared by the Nursing Education Department, approved by the Director of Nursing Services and applied to all nursing staff within the division of nursing. They aimed to identify the organisational requirements pertinent to the orientation of new staff during the preceptorship period and to regulate the preceptorship process within the nursing division.

However, it is imperative to note that this review of the documentation was not proposed from the outset of the study. It was considered to be important as the study progressed. More specifically, I decided to examine the documents as a consequence of the participants' comments regarding the inconsistency, ambiguity and lack of clarity within and between the policy documents which were identified during the interviews. Accordingly, preceptorship documents were not examined as analytical pieces of text in their own right; rather they were reviewed in order to look for evidence to support or refute participants' claims that the documents were contradictory and confusing. Hence, these documents were examined to see if the confusion around time and the meaning of preceptorship that had been highlighted by the participants during the individual and focus group interviews was a reality or simply a misinterpretation of what had been written.

3.8.7 How the preceptorship documents were reviewed

In order to understand what the official organisational view of preceptorship comprised, the policy documents were examined to see if any ambiguities could be isolated which might prohibit nurses from understanding what preceptorship meant or was supposed to address and/or achieve. Hence, I immersed myself in both the whole and parts of these documents because each sentence comprised a sequence of individual words that had the potential for misinterpretation (Silverman 2006). By looking to both the sentences and the individual words, the meaning of preceptorship from an organisational perspective could be gleaned (Flick 2006, Silverman 2006, Flick *et al* 2004).

The content of the preceptorship documents in terms of their meaning were then compared with each other to look for consistency and compatibility both within and between the content. To add richness to this process, the conclusions drawn from this form of analysis were then compared with what was said by the participants in the interview data in order to provide a more complete picture of the nature of preceptorship and its impact on clinical nursing care in a Saudi Arabian context.

In total three documents were reviewed: the preceptorship internal policy and procedure (IPP1), orientation and probationary requirements policy and procedure (IPP2), and pre-reading material for the preceptorship workshop. The IPP1

addressed issues, which applied to all grades of staff nurse within the nursing division. In particular, the IPP1 was designed to '*regulate the preceptorship process*' (p.1). The IPP2 applied to all nursing staff within the division of nursing, and was designed '*to identify the organisational requirements pertaining to the orientation of new staff during the first 90 days of employment*' (p.1). Finally, the pre-reading material was targeted at those nurses who were registered to attend the preceptorship workshop including preceptees and all those involved in the preceptorship process.

Hence, these documents allowed me to envision the organisational philosophy regarding preceptorship (Flick 2006). In this way, reviewing the documents provided useful additional information, which I could correlate with the experiences expressed during the interviews. In effect, reviewing these documents opened up a new perspective on the investigated phenomena and furnished me with a broader picture (Flick 2006). Documents were examined in a neutral and objective way. In essence, my examination of the preceptorship documents provided me with greater insight into the clarity and meaning of preceptorship as it was perceived both by the organisation and the participants (Bryman 2008). Nevertheless, the main sources of data generated in this study, and on which the findings are based were the individual and focus group interviews.

3.9 Data analysis

Qualitative research is characterized by concurrent data collection and analysis where both processes reciprocally shape the other (Sandelowski 2000). According to Burns & Groves (2007), the analysis of qualitative data occurs in three stages: 1- description, 2- analysis, 3- interpretation. As this study was based on a generic qualitative design, thematic analysis based on constant comparison was applied to the analytical process (Burnard *et al* 2008, Boeije 2002).

3.9.1 Thematic analysis

Thematic analysis has been a method of analysing data typically used in qualitative studies based on naturalistic inquiry as it can facilitate rich and detailed understanding of the data (Sandelowski 2000). Thematic analysis is a method of comparing and contrasting visual and verbal data in order to produce an overall summary. It requires the researcher to be 'reflexive and interactive' (Sandelowski

2000, p.338) as this help him/her to manage the study data in a way that ensures data generated are purely representative of participants' perceptions. Therefore, use of the thematic analysis technique enabled me to modify or discard any coding systems that had been preconceived before commencing the analytical process to ensure that the themes generated emerged only from the data itself rather than from any preconceptions (Clynes 2008, Sandelowski 2000).

In this study, thematic analysis was considered the most appropriate analysis method that could be used to explore multiple perspectives in order to obtain a collective and shared reality describing the meaning of the nature of preceptorship and its impact on clinical nursing care (Erlandson *et al* 1993, Lincoln & Guba 1985, Guba 1978). Thematic analysis enabled me to cluster similar views together to construct a series of broad categories. These categories were further studied and reduced to generate major themes and sub-themes from the interview texts. Accordingly, themes represented meaning, which equated to the participants' experiences or perceptions of preceptorship, which emerged via exposition of collective and recurring ideas or concepts identified in the data (Braun & Clarke 2006). The notion of thematic analysis has been adapted from Glaser & Strauss's grounded theory method and is based on the processes expounded within the constant comparative method (Burnard *et al* 2008, Thorne 2000, Burnard 1991, Glaser & Strauss 1967).

Constant comparative analysis builds on the principle of comparing one piece of data with other similar or different data in order to explore possible relationships between them (Thorne 2000). This comparison includes for example looking for links between interview data both within the same group of participants and interview data from different groups. In the case of the present study, this comparison focused on examining perceptions of participants regarding preceptorship (Boeije 2002). Thematic analysis based on the constant comparative process can be used to gain a clear and holistic understanding of human phenomena within a naturalistic context (Thorne 2000).

Thematic analysis applies inductive techniques to analyse data. Themes that emerge using inductive thematic analysis are closely linked to the study data as inductive coding allows the data itself to guide the analytical process (Braun & Clarke 2006).

Inductive thematic analysis is appropriate for analysing data with little or no pre-determined theory or framework (Burnard *et al* 2008). Although inductive analysis is a comprehensive approach, it is nevertheless time-consuming. Despite the latter, it is the most frequent data analysis method applied in qualitative research (Burnard *et al* 2008). Inductive thematic analysis was the most relevant approach to adopt in this study, in order to uncover key themes and sub-themes from within the data itself as a result of combining the ideas expressed in the individual and focus group interviews with participants. More importantly, the inductive analytical approach was particularly relevant given that I was a novice researcher due to its flexibility and relative ease of application (Braun & Clarke 2006).

3.9.2 How the data were analysed.

Before commencing the process of data analysis, I was concerned with ensuring fairness and accuracy of the analysis by reflecting on and outlying my previous experiences/perceptions of preceptorship in the study setting and then putting them aside in order to make certain that the data, and not my perceptions, guided my analysis. As stated earlier, data analysis began immediately after each individual and focus group interview. This helped to reduce the potential for confusion among different interviews and to enhance the quality of the analytical process. In this study, transcript-based analysis was chosen as the main analytical strategy as it is the most rigorous analytical approach to adopt (Krueger & Casey 2008).

Each interview transcript consisted of the tape content transcribed verbatim and the notes that were discussed with the moderator. Furthermore, the notes recorded by the moderator including verbal and non-verbal communications, which were not reviewable from the audio tapes, were written in the margin of each transcript and reviewed carefully during the analysis stage. Throughout the analytical process, I frequently returned to the aim, objectives and research questions of the study and reviewed the topic guide including the objectives of individual and focus group interviews in order to determine the depth and intensity of analysis (Krueger & Casey 2000). This was combined with reading each transcript and listening carefully to the related tapes in order to familiarise myself with the nature of the interview and gain an overall understanding of the topics that concerned the participants about preceptorship.

Data analysis was therefore carried out in four stages. The first was open coding where each interview text was read and re-read. The data were then analysed initially by me, following a line-by-line mode of data analysis (Burnard *et al* 2008). Notes on what was said within each line, sentence and paragraph were recorded in the margin. Subsequently, participants' words were used to inductively identify the codes used to describe the content of the interview (Cris 2002). Re-occurrence of any words was searched for manually. The codes identified were then collected and listed. Similar codes were collected to form the initial categories (sub-themes). This was done by re-reading each phrase, sentence and paragraph in detail to decide 'what it was about' in order to determine meaning and establish how the data fitted together (Ritchie & Lewis 2003). Movement between the 'part' and 'whole' of the transcript continued. Hence, by comparing different parts of the interview transcript, similar content or properties were located together to allow me to focus on each subject so that maximum detail and any dissimilarity could be identified. Once the codes had been established, connections between the data and objectives of individual and focus group interviews were made.

In terms of analysing the focus group transcripts, several points were considered during the open coding stage. First, I had considered that there were a number of participants within a focus group who repeated ideas or raised similar topics. Second, there were participants from various focus groups who made the same statements. I also perceived that when someone in the group raised an issue, a substantial numbers of persons in the group demonstrated agreement either verbally or non-verbally. Accordingly, I was careful during the analysis to identify the nature of any interaction between the group members, the influence of the group members on each other and to discover whether the conversation was dominated by one or more members and not reflective of the entire group. Whilst analysing both the focus group and individual interview transcripts I was also concerned with listening carefully to the tapes many times in order to pick up the tone, talking speed, frequency, specificity, internal consistency and intensity of participants' remarks in order to compare what I heard with what was written in the transcripts. This helped to capture major issues and themes, which had been missed in the moderator's notes and deemed by the participants to be of considerable importance.

During the focus group transcripts analysis, non-verbal communications such as nodding, intakes of breath, gasping and comments that were emphasised by the participants were considered as these extended the discussion and changed the direction of the conversation. For example, a member of the group gestured negatively to another person's comment; I noted this gesture and explored its significance. I was also careful to listen to inconsistent comments and the views exchanged by participants as a result of their having listened to others' explanations and to identifying the logical explanations behind that change in order to reveal the nature of interactions between the group's members and what was influencing the change of opinion. This helped to reinforce some of the overt messages that were made verbally by individuals or subsequently challenged by others.

I also examined the exact words used and their meanings in order to determine the degrees of similarity and difference among the participants responses. In addition, I also considered the context in which a participant's response was given during the focus group discussion and then interpreted each response in the light of that context. The latter was felt to be particularly important in order to avoid lifting responses out of context or drawing premature conclusions. Hence, during the analysis stage, I gave more weight to the participants' perceptions, as they arose based on their experiences as it was these perceptions and experiences that I was most interested in capturing and understanding as part of my study.

In the second stage, data were analysed from individual interview texts within the same group, and these were then compared to identify further similarities and differences. For example, individual pre-preceptorship interviews with preceptees were compared with each other, and the results (sub-themes) compared with results drawn from comparative data generated during individual interviews with the same group post-preceptorship. This stage aimed to develop sub-themes and label them with an appropriate code within each single group in order to identify core messages derived from each type of interview.

Comparisons in stage three were made between individual and focus group interviews within each group. For example, in this stage, individual interview results were compared with the focus group interview results obtained from preceptees. The

aim of this step was to discover or highlight any similar or dissimilar codes extant within the data to '*develop conceptualizations of the possible relationship between various pieces of data*' (Thorne, 2000. p.69). This approach revealed considerable similarities and minimal differences between the groups. For instance, all participants raised the concept of time as an important factor influencing the preceptorship programme but each group revealed discrepancies in their understanding of what length of time actually constituted the preceptorship period within and across the organisation.

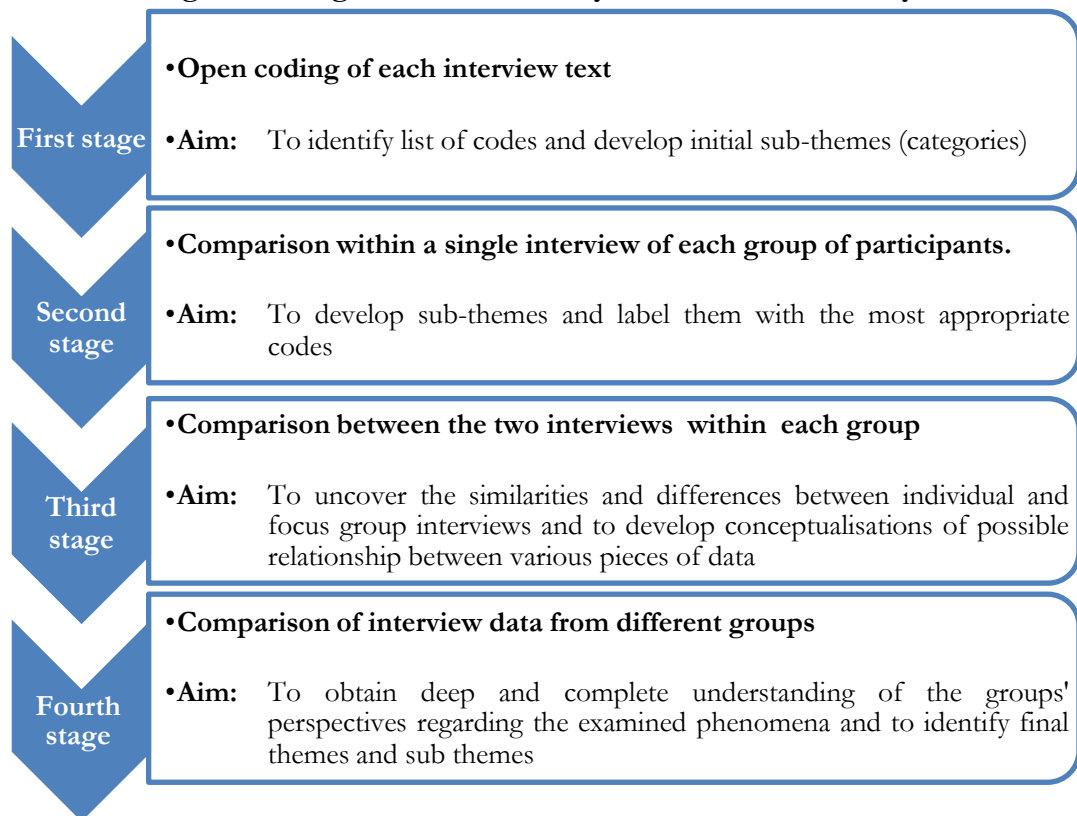
The fourth stage comprised comparisons of interview data from each group's perspectives. In this stage, data analysed from individual and focus group interviews across all four groups were compared with participants' perspectives of preceptorship (see figure 4, page 141). For instance, data extracted from preceptee texts were compared with data resulting from each of the other groups. Comparison of the data between the groups focused on the topics discussed by participants, the diversity of perceptions related to the topics highlighted by members of the group, and how the discussion proceeded as the focus groups unfolded. This step was conducted to increase the depth of analysis and generate the final themes. These themes demonstrated the connection between each groups' perspectives which enabled a deeper and richer understanding of preceptorship to be gained from multiple group perspectives. This last comparative analysis did not raise any new codes but provided a richness of data that identified what the essence of preceptorship was for participants as a collective. Thus it helped me to identify what was known or suspected about the topic and then confirm and/or challenge any *a priori* constructs by comparing these with the interview data.

Data were then sorted both manually and electronically by putting similar data together into thematic sets (Clynes 2008, Ritchie & Lewis 2003). Consequently, a colour was allocated to each theme and its related sub-themes to differentiate between themes. Finally, all of the data under each theme was pasted on to A4 sheets with an identifying label as shown in Figure 4, page 141 below.

Thus, the data were analysed based on my familiarity with, understanding and interpretation of the participants' transcripts. However, it is also important to point out that these interpretations were also influenced by my own pre-conceptions of

preceptorship (Silverman 2006). Despite the above, data were sorted into general themes and sub-themes to reveal a deeper perception of preceptorship from preceptee, preceptor, nurse manager, clinical resource nurse and nurse educator perspectives. Interpretation of each individual and combined text was documented and discussed sequentially with my co-researcher and study supervisor over several meetings in order to minimise misinterpretation potentially resulting from data-processing bias and to some extent my own philosophies as outlined in the following section 3.10.1 on page 143. In this way, there was a greater propensity for consensus to be established to ensure the data were represented appropriately.

Figure 4: Stages of the data analysis in the current study



Furthermore, to ensure that the thematic analysis and data interpretation was balanced and reflected the content of the interview so as to also reduce the risk of my own biases interfering with the data interpretation process a co-researcher was used. This latter individual was an independent person who looked at the data with a fresh eye. Therefore, she commented on the texts in a more objective way than it would be possible to have achieved on my own. During our discussions, she agreed with the majority of the coded data but there were aspects of the data coding where

disagreement with my interpretations manifest. In such cases, the co-researcher and I discussed the issues until it was possible to reach shared understanding and agree a meaning.

The co-researcher and I initially independently created the themes and sub-themes. However, the final themes and sub-themes were decided collaboratively via discussions with not only my co-researcher but also my supervisor. Finally, findings from each of the themes and sub-themes were synthesized so that the meaning of preceptorship and its impact on clinical nursing care could be summarized. The latter will be reported on in more detail in the findings chapter by using specific examples from the transcripts, underpinned by references from the relevant literature related to the topic for comparison at this stage. Examples used from the transcripts of focus group data to support the study findings have been presented as individual quotes. The reason for this is due to the fact that a consensus was not always present within the group.

3.10 Reflexivity

Reflexivity in qualitative research is a reflection on the researcher's experience in relation to the study phenomenon in order to examine his/her impact on all aspects of the research process (Speziale & Carpenter 2007). Hence, reflexivity is a critical thinking process whereby the researcher analyses his/her research process, confronts and challenges his/her own suppositions and identifies how his/her perception influenced the way the research was conducted (Mason 2002).

As a novice researcher interested in exploring the nature of preceptorship and its impact on clinical nursing care from multiple perspectives, my own philosophy and experience of preceptorship had the potential to impact on the conduct of the current qualitative study as this experience and my own view points were in themselves an integral part of the research process (Flick 2006). In other words, findings generated by naturalistic studies are created from multiple realities constructed in the minds of the participants that are reflected via language and then explored by collecting, analysing and interpreting the participants' words (Erlandson *et al* 1993). As the researcher him/herself is also one of the study participants (Erlandson *et al* 1993), reflection on my own experience and preceptorship

philosophy could also be considered one such reality which could not be ignored (Lincoln & Guba 1985) and needed to be considered during the interpretation process, as they had the potential to influence the development and analysis of the study findings (Flick 2006).

Moreover, it was not possible for me to be wholly objective, neutral or detached from my own experiences in terms of data generation, analysis and interpretation (Mason 2002). Thus, it was important to think critically and analyse my potential influence on the data, reflect on it and use it for the benefit of the study (Primeau 2003). As a novice researcher, this self-examination was conducted by analysing my past experiences, expectations, beliefs and values of preceptorship and their potential influence on the study's data collection, analysis and interpretation (Speziale & Carpenter 2007). To achieve this was difficult, as I had to look at my experience with a critical and analytical eye and use this experience in a way, which enabled me to analyse, interpret and understand participants' words. Then report the findings without bias. This was achieved by double-checking my interpretation with a co-researcher's interpretation. Furthermore, the findings were discussed with my supervisor in order to ensure that they reflected the participants' view point. In the following section, I am going to highlight how my own philosophies and beliefs impacted on the data analysis and interpretation process.

3.10.1 Reflexivity and acknowledgment of the impact I as the researcher was able to exert on the data and its interpretation

As indicated earlier, when engaging in qualitative work it is important to acknowledge the impact the researcher him/herself can exert on the research process and more importantly on how the data is interpreted. Thus, it is important to point out that as part of this study I was not only an integral part of the research process in my own right but I had also engaged in preceptorship from three distinct standpoints. For example, I had undertaken the preceptorship programme as a preceptee in my role as a newly qualified nurse, as a preceptor when in the role of an experienced staff nurse and finally as a clinical resource nurse (CRN). Moreover, it is important that I declare an interest in the outset of this study as I undertook each of the aforementioned roles in the chosen study setting. This means that my own experiences had the potential to bias the outcomes of the study.

Nevertheless, my experience has in fact been extremely diverse in that it encompassed not only the preceptee role but also that of an educator, clinical practitioner and manager. In these three roles, I not only experienced preceptorship myself but accordingly such experiences also helped to shape my personal philosophy of preceptorship. The following paragraphs are therefore offered as a reflection on my own philosophies regarding preceptorship, first as a preceptee, then as a preceptor and finally as a CRN. Moreover, these reflections outline what I felt were appropriate and inappropriate actions to undertake during the preceptorship process; factors that undoubtedly had the potential to impact on my views of what I uncovered during the study. More importantly, such views had the potential to impact on how I managed, and reported on the data. Hence, it was important not only for me to be open about the influence I was able to exert on the study, but to ensure that other processes were built into the data analysis phase, that would enable me to be as “objective” as possible when undertaking my analysis of the data and interpreting my findings.

From a personal perspective, I conceptualised that preceptorship was not simply an instructional programme but rather a “sheltering” programme during which time a preceptee should feel welcomed, supported and well directed in order to fulfil her/his new role effectively, by integrating into the team and his/her new role in the shortest period of time. Thus, I felt that successful preceptorship was not solely limited to the preceptor’s role, as reflected in the organisational philosophies, but that it was the responsibility of each party involved in the programme/process to engender a positive outcome for the preceptee and ultimately the organisation.

From a preceptee perspective, I had felt that at the outset such individuals were anxious and worried, knew little or nothing about their new role, the environment and type of people they were going to be dealing with, especially for international nurses who were not always aware of the differences in culture. The latter groups of preceptees were therefore at greater risk of experiencing a culture shock than Saudi nationals or those who had come from other Saudi hospitals, as the latter were already familiar with the Saudi culture. Furthermore, at this stage, preceptees may fear failure in their new role (Myrick & Yonge 2005). Therefore, having appropriate support, training and a sense of belonging could help them to overcome such issues

and complete their training period effectively and efficiently. In order to achieve this, I believed that it was important to have a well-prepared professional team, which included a preceptor, nurse manager and educator to support the newly hired nurse make the necessary transition into the role.

As a preceptee myself, I felt one of the strengths of the preceptorship programme was to involve both the preceptor and the manager in the process. The reason for this was that when I had undertaken my preceptorship programme the persons in the latter roles had been supportive of me when I started at the hospital and made me feel like one of the ward nurses rather than a preceptee. This feeling enhanced my confidence and encouraged me to ask questions freely in order to clarify any ambiguities. Hence, I felt that building a good relationship between the preceptee and preceptor, and a trusting relationship with the ward manager helped to produce a more competent member of the ward team thereafter.

Despite the support that I received from my nurse manager and preceptor, I still felt that workload and staffing issues were problem areas affecting my preceptorship period. This was mainly because the preceptor was busy with responsibilities as a team leader. In this case, the preceptor assisted all ward nurses on duty and managed the ward in the absence of the manager, ensuring that patients received appropriate nursing care; and the unit was managed effectively and ward nurses worked safely.

Conversely, some ward nurses were uncooperative, reluctant to help, or direct me as a preceptee as they feared losing their position in the hierarchy or being replaced by me. Furthermore, my own philosophy regarding preceptorship was that if I as the preceptee had the correct support and training based on my needs, this would help me to become a better staff nurse able to integrate into the team quickly and deliver high quality nursing care. In addition, this action would increase the number of nurses available to administer patient care and decrease the problems encountered by nursing shortages thus patients and unit workloads would be reduced. The net result being, that there would be more time available both to administer patient care and train preceptees.

As I became a more experienced staff nurse, I subsequently became a preceptor myself. At this stage, my philosophy of engaging with preceptees was oriented towards building a trusting preceptor-preceptee relationship and eliciting from the preceptee his/her individual learning needs. However, I tried to underpin this process with my own evaluation of the preceptee through observation, discussion and engagement across a variety of learning opportunities to enable me to compare what the preceptees said they needed with what I as an experienced nurse expected him/her to achieve as a new staff nurse. In this way, it was then possible to identify any gaps in the preceptees knowledge and skills in order to offer appropriate additional support, an activity, which has since been supported within the education literature (Myrick & Yonge 2005). When building an effective relationship with preceptees, my approach was to become their guardian: a professional nurse capable of translating professionalism and professional practice into every day actions in the clinical environment; including dealing with colleagues and patients.

However, in the preceptor role, I felt that specific training and preparation for the role was extremely important, as I needed to know how to:

1. Apply adult teaching-learning principles to the teaching context,
2. Use the preceptorship programme objectives to guide the learning process,
3. Encourage the preceptee to engage actively in the clinical work and think critically, encourage open and positive communication with the preceptee,
4. Be fair and equitable when evaluating the preceptee based on the programme and learning objectives, and finally,
5. Demonstrate support and provide constructive feedback.

In addition to the latter issue, the need to support me as a preceptor in order to undertake my educational role effectively was also felt to be important. Although there was, and still is, a preceptorship workshop in the hospital, I felt it was not enough to prepare me to take on the preceptor role effectively. Instead, I felt I needed a greater level of support from my nurse manager and other colleagues to feel valued and appreciated by the ward and hospital administration in the preceptor role and thus enable me to enhance my overall commitment to the role.

Consequently, in my role as a CRN, which was an educative/managerial position, I felt responsible for facilitating the formulation of effective interactions between the preceptee and preceptor. In this way, I could create valuable learning opportunities for the preceptees and encourage both preceptors and nurse managers to generate the necessary learning opportunities to ensure the preceptee was able to become an integral member of the ward team. Hence, in this respect, I tried to provide the preceptor with the necessary support to fulfil the role effectively.

Subsequently, I would intervene if I felt a manager did not seem to appreciate the value of the preceptorship process. In order to achieve the aforementioned personal goals and operational principles, it was crucial that I looked at the resources available in the clinical area to see how they could be used to best effect. For example, by looking at the cases available on the ward it was possible to establish whether there were patients with a particular condition, which the preceptee could work with and then discuss as part of a case review with the preceptor in order to enhance his/her critical thinking skills and subsequent ability to handle critical cases alone.

In addition to the above, I also felt it necessary to discuss the preceptee's and preceptor's needs with all parties including the nurse manager and endeavoured to meet these needs during the preceptorship programme. Providing preceptors and preceptees with the necessary learning resources was also important; as was encouraging preceptees and preceptors to successfully fulfil their respective roles and feel valued. In essence, for me it was important that preceptees felt part of the team and that the preceptors felt valued particularly as the role was contributing to the assuagement of staffing and workload problems. Additionally, by resolving potential conflicts between the preceptor and preceptee through active listening to discover the root cause of the problem was considered by me to be a vital part of my CRN role. Furthermore, negotiating with nurse managers regarding the preceptor's patient assignment to reduce his/her workload to make it manageable by encouraging other staff nurses to support the preceptor either by contributing in the preceptee training or by engaging in patient care was also an important element of my CRN role.

However, the notion of pragmatism espoused by some nurse managers made the preceptorship process more difficult than necessary, given they were more concerned

with having a nurse who could “do” the work in the shortest time rather than having an efficient, well qualified nurse who could be trained within a reasonable time frame to deliver high quality nursing care. Furthermore, I also felt the contribution that the preceptorship process could make to the fulfilment of the latter goal needed to be more overtly recognised by hospital administrators in order to enhance the preceptor’s and indeed all programme stakeholders willingness to commit to their respective roles.

Given the above, it is clear that having experienced preceptorship on three distinct levels, that of preceptee, preceptor and CRN collectively shaped my ideas about what preceptorship should encompass to the point that these perceptions and personal philosophies are an integral part of me. As a result of these and other reflections I began to realise that there were gaps and concerns that needed to be resolved as they impacted on the preceptorship process within the study setting. Nevertheless, my strong views needed to be put on hold where possible when interpreting the data in order to allow me to look at what others had to say about preceptorship with new eyes and not to make a judgement about their ideas or feelings and thus foreclose on the data early. More importantly, I needed to make a conscious effort to not let my feelings prohibit me from examining the data in the required detail as outlined in section 3.9 above.

3.11 Ethical issues

Ethical issues that govern any qualitative research cannot be neglected as they are considered part of, or criteria for, assessing the study’s trustworthiness and integrity (Bryman 2008). Therefore, in this section I am going to discuss various ethical issues that impacted on this thesis in order to ensure that the study was undertaken in an ethical manner. The first issue to be addressed is ethical approval.

3.11.1 Ethical approval

Official approval from the Hospital Research & Ethical Review Committee was obtained prior to conducting the study. Permission to conduct the study and access study participants was also granted from the Director of Nursing Services and Director of Nursing Education Department. Additionally, approval for the study to

take place was also obtained from the University of Manchester Nursing, Midwifery and Social Work Ethics Committee (See appendix C, page 363 & 364).

3.11.2 Informed consent

Every effort was made to ensure that all included participants had complete understanding of the study and were safeguarded from any eventual harm they could be exposed to during their period of participation. To this end, participant information sheets were distributed and discussed to ensure that each point was clearly understood. Signed informed, valid consent together with follow-up verbal agreements to participate in the study were obtained from all participants. All participants were informed that their participation was strictly voluntary and that they could withdraw from the study at any time without prejudice to their career or employment prospects. Participants' approval for tape recording the interview was also obtained at the outset of the interviews.

Furthermore, I tried to provide the participants with enough time to think about taking part and not to feel pressurised to participate. I also was concerned about confirming their voluntary agreement to participate in the study at the beginning of each interview

3.11.3 Confidentiality and anonymity

Confidentiality and anonymity of the data and participants' identity may cause problems in qualitative research if they are not maintained; which had the potential to impact on the research and cause harm the participants (Bryman 2008). Therefore, it is recommended that researchers should ensure the privacy, dignity and sensitivity of each participant is assured and protected during the research process and focus group interview (Bryman 2008, Lincoln & Guba 1985). In this study, confidentiality of the research data was ensured by omitting to provide information regarding the identity of the hospital involved, while arbitrary initials have been with participants' permission to identify different participants within the reporting of study findings sections in chapters 5 and 6.

To maintain confidentiality of data whilst also respecting the feelings of self-worth of each participant, all participants in the focus group interviews were asked and agreed not to disclose what was discussed in the interviews with anybody outside the groups

after the interviews ended. Furthermore, at the beginning of each focus group interview I made sure to remind them of this and ensure that each participant agreed, particularly when the group members knew each other. Similarly, the external transcriber was selected from outside the study setting and was asked to sign a consent form to maintain confidentiality.

Additionally, the Head Nurses' requests to be interviewed individually were considered in order to encourage them to participate as well as protect them from any risks that could affect their job. This helped them feel more secure and confident to talk about their experiences more freely during the interview.

The participants were also assured of anonymity, which meant that no names were mentioned in the transcripts or any subsequent publications. Furthermore, they were assured that only the researcher, co-researcher and, research supervisors would access the raw data, and that all tapes would be stored in a locked cupboard separate from any identifying information and destroyed following publication of the data in accordance with University policy.

3.11.4 Protecting participants from harm

Focus group and individual interviews may lead to unexpected consequences, such as conflict, particularly when the participants share or raise experiences of distress or sadness. These issues might impact on the participants' emotional status and their ability to resume the interviews normally (Goodman & Evans 2010). In such cases, I had to ensure that the participants felt secure and safe by asking them if they felt comfortable continuing the interview. I also changed the topic of discussion until the participants were relaxed and then revisited the initial issue if I felt it necessary to be discussed further. Alternatively, the interview could be terminated if I felt that the participants might feel exposed in some way to risk or that the discussion may harm them.

3.11.5 The power of the researcher

During the period of fieldwork, almost all nurses were aware of my nursing background as a senior Saudi staff nurse and my identity as an independent researcher. Therefore, I had to consider my role as part of the interview process and

ensure it was understood by the participants. Moreover, I had to consider the extent to which those participants were prepared to talk about their own views (Goodman & Evans 2010).

In the beginning I thought that my being one of the nursing staff in the hospital may impact negatively on the participants' willingness to participate or to sign their consent or could possibly have an effect on their ability to discuss openly their experiences and perspectives. In fact, I found the opposite to be true; my being known to the nurses appeared to encourage them to participate and discuss their experiences with other colleagues openly. Not only did they express their ideas freely but they also made clear their intention to call me if they felt that there were any further important issues which needed to be considered related to the examined phenomenon and not previously discussed during the interview stage.

3.11.6 The impact and challenges of my role as both practitioner and researcher and the role of the co-researcher

Although the idea of this research enquiry emerged from my own practical experiences of preceptorship as stated earlier in section 1.2 page 19, combining both the practitioner and researcher role in order to study this topic presented me with a challenge. For example, as part of my researcher role I needed to focus predominantly on research matters yet there were also professional considerations that needed to be taken into account as well as my relationship with the nurses who were already my work colleagues and who would later become my research participants. Despite the above however, my role as a practitioner actually provided me with considerable insider knowledge which helped me to better understand the background to my research topic. In addition, enrolling on my PhD programme helped to prepare me to work as a researcher as it increased my knowledge and understanding of what it meant to undertake research.

However, the greatest challenge for me as a researcher was to be able to reflect on my practical experiences and then ignore or put them aside. Another challenge was to deal neutrally with participants (colleagues) without expressing my personal views in order to avoid data contamination, bias and thus ensure that the data generated was sourced solely from the participants. Nevertheless, at the same time, reflection on my experiences provided me with the opportunity to generate and share new

insight into the preceptorship experience and thereby gain greater understanding of the phenomenon by asking participants to explain, amplify and justify their ideas and perceptions in more depth.

The trusting relationship between myself and participants, which was established during my preceding years of practice experience and enhanced during my field work, facilitated the data collection and analysis process. In particular this relationship between myself and the participants allowed them to feel that their contribution was valued which enhanced the quality of my research, specifically in relation to the rigour of the data generated (Campbell & Groundwater-Smith 2007).

In addition, in order to increase the objectivity of my data a co-researcher who already had a PhD and who works as a Vice Dean for one of the nursing schools in Saudi Arabia was invited to help confirm my findings. The reason this person was targeted for the co-researcher role emanated from her previous training and experience in conducting focus group interviews and analysing qualitative data. Hence her background and experience in engaging in such research procedures was a considerable advantage as her feedback regarding the data analysis was particularly beneficial as she was able to review my themes and preliminary conclusions with a “fresh eye” and present an unbiased view of the data.

Additionally, the co-researcher was selected from outside the study setting, as she then had no preconceived ideas about the preceptorship programme forming the basis of this research, a factor that further reinforced the independence of her review of not only her own but also my analysis of the interview data. This level of detachment from the research setting therefore enabled her to make a more objective comparison of her own and my analysis of the data so as to challenge my conclusions. This latter process helped me to have a more balanced and reflective stance towards the contents of the interview to encourage me to take a step back and look at my own data with a more objective eye.

Having a co-researcher as a second person looking at the data with fresh eyes also helped to minimise any misinterpretations that might have arisen from my own biases and my personal research philosophies. This co-researcher role therefore had a

positive impact on the rigour of my study by enhancing the reliability and trustworthiness of my findings by helping to ensure that my findings reflected the participants' perspectives and not what I believed or expected about the preceptorship programme.

3.12 Summary

The aim of this study was to explore from the perspectives of newly hired experienced nurses and other preceptorship programme stakeholders the meaning of preceptorship and its impact on the newly hired nurses' clinical care in one Saudi hospital. Based on the study's aims a generic qualitative approach drawn from the naturalistic inquiry paradigm was selected as an appropriate methodology to be adopted in this study. In this chapter, I have discussed the characteristics and principles that underpin this research methodology. In addition, the sampling methods, data collection and data analysis tools together with a justification for their usage have also been explored.

Two sampling strategies were applied to recruit study participants: purposive and convenience sampling. Participants included preceptees, preceptors, nurse managers; clinical resource nurses and nurse educators who were selected because they had experiences of preceptorship and would be able to reflect on their experiences by describing their perceptions of the preceptorship concept and its impact on clinical nursing care. The findings of the participants recruitment highlight the specific characteristics of the four groups of participants drawn from a variety of clinical wards across one Saudi hospital. More importantly, participants including preceptees and other programme key stakeholders were largely multi-national expatriate nurses who came to Saudi Arabia with a diversity of clinical qualifications, backgrounds and practical experiences. The latter were also supported by four Saudi nurses who were employed either as a ward manager or CRN.

Semi-structured individual and focus groups interviews as well as a review of the preceptorship documents were adopted to collect the study data and obtain greater insight into the concept of preceptorship from the perspectives of those nurses who had been involved in the preceptorship experience as well as from an organisational perspective. Thematic analyses based on constant comparative analytical principles

were also used in this study to analyse data collected from both types of interview to uncover major themes and sub-themes. Major themes and sub-themes were latter explored and validated using a collaborative process, which included a co-researcher, my study supervisor and I. Finally, reflexivity and ethical issues were discussed. Trustworthiness of the study will be discussed in more detail in the discussion chapter. In the next chapters, findings from the study will be presented and discussed in detail. Hence, these chapters will examine participants' perceptions of preceptorship in order to generate a collective account of what preceptorship was, what it involved, how successful it was considered to be and the impact it was able to exert on clinical nursing care. The findings have been divided into two chapters.

The following two chapters present the findings generated by the interview data. From the analysis of the qualitative individual and focus group interviews, six themes emerged. These themes included: the meaning of preceptorship; time as a confusing and restrictive concept; the impact of preceptorship on clinical nursing care; recruitment and its role in the success/failure of the preceptorship, preceptor preparation and selection; and finally support for preceptorship. Each of these themes reflects the participants' experience of the preceptorship programme from a managerial, clinical, educational and personal perspective. In the following chapter, the participants' perspectives of the preceptorship process itself will be explored.

Chapter IV
The Preceptorship Process

4.1 Introduction

Preceptorship has been seen as an essential part of the professional enhancement of newly hired nurses (Kuroda *et al* 2009, DeCicco 2008). Effective implementation of a preceptorship programme within a clinical setting has the ability to affect the quality of care provided by the new nurses who have been through a preceptorship programme (Rose and Clifford 2002, O'Malley *et al* 2000). During the individual and focus group discussions, diverse experiences and expectations regarding preceptorship and its impact on clinical nursing care were identified. In this chapter, three of the six themes that emerged as a result of the analysis of participants' individual and focus group interview data are explored. The themes are the meaning of preceptorship, time as a confusing and restrictive concept, and impact of preceptorship on clinical nursing care. The reason these themes have been highlighted as the focus for this chapter is that each underpins the other and inter-relates in that they focus on the preceptorship process itself as will be revealed as the subsequent text unfolds.

The first theme explores the nature of preceptorship in relation to what preceptorship meant for participants; what was expected, perceived and documented in respect of the preceptorship programme as well as the roles and responsibilities of all parties involved in the programme. This theme is further divided into two sub-themes:

1. lack of clear understanding and
2. role clarification and expectations.

The second theme explores the participants' perception of time namely the duration of the preceptorship programme and more specifically, when it began and ended. Hence, for several participants' the concept of time was seen to be both a confusing and restrictive concept. This second theme consists of four sub-themes:

1. the preceptorship period as perceived by the participants
2. time versus preceptor-preceptee relationship
3. time for the preceptee to meet the CRN and
4. time versus preceptorship requirements and information needs.

The third theme: the impact of preceptorship on clinical nursing care is also divided into two sub-themes:

1. preceptees' clinical nursing care and
2. preceptors' performance.

The themes listed above have been grouped within the current chapter examining the process of preceptorship because it was a feature highlighted in the literature that an understanding of the meaning of preceptorship by all parties involved in the programme should be elucidated from the outset. For this reason, it was considered vital to address this issue first. Moreover, providing sufficient time for the preceptor-preceptee relationship to develop was considered an important component for nurturing the preceptorship process as this was felt to have the potential to impact on the clinical nursing care preceptees and/or preceptors might be able to deliver for patients. Furthermore, in the first theme the diversity of understanding with regards to what preceptorship represented added to the confusion participants felt about the preceptorship period. This is highlighted in the second theme. Additionally, this confusion then affected the preceptees' clinical performance both during and after the preceptorship programme as highlighted in the third theme.

Selected quotations from the interviews are presented in the text in order to illustrate and reinforce the points being highlighted in the themes. Quotes from individual interviews are identified by the abbreviation (II); focus group (FG); nurse managers are abbreviated to (NM); preceptees (PE); preceptors (PR); CRNs⁹ (CR); and nurse educators (NE). Each participant has then been identified using her/his chosen initials in order to maintain confidentiality. Policy documents specifically related to the implementation of preceptorship within the institution have also been compared with comments made by participants during the individual and focus groups interviews. These policy documents have been used to substantiate and underpin the participants' confusion or understanding regarding the concept of time coupled with what the preceptorship programme was meant to encompass and how long it was expected to last. Quotes from the preceptorship documents are identified as (PRM) for the Pre-Reading Material related to the preceptorship workshop; (IPP1) for the

⁹ CRN: Clinical Resource Nurse

preceptorship document Internal Policy and Procedure; and (IPP2) for the orientation and probationary requirement document Internal Policy and Procedure.

The theme 'the meaning of preceptorship' is the first to be discussed in this chapter as this was considered a key theme for participants and accordingly shaped their understanding of what constituted the preceptorship period, how it should be structured and the impact the preceptorship programme had on those parties involved in its delivery.

4.2 Theme one: the meaning of preceptorship

4.2.1 Introduction

It was deduced from the documentary analysis that preceptorship was developed in the study setting for all newly hired nurses, to assist their integration into their assigned clinical unit, work safely, and deliver high quality nursing care within the confines of the respective ward/hospital policy and procedural documents (IPP1 2009; PRM 2009).

Successful implementation of the preceptorship programme would seem to require, as a minimum, a collective understanding of the concept between all those involved in the process – in this case, preceptees, preceptors, nurse educators, clinical resource nurses, and nurse managers. Hence, each party needed to understand the meaning of preceptorship; their respective role in its delivery, and what to expect from a preceptee during and after the preceptorship programme (Myrick & Yonge 2005, Billay & Yonge 2004).

The term preceptorship, when used in this study context, has been generated as a result of my own understanding of the words participants themselves used during the focus group and individual interviews. Thus, interpretation of the participants' understanding of preceptorship has been generated from their own worldview after having interacted with others and experienced the preceptorship process from their own unique standpoint. According to Holroyd (2007), an individual's understanding of a phenomenon is not formed by learning rules, but through unique experiences, derived from being part of a phenomenon. Hence, individuals are motivated to create meanings and interpretations about experiences that shape their life - in this case the preceptorship process.

From the interview and focus group data, it was clear that the meaning of preceptorship and participants' role expectations and the need for role clarification were issues of considerable importance for the study participants as indicated in sections 4.2.2 and 4.2.3.

4.2.2 Lack of clear understanding

To provide a baseline understanding of what the organisation itself understood and meant by the term preceptorship, a definition of preceptorship was sought from the relevant policy documentation. The policy document (IPP1) and pre-reading material (PRM) stated that preceptorship constituted '*an organized instructional programme in which an experienced staff nurse facilitates the integration of a new staff member into their role, and responsibilities in the work setting*' (IPP1 2009, p.1, PRM, p.3). In order to disseminate this definition to all those involved in the preceptorship programme a copy of the preceptorship policy was handed out to each preceptee as part of their nursing orientation package. In addition, the policy was similarly discussed with the preceptors, clinical resource nurses and nurse managers when they attended the preparatory preceptorship workshop. To facilitate effective implementation of the preceptorship programme, the policy was also uploaded onto the organisation's website for ease of access by all nursing staff when required.

Although all participants agreed preceptorship was established to facilitate the preceptees' adjustment and integration into their new role, their respective understanding about the meaning of preceptorship was inconsistent. Hence, different perceptions of preceptorship emerged between participants with the terms preceptorship, mentorship and orientation. In addition, participants also defined preceptorship as embodying career development and acting as a guide for preceptees, helping them negotiate organisational networks. This was in contrast to the hospital documentation, which described the role of preceptors as directing preceptees within the context of a clinical/educational process rather than simply acting as a guide.

In this study, the meaning of preceptorship as perceived by some participants was that mentorship and preceptorship equated to the same thing given they openly referred to preceptorship as mentorship. Hence, as indicated above, preceptorship was perceived as a guiding process, not an instructional one as outlined in the

preceptorship documentation. In other words, preceptorship was perceived as a time when preceptees were guided by their preceptor to help them settle down and integrate into their new role. For some participants therefore preceptorship did not equate to the preceptor actively teaching preceptees but guiding them in their new role, as illustrated by the following comment:

For me preceptorship is a period where a person is helped to acclimatize to the new environment, new rules and regulations. Basically to guide the new person through the whole procedure but not to teach the person basic things' (FG.CR.GW).

The above comment was supported further by another CRN who expanded on the idea that preceptors should not need to teach preceptees since the latter came to the hospital with his/her own unique set of knowledge and skills.

I believe preceptorship is a programme or process to assess the newcomer's learning needs and to support [these] needs. [So] they can adjust in the new institution ... What I found here is that preceptorship is different. Most of the time whenever you have a newcomer you are teaching. You are not supporting or evaluating learning needs... when you have newcomers you expect that they know most of the basic things so you do not teach. It is a process for assessing learning needs, to support learning needs, to guide new staff with the new policies, routines, the culture, and hospital standards' (FG.CR.AB).

Equally, one of the nurse managers reinforced this interchangability between preceptorship and mentorship in that teaching and guiding were seen to be inextricably linked.

Preceptorship for me is having an experienced mentor that will guide you through the process because you are new; they will show you what they can in the time period they have been assigned. It's a matter of guidance and teaching' (II.NM.LI).

In contrast to the above, the second definition of preceptorship offered by participants clearly identified that it was an instructional programme where preceptors actively tried to integrate preceptees into their new environment via a pre-determined one-to-one relationship. The latter perception corresponded with the hospital policy where preceptorship, as illustrated above, is defined as an instructional programme during which new staff should be supported to adjust to their new practice environment via a one-to-one relationship with a preceptor.

This second interpretation of preceptorship as an instructional programme designed to enhance preceptee adjustment into their new role was seen to pass through several stages. These stages began with assessment of the preceptees' needs; followed by the planning of appropriate teaching processes; and then providing preceptee training to integrate previous and newly acquired knowledge and skills into

their clinical role in order to reduce any deficits they may have as the following quote illustrates:

'Preceptorship for me is a system that has been put in place to enhance the adjustment of a new member into their new role or into their new situation. Basically what gets done in preceptorship is trying as much as possible to know how much the person knows, work on what the person doesn't know, and help them to relate or to incorporate what they learn in the situation here with what they already know' (FG.CR.NG).

The final stage of preceptorship was seen to incorporate an evaluation phase to verify the preceptee's clinical performance and establish whether s/he was ready to take on her/his assigned new role as illustrated below.

'Preceptorship means a period of time to assess [the preceptee], update her on the policies of the hospital, and to find if there is any new thing that she needs to work on, to teach her about it, [and] then to evaluate¹⁰ her at the end, to see if she is suitable for the position or not' (FG.CR.SM).

Similarly, these stages were stated in the pre-reading material for the preceptorship workshop, with the educator role of the preceptor being seen to have particular import as illustrated below:

'[The] preceptor [should be] a role model, socialiser by helping preceptees feel welcome and facilitating their integration with their peer group, co-workers and employers. [In addition the preceptor should be] an educator by assessing their learning needs, planning their learning experiences, implementing their learning plan, and evaluating¹¹ their job performance' (PRM, p.5).

The above notion of preceptorship mirrors that of Block *et al* (2005) who indicated that preceptorship was a way for new nurses to adjust their previously acquired knowledge and experience to fit with the new work setting, role, language and/or patient population. In addition, to the above the preceptor should be a knowledgeable role-model for the preceptee whereby s/he is able to orientate the preceptee to the unit as a form of welcome, correct and direct the preceptee's practice, offer teaching and knowledge exchange and answer the preceptee's questions as reinforced below by a nurse educator:

'It means that somebody is there to show [the preceptee] around the work environment, to lead [the preceptee] in the right direction of what is supposed to be done, what are [the preceptee's] expectations and of course [the preceptee] can always ask questions and find out if [s/he] wants to know anything. And someone as a role model who is there who has the knowledge and background' (II.NE.SE).

¹⁰ Underline added in order to demonstrate the link between the participants' understanding of preceptorship and preceptor role stated in the pre reading material

¹¹ As footnote 10

This was also reflected by one of the preceptors:

'[Preceptorship is where] the preceptor familiarizes [the preceptee] with the hospital system, the place, the traditions, documents, procedures that we follow, the education and administration systems. To make him more welcome in our area' (FG.PR.TS).

One of the nurse managers reinforced this further:

'Preceptorship is where you help or support a newly hired nurse from the point of hire and provide them with personalized, individualized training, advice and ...meet with them periodically [so] they can function independently and confidently' (II.NM.BE).

This incongruence regarding the meaning of preceptorship was also manifest within one specific ward. Here perceptions of what preceptorship constituted as articulated by the nurse manager, clinical resource nurse and preceptor all differed. Hence, consensus about the meaning of preceptorship was not successfully achieved in this case. For example, the nurse manager viewed preceptorship similar to mentorship, by referring to the preceptor as a mentor, given the role was to guide and teach the preceptee.

'Having an experienced mentor that will guide you through the process; they show you what they can show you in the time period they have been assigned. It's a matter of guiding and teaching' (II.NM.LI).

Nevertheless, the clinical resource nurse felt preceptorship was not an instructional programme but a process for assessing the preceptee's learning needs, during which the preceptor supported and guided the preceptee to achieve such needs. Moreover, preceptorship was not seen as a process of giving any formal teaching because it was expected that the preceptee was an experienced nurse at least in terms of basic nursing care. Interestingly, one of the preceptors felt preceptorship was simply an orientation process, which involved:

'Assisting new staff to [adjust] to the ward. So, they will be oriented to the hospital IPPs and APPs [Administrative Policy and Procedures]' (FG.PR.IA).

In contrast, the preceptees' own understanding illustrated that preceptorship should consist of a one-to-one relationship during which the preceptor (senior nurse) guided and taught the preceptee (new nurse) in order to deliver "good care" to the patient as outlined below:

'Preceptorship is like guiding someone new. For example, there is a new staff member and I'm senior. I have to guide this new member and I teach them the correct way, the better way to provide good nursing care for the patient' (II.PE.AE).

The above preceptee's perception was expressed during the pre-preceptorship individual interview and reflected his understanding of preceptorship and expectations of the preceptor in his assigned ward. It is therefore likely that this preceptee would not receive the expected guidance, training or teaching in this context. Hence, the goal of preceptorship would not be achieved in this case, due to the preceptee-preceptor's divergent understanding and expectation of the role. In this ward, the nurse manager expected the preceptor to act as a mentor, whereas the CRN expected him/her to assess the preceptee's needs and support him to fulfil these needs. The CRN did not expect preceptors to teach, but guide preceptees. This lack of convergence regarding the meaning of preceptorship among participants affected their understanding of the role and the responsibilities each member should be expected to undertake. Furthermore, it also influenced what the CRNs and nurse managers expected from preceptees and equally what preceptees expected from each key stakeholder in turn, a factor which forms the focus of the subsequent section.

4.2.3 Role clarification and Expectations

Role clarification is an important aspect to help carry preceptorship forward and enhance job satisfaction (Shermont & Krepcio 2006). As outlined above, lack of clarity regarding the meaning of preceptorship extant amongst study participants, was considered to be one of the factors leading to the inconsistent application of the preceptorship in the study setting.

4.2.3.1 Role of Clinical Resource Nurse (CRN)

According to the CRNs, their role in preceptorship was not clearly identified causing them to work to their own set of rules as indicated below:

We do not have clearly identified roles and responsibilities. [This] raised a lot of differences among us. Now everybody is doing their work [based on their own] understanding. That is why our role and responsibility is different' (FG.CR.RD).

The perceptions regarding the role of the CRN of some of the clinical resource nurses themselves, the preceptors, preceptees and nurse managers were clearly similar to those stated in the policy documents. However, some still appeared confused. For example, some clinical resource nurses felt that their role was to orient preceptees to the ward layout and ward's staff as illustrated in the following quote.

My responsibility as a CRN is to meet the preceptees on the first day of their arrival to the ward to orient them to the ward and introduce them to the ward's staff, but I did not think that I had to teach them because they are already expert nurses who just need a general orientation to the place to settle down' (FG.CR.GW).

Conversely, some nurse managers felt that the role of the clinical resource nurses was to act as a resource person for all nurses in the unit, new or senior. However, they did not believe that the clinical resource nurses duty was to contribute in the selection of suitable preceptors and discuss the preceptees' performance with the nurse managers.

'The CRN should provide us with the necessary learning material and work as a resource person not only for the new nurses but also for the senior nurses in the ward. It is not the CRN responsibility to select the suitable preceptor for each coming preceptee or to discuss preceptees performance with me' (II.NM.AN).

Nevertheless, some preceptors and preceptees felt that the CRN had many responsibilities, not only in relation to teaching but also management, as they were felt to be responsible for providing feedback and evaluating clinical performance as demonstrated by the following preceptee comment.

'The CRN is a resource person here in the hospital. They should provide me with all the teaching and learning that I need. Furthermore, they should be around for guiding me in the correct procedures and giving me feedback on my performance as they are responsible for evaluating me' (II.PE.AE).

Although the role of the CRN was not stated in the preceptorship policy document (IPP1), the pre-reading material for the preceptorship workshop (PRM) illustrated that the role of the CRN was to assist the ward nurse manager in selecting the preceptor. Moreover, the CRN was expected to help preceptees and preceptors set and meet their goals/objectives during the preceptorship process by working as a role model and resource person; providing both of them with the necessary guidance, support, supervision and feedback as demonstrated in the following quote:

'The CRN should provide the preceptee with an orientation plan, assist the nurse manager in selecting a preceptor, assists the preceptor and preceptee with setting and meeting goals and objectives during the preceptorship period. The CRN role models professional practice for the preceptor, provides preceptor training, guidance, support and feedback to the preceptor, assists the preceptor and preceptee in problem identification and supplements additional instruction or supervision when indicated' (PRM 2009, p.26).

Likewise, the CRN role was also outlined in the orientation and probationary requirement policy (IPP2) document. However, the role in this case was not limited to the preceptorship period but included the 90 days of supervision, which

constituted the probationary period. As indicated below the stated role of the CRN outline above was similar in its meaning to that stated in the PRM as shown below:

'The clinical resource nurse will, make initial contact with new members of staff during the first three days of clinical practice, assist in the completion of the orientation process and in particular will assist with the completion of unit specific clinical competencies, be responsible for completing the clinical component of the physical assessment competency, provide appropriate learning resources to support the new member of staff in meeting the probationary requirements, ensure a minimum of five hours of contact with each newly hired nurse during the probationary period, contribute to the evaluation process and submit a record of clinical support to the nurse manager prior to completion of the final probationary report' (IPP2 2009, p.5-6).

4.2.3.2 Role of Nurse Managers

In contrast to the ambiguity regarding the CRN role in preceptorship outlined above, there was consensus among the study participants (preceptors, CRNs, nurse managers) in respect of the nurse manager role during preceptorship. This role was stated by one of the nurse managers to be as follows:

'The NM is the one who chooses the preceptor. It is her responsibility to check and make sure that what is supposed to be done is done ... set a timeline for the competencies to be achieved... [Informs all parties of] the preceptee, the evaluation date, support the preceptee and facilitate her/his competency achievement and finally document her progress' (II.NM.SA).

Participants' understanding of the nurse manager role was similar to that identified in the preceptorship documentation and concurred with Ridge's (2005) definition namely that of being responsible for selecting an appropriate preceptor, planning regular meetings with the preceptee, evaluating preceptee performance; and providing appropriate support for preceptees. Thus, the nurse manager's role was set out in PRM, IPP2 and confirmed in the IPP1 as follows:

'[The nurse manager role is to] select a preceptor for each preceptee, schedule [the] preceptor's time and assignment to ensure availability for the preceptee' (PRM 2009, p.27).

'The nurse manager will identify an appropriate preceptor, meet with the new member of staff [preceptee] at least once every two weeks to discuss on-going progress and complete a formal evaluation of the new staff member's [preceptee's] performance and must be satisfied that all orientation requirements have been met' (IPP2 2009, p.5).

In addition to the above, the IPP1 document outlined the nurse manager role as:

'outlin[ing] the level of support to be provided and in particular identify[ing] the clinical competences to be completed. The NM must meet with both [the preceptor and preceptee] at least two-weekly to discuss the progress of the [preceptee] and

...evaluate [preceptee's] performance ...to complete final evaluation of the [preceptee]' (IPP1 2009, p.2).

4.2.3.3 Role of Nurse Educators

However, all participants believed the nurse educator's role was limited to facilitating preceptorship workshops for preceptors and running the orientation programme for preceptees:

'[my role is] facilitating the preceptorship workshop, where we guide staff through the process of being a preceptor and getting them to understand what it is like for the preceptee; the feelings that some preceptees might have, to teach them about evaluating staff so they can evaluate staff in a positive manner' (FG.NE.SG).

Whereas, the organisation viewed the role of the nurse educator as extending beyond the classroom setting to cover clinical units in order to support the preceptor during her/his first experience of the preceptor role as highlighted in the following extract taken from the policy document.

'Each staff nurse will be offered support by a nurse educator during their first experience within the preceptor role' (IPP1 2009, p.2).

This discrepancy suggests the educator's role may not have been carried out as expected as nurse educators were not present in the clinical area during the preceptorship period. This fact was reinforced by the following nurse manager's comment, which concurred with all other comments, including one from a nurse educator and a preceptor:

'Once the [preceptees] finish [their] orientation week and they come to the [unit], we don't see the educators' (II.NM.SA).

'After the preceptor workshop we did not follow up. No, I did not follow up' (II.NE.SE).

'This is my first time being a preceptor and I did not receive support from the nurse educators' (FG.PR.DT).

4.2.3.4 Role of Preceptors

As in other studies related to preceptorship (Kramer 1974; Kuroda *et al* 2009), the preceptor was universally perceived by participants in the current study to have the most active and important role in the preceptorship process. Hence, most preceptors agreed it was their responsibility to analyse and assess each preceptee's needs and encourage preceptees to work on these in order to discover any weaknesses and improve on them. Conversely, some preceptors considered their role to be limited to guidance and general orientation to the unit or acting as a mentor, while needs

assessment constituted the preceptee's responsibility as illustrated in the following quotes:

'.. I will analyse her [preceptee] needs first and go on to improve her weaknesses and emphasize how it [the work] is done in the hospital, and then encourage her to ask more questions and solve what other problems she encounters' (FG.PR.EP).

'My role is to act as a mentor, I orient him to the hospital facility, I also orient him about the policies and procedures and everything and act as a facilitator' (II.PR.IA).

'They [preceptees] should be the one assessing their needs and running after the preceptor not the preceptor running after them' (FG.PR.CS).

Based on the preceptees pre-preceptorship experiences, they expected preceptors to be role models, teachers, evaluators, guides and directors as well as resource persons they could turn to for answering any queries they had during and even after the preceptorship period.

'..the preceptor is a role model, her responsibility is to help me and guide me how to get things done and how it should be done. She should be the one who evaluates me, should be my second mother here' (II.PE.Vi).

The above preceptee perception concurred with the organisational perspective of preceptorship. The organisation expected the preceptor to act as a role model, socialiser and educator and to provide the preceptees with the necessary support, feedback and evaluation of their performance and then discuss his/her evaluation with his/her nurse manager during their bi-weekly meeting. The role of the preceptor is delineated in the hospital documents as illustrated by the following three extracts namely that the preceptor is there to:

'... support the [preceptees], .. to discuss the [preceptee] needs prior to their arrival and progress with the nurse manager, to discuss goals and objectives with their preceptee, and set timelines for these to be completed and reviewed' (IPPI 2009, p.2).

'Act as a role model and assist in the socialisation of the [preceptee] into the team, ensure that the [preceptee] receives the assignments and clinical experience necessary in order to complete the clinical competencies, provide feedback on performance to the [preceptee], evaluate the [preceptee's] progress and communicate this verbally to the nurse manager on a two-weekly basis' (IPP2, p.6).

'act as an educator; assist preceptees by helping them assess their orientation learning needs, by planning their experiences, by implementing their learning plan and by evaluating their job performance' (PRM 2009, p.5).

4.2.3.5 Role of Preceptees

Nevertheless, the role of preceptees as perceived by the preceptors, CRNs and nurse educators as well as the organisation was to be actively involved in the preceptorship

process. Thus, preceptees were expected to identify their own learning needs, demonstrating self-direction to address these needs and bring these to the attention of the preceptors, CRN, and nurse manager as stated in IPP2 and outlined by the following CRN:

'They [preceptees] need to be actively involved in preceptorship' (FG.CR.GW).

The above perception was reinforced by a nurse educator, who expected preceptees to:

'actually verbalize that they are not competent and come to me and tell me can we do something or can we get an opportunity for looking at something like that?.. I expect them to feel confident and not be scared because they lack knowledge. If they lack knowledge, they have to read, use the resource persons CRN and NM to build up their knowledge' (II.NE.SE).

In contrast, during the preceptees individual and focus group interviews it was revealed that preceptees demonstrated a passive role during the preceptorship period, preferring to listen to and follow their preceptors' direction rather than get involved in discussions. The reason for this latter action, as expressed by preceptees, was that they perceived themselves to be new employees, who did not have the right to oppose those in authority. Furthermore, they believed raising questions or engaging in open discussion with preceptors or any other educators might affect their relationship with them and other colleagues, which might cause problems latter as indicated below:

'Sometimes the one who's teaching you does not do the ideal, the ideal way of the procedure. So, I just wondered why they teach me that way. Because I am new, I have to deal with them' (FG.PE.Sh).

'...as a new member of staff you do not want to create many troubles' (FG.PE.RE).

'I don't want to be hated' (FG.PE.Vi).

Furthermore, preceptees perceived that asking questions or opening a discussion might impact negatively on their evaluation as a new employee and their ability to pass the probationary period. The latter was especially important given that successfully completing the preceptorship programme was one of the goals to be achieved by the end of the preceptorship period for most preceptees as identified during the pre-preceptorship interviews. For example, the following preceptee said:

'I need to be able to catch up with the speed of this hospital, and their requirements and be able to work like the senior' (II.PE.SU).

While another stated:

My goal is to pass this preceptorship. So, I have to show my best to my preceptor and rest of the staff especially my manager, so that I can pass my probationary period' (II.PE.AE).

4.2.3.6 Expectations of Preceptees

Just as each participant had her/his own understanding of the role and responsibilities expected of her/him during the preceptorship programme, the expectations of what the CRNs, preceptors and nurse managers felt preceptees could achieve in the time available also varied. Although, most participants expected preceptees to complete the generic competencies¹² before the last day of the preceptorship period, others had different ideas. For example, the following CRN expected preceptees to:

'finish their generic competencies within the 8 shifts, While, other requirements will be after the 8 shifts' (FG.CR.GW).

In contrast, a preceptor felt that because of the short amount of time available it was not possible to:

'expect a lot from the preceptee but to at least be a safe nurse, know how to approach any person around him ask for help and to understand and be familiar with the system' (II.PR.TS).

Unlike the following nurse, who expected preceptees to function like a preceptor by the end of the eight shifts/10 day preceptorship period.

I expect her to be like me, so she can give what she learnt from me to the others. Be competent, compliant, and sensitive' (II.PR.CH).

The following nurse manager's expectations were similar in that they counted on preceptees to

'take a full patient load and cope because we are not training them here, she came trained. She is coming with experience. So, she has 8 supernumerary shifts, by the 9th she should be able to do the work on her own' (II.NM.SA).

While another nurse manager expected preceptees to be able to:

'successfully complete all the competencies that are expected and be able to adjust to the ward's goals and standards. My expectations are to start with [these competencies] and as time goes by they will learn more and more. They will have to meet the expectations and be able to successfully manage patients independently and be able to use their critical thinking skills to manage and troubleshoot any problem they encounter' (II.NM.AN).

¹² See page 101

Education versus orientation

In contrast to the above, during the pre-preceptorship interview, without exception, the preceptees felt that, as they were newly hired nurses and had no idea about the new environment, they should receive appropriate teaching and guidance from their preceptors and CRNs regarding their new role and responsibilities. In this way, they felt they would be better able to settle down and work safely. Consequently, they expected to receive appropriate support from their nurse managers to facilitate the teaching-learning process as the following preceptees' comments indicate.

'During my preceptorship...I am expecting [my preceptor] to teach me all the correct things.. and to [have] support [from my nurse manager] facilitating this teaching process because I really do not know this new environment' (II.PE.AE).

'This is my first time in Saudi Arabia, I know nothing, to be honest, about the health care system here, so, I need more than orientation. I am expecting my preceptor and CRN to teach me everything, how can I do this and that and to help me pass the preceptorship period successfully' (II.PE.VI).

Furthermore, all participants expected that the preceptorship programme would help them settle down and integrate into their new role and environment easily. For example, one preceptee said:

'First it could help me [adjust] to [the] culture, and then I could easily understand¹³ how things are done' (FG.PE.Vi).

Were the participants expectations fulfilled?

Given the mismatch between the expectations of the parties involved in preceptorship by the end of preceptorship programme, participants' expectations were not always completely fulfilled. For example, some preceptees were unable to achieve their goals, while others felt able to meet them in totality. Concerning whether goals, needs or expectations were fulfilled participants indicated that time was a major factor influencing whether preceptees' were able to fulfil both their own and others' expectations. For example, a CRN pointed out that:

'time affects the programme because if you look at the expectations that we put for a new comer, we are expecting them to be fully functional after 8 supernumerary shifts, given their different background they will cope differently with that' (II.CR.NG).

When preceptees were asked if their expectations were fulfilled by the end of the preceptorship period, one said

'No, I don't think so, there is such an extensive list. And my preceptor always had a full patient load so she was running around like a headless chicken. She [was] supposed to

¹³ As footnote 10

teach me all these things, and oh, and then when I got a minute to go through this list, here's this and here's that and here's the other, there was no time' (FG.PE.RE).

Most preceptees acknowledged that their expectations were achieved with the continuous support and help received from preceptors even after the preceptorship period ended. For example, one said:

What I expected the first time was to teach me and help me [settle down]. They are still helping me for being a new staff in the clinic. Although I am having a difficult time in my routine, my preceptor is still there helping me in the work and teach me how to communicate with the patients, how to do these things and how to manage the work in the clinic' (FG.PE.Vi).

Three preceptees felt their expectations had been partially met because they had received the required knowledge and skills that allowed them to work confidently.

I think I almost got it [my expectation] because during my preceptorship I got more idea about ICU, procedures and policies. I think I can say frankly I got more confidence to do my work' (FG.PE. Mi).

However, the following preceptee felt that his expectations had been fully met during the preceptorship period and that he did not require any extra days.

I have met my expectations and needs during the 8 shifts of the supernumerary period otherwise I would not have refused an extra 4 days supernumerary' (FG.PE.RR).

Confusion in Terminology

Although the term preceptorship was defined in the policy documentation, considerable confusion was manifest between the term preceptorship and mentorship across the study participants as hinted at already in some of the quotes outlined above. Furthermore, the term orientation generated similar confusion, as staff were not sure if this was an integral part of the preceptorship programme or something different. Hitherto, no one seemed to understand clearly, what the role of the preceptorship programme was. Thus, some of those involved in the process were not sure if it was an educational/developmental process, or something else. Hence, each member involved in the process acted in accordance with his/her own understanding of the term preceptorship. Interestingly in the IPP1 and PRM document, the organisation also used the term orientee when referring to preceptees and considered the preceptorship programme similar to an orientation process as illustrated below:

'[a] Preceptee is a newly hired staff nurse who participates in a preceptorship programme for orientation to an assigned unit. [A] preceptee may also be called [an] orientee' (PRM 2009, p.3).

The use of the term orientation could have been another reason why preceptees sometimes adopted a passive role, especially as there is considerable difference between an orientation and preceptorship programme. Potentially the terms preceptee and orientee do not necessarily mean the same thing. For example, a preceptee is a person who needs to be taught a set of skills to be able to function effectively in a new clinical setting and become one of the team. While an orientee, is a person who needs to know the location of specific items in the clinical area. Thus, orientation may be a superficial/quick introduction to the philosophy, goals, policies, procedures and services of a particular ward setting, during which the preceptor and preceptee do not necessarily engage in a one-to-one instructional relationship.

Hence, there is a significant difference between the notion of orientation and preceptorship in terms of the roles, expectations and also the length of time a person has to complete such processes. Ridge (2005) therefore attempted to distinguish between these two constructs by describing orientation as '*the first exposure the newly hired has with your [new] hospital and its staff ... to facilitate the initial transition of staff into a specific nursing speciality*' [via a] *classroom*' (p.30). Conversely, preceptorship is a one-to-one clinical learning experience aimed at providing new staff with the initial knowledge and skills they require to work safely in a specific nursing speciality.

Consequently, following my interpretation of the participants' narratives and experiences of preceptorship, I deduced that the rationale for the above confusion was that all except the preceptees, tended to have read the policy documentation only once; frequently this was several months or a year prior to the present study having taken place. Moreover, they had not discussed the concept with others to gain a clearer understanding of what each party was expected to do as part of the process. Furthermore, despite participants having read the policy documentation they were not convinced about what it meant or how the process was to be implemented in practice due to their claim, that the preceptorship documents were confusing, unclear and at times contradictory in their definition and/or meaning.

When analysing the contents of the preceptorship documents, it was not surprising that making sense of them proved difficult as each document referred to a different facet of the preceptorship process, and used inconsistent language even when

referring to the same thing. Thus, there was noticeable confusion regarding the meaning of preceptorship and orientation among preceptors and preceptees resulting from the ambiguous statements made within the official policy documents. Although it was possible to generate a complete picture of what the organisation meant regarding the preceptor role after having read all three documents, this seemed not to have been noted by the participants themselves.

As a result, confusion abounded within the formal documentation provided by the institution thus there is little wonder that the participants' understanding of the nature of preceptorship was ambiguous. This ambiguity undoubtedly affected the participants' understanding of the term preceptorship and its expected duration, a feature explored in more detail in the subsequent theme.

4.3 Theme two: Time as a confusing and restrictive concept:

4.3.1 Introduction

The length of time assigned to the preceptorship programme was one of the main topics raised by all participants during both the individual and focus group interviews. The notion of time is typically measured in minutes, hours, days and years. Furthermore, it is the period we spend doing something or when something has been happening (Macmillan Education 2007). For the purpose of this study, time was predetermined by the study setting and was measured in days or shifts.

According to the policy documentation, the length of time allocated to the preceptorship period was pre-determined as eight shifts/ten days during which a formal one-to-one relationship between the preceptor and preceptee was expected to be established in order to assist the preceptee successfully adjust to and perform his/her new clinical role. However, the preceptorship period was not clearly stated or specifically defined in the preceptorship policy documentation.

Furthermore, there was confusion within the documents regarding the actual duration of the preceptorship period. Preceptorship, particularly its duration, was defined and referred to interchangeably with the notion of the probationary period in one part of the IPP1 document, while in another part it was identified as the supernumerary period despite each one having a different meaning and duration. The probationary period was defined as '*supervision during a trial period of 90 days*' (IPP1

2009, p1). The supernumerary period was identified as *'a period of 88 working hours (2 weeks) during which time the new staff member does not form part of the rostered nursing workforce'* (IPP1 2009, p1). *'Shift workers will therefore have a period of eight supernumerary shifts. Staff working regular hours will have ten supernumerary days'* (IPP2 2009, p1).

For instance, clause two of the IPP1 document indicated that *'the preceptor will be assigned to support the new staff member over the entire three-month probationary period'* (p.2). This comment suggests that the preceptorship period equated to three months, and the preceptee had the right to work with her/his preceptor in a one-to-one relationship over the entire 90 days. Conversely, clause fourteen of the same document stated that *'the preceptee will be rostered on the same duties as the preceptor during the eight-day supernumerary period'* (p3), which indicated that the preceptorship period equated only to the supernumerary period, which was identified as being eight days. Clauses seven and eight respectively also reinforced this notion, as shown below:

'The nurse manager will outline the level of support to be provided during the supernumerary period...' (IPP1 2009, p.2).

Thus, the term supernumerary period was used in both documents as an alternative expression when referring to the preceptorship period. Eighty-eight working hours (2 weeks) had been identified clearly in the orientation and probationary requirements section of the Internal Policy and Procedure Document (IPP2), which equated to eight shifts for those on rotational shifts and ten supernumerary days for staff working regular hours (8-5 pm).

Staff working shifts are expected to work 15 shifts per month, each shift equating to 12 working hours. The total number of working hours for any full-time member of staff over a two-week period is 96, but because eight hours are deducted from the total for rest breaks and prayer, the actual hours worked are 88. Hence, eight shifts equated to 88 working hours per two weeks. Those working regular hours are on duty for ten hours/day over a fixed five-day period as the duty dates start from Saturday – Wednesday. Thursday and Friday are rest days. Therefore, 10 working hours per day necessitated that the post holder worked 10 days over a two-week period.

Despite the above, there was no definitive answer regarding the preceptorship period or when it began or ended as the 'preceptorship period' was not clearly identified and determined in the preceptorship documents. This is because although one set of documents said what the preceptorship programme should comprise and how long it should last, another set contradicted this. Therefore, there was ample opportunity for confusion amongst all study participants to emerge. Subsequently, participants' perceptions and interpretations of what the preceptorship period represented were subjective and varied. Accordingly, in the current theme it is intended to explore how participants' perceived the preceptorship period based on their own unique experience. For this reason, theme two is further divided into four sub themes:

1. preceptorship period as perceived by the participants
2. time versus preceptor-preceptee relationship
3. time for the preceptee to meet the CRN and
4. time versus preceptorship information and requirements.

4.3.2 The preceptorship period as perceived by the participants

As indicated above considerable confusion existed between study participants in relation to the exact length of time that should be devoted to the preceptorship period namely when preceptorship should begin and end. Nevertheless, this confusion appeared to manifest more overtly among the CRNs, nurse educators, preceptors and nurse managers, while the preceptees clearly recognised the preceptorship period as representing eight shifts/ten days. Consequently, the preceptorship period was redefined by each group of participants in a way that reflected and equated to their own specific and unique time-frame.

In essence, the notion of the preceptorship period was interpreted in different ways hence it was equally criticized for being too short or too long by the different participants. Therefore, the preceptorship period became an elastic concept expanding and contracting in accord with each person's unique standpoint. For example, in some wards, the preceptorship period was extended to suit the needs of the ward or preceptee; while on other wards the preceptorship period was more reflective of the policy documentation. Consequently, some participants perceived

the preceptorship period to last for eight shifts/ten days; starting when the preceptee commenced his/her first shift in the clinical area and met the preceptor for the first time. In this case, the preceptorship period ended when the one-to-one relationship was supposed to have been completed on day eight or ten. This perception regarding when the preceptorship period began and ended is demonstrated in the following quotes. For example, one nurse educator stated:

'...The preceptorship period [begins] when [the preceptees] are precepted by the preceptor for 8 days as per policy' (FG.NE.SG).

This perception was echoed by two CRNs who commented the preceptorship period started:

'the day [the preceptee] comes to the unit ...the beginning of the supernumerary shifts' (FG.CR.NG).

'when [the preceptees] go to the ward and start the 8 shifts where they meet the preceptor' (FG.CR.MB).

From a managerial perspective, three nurse managers supported the above concept as the following quote demonstrates:

'Well officially [the preceptorship period] starts on [the preceptees] first day of the supernumerary period, ok this is when they do their first shift on the ward so they have a preceptor. They [preceptees] work totally with the preceptor for that supernumerary period which is 8 shifts, so, give or take; it's almost 2 weeks' (II.NM.LI).

Nevertheless, on some wards the preceptorship period could be extended to 12 shifts instead of 8, to ensure the preceptee had a chance to work on, or be exposed to all areas of the ward, especially in wards that delivered multiple types of service such as ER as the following preceptor illustrates:

'Because ER is a big unit, it has more than [one] area: triage, resuscitation and other rooms. So, sometimes they [nurse managers] give the [preceptee] 12 shifts' (II.PR.TS).

However, the above view of what constituted the preceptorship period was not the only interpretation offered. In some cases, participants took a broader view of the concept. In these instances, participants perceived the actual preceptorship period to be longer equating to 76 days, the latter being the point when the generic and unit specific competencies had to be signed off and the final performance report submitted. This latter interpretation of time demonstrates the elasticity of the concept, which clearly reinforced the participants' confusion regarding when preceptorship began and ended. For some, the preceptorship period was thought to

commence on the day the preceptee actually set foot on Saudi soil and ended with the submission of the performance report on day 76. This interpretation was reflected by two CRNs, a nurse educator, nurse manager and one of the preceptors. For example, one CRN reported preceptorship began:

'from the time [a preceptee] meets with her preceptor and it ends by 76 days, because by [that] time I have met them and we have decided if they can work independently' (FG.CR.SM).

While one nurse educator stated preceptorship began.

'the day the person [started their] nursing orientation [programme]' (II.NE.SE).

A third time-frame however, was identified by a further CRN who suggested that preceptorship commenced on the preceptee's induction day as illustrated below:

'I believe preceptorship begins from the induction day when the [preceptees] come to the hospital' (FG.CR.AB).

Contradictions and ambiguities that arose in terms of understanding and interpreting the preceptorship policy across both the educational and managerial groups generated inconsistencies regarding how to implement the policy. In this latter context, each nurse manager followed the policy based on her/his own personal constructs such that they reflected unit specific organisational needs and requirements. Nevertheless, it would appear that these informal modifications were made to ensure the overall learning objectives were met as illustrated below:

'I may do it [preceptorship programme] in this way, another manager might do it in a completely different way, and another manager can do it in a very simple, easy way as long as the work is done. But I can ... For me I know I will take it step by step, point for point, making sure everything is explained and keep documentation. So, that is something you find, inconsistencies' (II.NM.BE).

'..We are all working in the same hospital but each department has their own policies and procedures apart from IPPS. So in ICU we follow our own protocols' (FG.PR.BP).

The participants' notion of the preceptorship period varied with experience; hence, they revealed that the preceptorship programme/period was restrictive particularly in terms of the length of time allocated to it. Consequently, most participants agreed the preceptorship period was not enough and was somewhat self-limiting. For example, one CRN pointed out that assigning eight shifts to the preceptorship period for all preceptees was not suitable as each person was different.

'Eight [shifts] is rather restrictive in the sense that everybody has been subjected to the same number of days as if everybody is the same' (II.CR.NG).

Furthermore, she illustrated some preceptees

'may be able to adjust to a situation faster than the next person, but the next person [may] take longer to adjust' (II.CR.NG).

Being new to the health system's rules and regulations was another reason why eight shifts/ten days was not considered sufficient for the preceptorship period to achieve its purpose. This latter point was considered vital for international nurses entering the Saudi health system as this was felt to be very different from the health system(s) they had been used to. Therefore, they needed more time to understand the different work practices and any associated policy regulations extant within the Saudi system. Thus, to integrate successfully into their new role and be able to provide the required quality of nursing care such nurses needed more time to get used to how things worked as illustrated by one of the nurse managers:

I think this [preceptorship] period is not really enough. Because some nurses come from countries that have a different health system from here' (II.NM.AM).

Another nurse manager perceived the preceptorship period was not long enough because it did not allow time to follow up on the preceptee's performance and finish all the required paper work. However, whether all components were achieved on time was felt to be largely dependent on the preceptee her/himself.

'76 days for the current preceptorship programme is too short. ... It is very tight for the nurse manager to follow up. It is fine if you have a good candidate, but if you have someone who's struggling then you really have to be on your toes and it's not enough time for us [nurse managers] as well' (II.NM.AN).

Furthermore, ward specific needs and requirements also played a major role in establishing whether the preceptorship period was long enough - in some areas of the hospital the (eight shifts/ten days) preceptorship period could potentially be considered sufficient while in others the latter would not have been the case. For example, one CRN believed ten days for a preceptee working in outpatients was enough while it might not be for other preceptees because according to her, OPD had minimum requirements to achieve compared with in-patient services.

'Yes 10 days for me [in OPD] is perfect, but for NICU, PICU, ICU no. I do not think so' (FG.CR.SM).

Despite the above, one nurse educator made a pertinent point when describing the preceptorship period as prescriptive, a fact consistent with the hospital policy and current legal requirements:

'The timeframe of eight [shifts] is very prescriptive' (FG.NE.SG).

Nevertheless, this inconsistent understanding and the *ad hoc* application of the preceptorship programme as well as its restricted time-frame in the study context also had the potential to impact on the preceptee-preceptor relationship as illustrated in the subsequent sub-theme.

4.3.3 Time versus preceptor – preceptee relationship

In an environment conducive to teaching and learning, it is crucial for the preceptorship experience to begin, proceed and end both positively and constructively. Hence, time is needed to begin and terminate the relationship properly (Myrick & Yong 2005). In this study, all participants agreed the eight shifts/10 days pre-determined period for preceptorship was not enough to build up a mutually trusting relationship. For instance, during the preceptee pre-preceptorship interviews they revealed that based on their previous experience of preceptorship or mentorship back home, having even a basic idea about what should take place in their new work environment needed more than eight shifts to achieve as illustrated by the following preceptee:

It takes time to get used to new things' (FG.PE.AK).

Moreover, such a short period of time worried some preceptees, as they were afraid of missing a day from these eight shifts in case it affected their ability to successfully complete the required training.

'A little bit scared because we also have a hospital orientation which takes one of those day[s] away. So, I am not sure if my ward manager will give me an extra one to make it eight days to be able to complete the preceptorship training. But eight days [are] not a lot' (FG.PE.RE).

Subsequently, failure to complete the preceptee's training during the pre-determined timeframe increased the workload for other nurses, which made them feel vulnerable to criticism and more importantly perhaps, negatively pre-disposed to the preceptor and his/her ability to precept effectively, as illustrated below:

'If she is not working with me she will keep asking her colleagues where is this and where is that, which is irritating. So, the comment will be the preceptor did not tell her or [teach] her' (FG.PR.CH).

In contrast, the preceptorship period appeared overly long for one preceptee who felt that working independently sped up the integration process and helped him to practice clinical skills more effectively than when working in a one-to-one relationship as the following comment indicated:

‘.. For some ... eight shifts would be enough but for other people would be too much. I ...think you don't actually get into .. And understand the job until you [are] working as an individual because that [is when you find problems] and have to deal with them. When you are working with somebody else, ...You just watch what they are doing’ (FG.PE.RR).

Similarly, some preceptees considered the eight shifts to be enough as more shifts meant more shadowing of the preceptor rather than engaging in supervised practice. Hence, in the latter circumstances the preceptor might not allow preceptees to discover their weaknesses, or may not challenge the preceptees’ ability to work independently.

‘Eight shifts are enough for everybody. .. More days mean we are more dependent’ (FG.PE.Mi).

Workload was a further factor that affected the preceptors’ perception of whether eight shifts were sufficient as this too impacted on the success of the preceptor-preceptee relationship and the teaching process as indicated below by two preceptors:

‘For the preceptor, sometimes [eight shifts] is really straining because until evening we did not teach them anything because we are busy with things and then at the end she finishes [the] eight shifts also without learning anything’ (FG.PR.BP).

‘There is not enough time to teach the preceptee. There are always interruptions because you are teaching at the same time as you are handling patients’ (FG.PR.CS).

This lack of time also impacted on the effectiveness of preceptee’s clinical preparation which challenged his/her ability to deliver safe nursing care.

‘You do [observe] him [the preceptee] on [a] specific procedure but you cannot go through all the procedures, even if you want to explain it or to see if he is competent about the procedure, you cannot find the time to go with him and check if he is OK with it or not. So, eight shifts I feel is not fair for new staff’ (II.PR.TS).

Another preceptor reflected on her own experience as a preceptee when deciding if the eight shifts were enough:

‘After my eight shifts I am taking care of patients and people are picking me up on each and every thing. Nobody told me what I was doing wrong they just [reported] me to my manager. I did not know what was happening, it was only after three months I realised what I must do’ (FG.PR.JT).

Similarly, the CRNs collectively felt that eight shifts were insufficient for the preceptor and preceptee to establish a one-to-one relationship particularly when the latter was new to the Saudi culture as this settling-in period was felt by one CRN to be intimidating. In addition, the CRNs felt that during this period preceptees were

afraid of failure resulting in their feeling anxious and worried. Hence, preceptees needed to spend longer with preceptors than was currently allocated.

'If this is the first time for the preceptee in Saudi then everything is intimidating. [So], eight shifts are not good' (II.CR.NG).

Two further CRN's similarly clarified the above view stating.

'My perception of the programme here is that the supernumerary period, as everyone said, is too short. If the [preceptee] has ... trained before in that area, then eight or 10 shifts are enough, if the person had experience [say] two years. But [if they really had no] profound knowledge about the [clinical] area, then this is too little and it needs to be extended' (FG.CR.GW).

'Some of the nurses come from a completely different system. So I don't believe that eight shifts are enough to let them know everything... to let them work alone' (FG.CR.RD).

The short time allocated to the development of the preceptor-preceptee relationship forced preceptors, who believed they had a teaching role, to adopt a 'speedy style' of teaching. The latter was felt to be a necessary component of the preceptorship process in order to fulfil the preceptorship requirements, especially the basic and generic competencies, as attainment of these skills enabled preceptees to work independently and administer basic nursing care for their assigned patients. Nevertheless, according to some preceptors and CRNs, this rapid style of teaching prohibited preceptees from digesting or understanding the information imparted.

'We are trying to speed the teaching process to accommodate a lot of information within short period of time. Speed teaching made them [preceptees] unable to digest, or understand information provide to them' (FG.PR.BP).

Moreover, preceptees also found it especially difficult to ask questions about what they had observed because the preceptor was too busy trying to balance preceptee, patient and unit needs as part of a simultaneous process. Therefore, some of the basic things preceptees needed to learn were omitted such that they were not always fully cognisant with what was expected of them as illustrated below:

'My preceptor did not tell me you use the Kardex and you give the report by the Kardex. She did not tell me the way I am supposed to do it. So I was giving the report [without] looking at the Kardex. So, the person who is taking the report said 'oh you are supposed to use the Kardex'. You should tell your student. But the thing is, my preceptor did not tell me' (FG.PE.AK).

Conversely, the speed with which preceptees carried out tasks to fit in with the busy unit also affected the quality of preceptor-preceptee and any additional peer-peer relationships, particularly when they started working independently as the following preceptees indicated.

I feel I need to speed up my work a little bit. I feel I am not keeping pace with the present staff because everything is new I take a little more time because they work very fast. But I think 'what is this?' and the time is ticking ... I have to speed up a little more' (II.PE.SU).

We get discouraged sometimes if there is a busy time they will tell you 'go a little faster'... But I care about this because I know I am new and they are busy also. So, I try to do my best. But I am always asking because I don't want to make any mistakes. But I understand them' (II.PE.Mi).

Generally, participants believed shortages of staff, unit workloads and the limited duration of the preceptorship period, as well as the preceptee's background, were all factors affecting the success of the preceptor-preceptee relationship. As a result, extending the preceptee-preceptor relationship was perceived by participants as one of the solutions that might help to lessen the negative impact of the above factors. In order to do so, preceptors recommended letting preceptees work with them for at least two rotas in order to fulfil the aim of the relationship as illustrated below:

Eight shifts is not enough, you cannot teach someone to do this overnight. It is a continuous process. So, [the] more of his shifts [that] are with me [the] better' (II.PR.IA).

It is nice to keep them [the preceptor and preceptee] on the same shifts let's say [for] two rotas to build up an effective preceptor-preceptee relationship' (II.PR.TS).

Consequently, allocating enough time for preceptors to furnish preceptees with the necessary information to enable them to work safely and independently was considered vital. Furthermore, the preceptee needed time to digest as much information as possible:

Time plays a very important role as enough time makes the preceptor and preceptee more relaxed [and] share a lot of information. So time plays a big role' (FG.CR.MB).

Therefore, one of the CRNs believed that having sufficient time for the preceptor-preceptee relationship to develop and consider each preceptee's individual needs was important, as illustrated below:

If I had to change a few things, one of the things I would like to change would be how the preceptor-preceptee relationship goes. I would like to manoeuvre on the timelines because it would be OK to spread [the time], but to restrict everybody to eight shifts or 10 days supernumerary, it's like saying everybody is black' (II.CR.NG).

Championing the notion of a flexible timeframe to allow the development of a one-to-one relationship based on the preceptee's needs and his/her clinical performance was also supported by preceptors as the following comment illustrates:

We are forcing them to take the responsibility alone from the first shift onwards. So, it is not for all nurses, some are capable and get used to the things but others feel a bit difficult' (FG.PR.BP).

Indeed, one nurse manager felt the preceptee-preceptor relationship should continue until s/he was satisfied the preceptee was capable of working independently.

I will not allow them (the preceptees) to go out on their own until I am personally sure that they know what they are talking about' (II.NM.SM).

As the participants perceived time was important for building a trusting preceptor-preceptee relationship, they also emphasized that time to meet with their CRN was crucial in order to fulfil the required competencies within the expected timeframe, a point that is discussed in more detail in the subsequent section.

4.3.4 Time for the preceptee to meet the CRN

As stated earlier, each CRN had responsibility for her/his preceptee(s) and preceptors during the preceptorship period. In order to meet this obligation, the IPP2 stated that CRNs should meet '*with new members of staff* [preceptees] *during the first three days of clinical practice*' (IPP 2, p5).

Although time for the preceptee to meet her/his CRN was not specifically determined in the preceptorship policy documentation, all groups of participants preferred to have this initial meeting on the first day of the preceptee's visit to the clinical area. In some cases, participants preferred that this took place prior to preceptees commencing their preceptorship period in order to orient them to the clinical area and reduce some of the load on preceptors. Some CRNs had already instigated this as standard practice in agreement with the nurse managers,

For me, I prefer to meet the [preceptee] before they [begin] on the ward before the 8 shifts [begin] to orient them to the ward because it will relieve some of the stress on the preceptor, especially if the ward is busy. [Therefore], whenever I have new staff [preceptees] I meet [him/her first]' (FG.CR.AB).

I meet [the preceptees] on the first day and then I introduce them to the CRN' (II.NM.AN).

Another CRN felt that it was important for him/her to spend the first two hours of the preceptorship programme when preceptees first commenced on the ward orienting the individual to the clinical area.

'The first two hours, I am the one who will take over with the new [preceptee]' (FG.CR.RD).

One reason why preceptees wanted to see the CRN on the first day was that it facilitated their integration to the new setting:

'The very first day we were with the CRN she introduced us to the basic things... procedures ... machines and how to operate them. ... It made our inclusion into the ICU smoother' (II.PE.SU).

However, not all CRNs were able to meet preceptees on the first day or even in the first week because they were responsible for more than one unit. As illustrated in the following example:

'Because I am responsible for more than one clinical ward and short period of preceptorship sometimes I do not see [the preceptees] the first week. I see them [in the] second week or third week when they have already finished the preceptorship [in order] to sign off the physical assessment competency' (FG.CR.SM).

More specifically, preceptors, preceptees and CRNs all concurred that it was preferable for preceptees to commence their preceptorship programme during the daytime because CRNs only worked day shifts. Hence, those preceptees who started their clinical training on night duty were unable to meet the CRN until these had been completed. By then, the preceptee may be near to the end of his/her preceptorship period while some of the requirements which were supposed to have been completed with the CRN, may not have been, for example, those competencies related to physical assessment. Consequently, one CRN concluded:

'What makes [training the preceptees] difficult [is] if the preceptorship starts on a night shift, because on night shift you are not going to see them, so by the time you pick up how [far] they are lagging behind [they are] already almost at the last [stages of the preceptorship period]' (II.CR.NG).

In summary, time to meet CRNs particularly during the day was perceived as necessary for the preceptees to fulfil the required competencies in the expected timeframe. However, the pre-determined duration of the preceptorship programme was considered to be restrictive and insufficient, especially when the time available was juxtaposed with the number of requirements that needed to be achieved by the end of the preceptorship period, as demonstrated in the following section.

4.3.5 Time versus preceptorship requirements and information

Time was also associated with the skills and procedures that needed to be accomplished during the preceptorship period (Wright 2002) as outlined on page

102. Therefore, the participants' estimation of the length of time the preceptorship period should ideally last depended on the location, and number of skills and procedures each preceptee had to demonstrate competency in, during the designated preceptorship period. The fact that some procedures were commonly practiced only in some units and not in others made it difficult for preceptees to achieve them in those areas where they were not practiced. This concern was articulated by one of the CRNs:

Physical assessment, urine [testing], glucose [monitoring] and blood administration, all these requirements should be finished I think during the eight shifts, as much as possible. Most of them can be done very simply. Blood transfusions may be one of the areas [that] are not easy to complete in the 8 shifts because our area is not one of the areas that regularly give blood transfusions' (FG.CR.RD).

Because of the need to complete specific skills and procedures during the preceptorship period in those areas where they could not be fulfilled, some preceptees had to go outside their designated clinical unit to be assessed as competent as the following comments from a nurse manager and CRN indicate:

In OPD [we] don't have physical assessment or, blood transfusion being done. So, they [preceptees] have to look at another area and the availability of patients as well. So it is all compressed' (II.NM.BE).

'So we usually take the new staff [preceptee] to ward X (Day surgery) where they cannulate on a daily basis, they can do phlebotomy on a daily basis. If [the preceptee is] lucky [she/he is] even able to do blood transfusion when they have [a] walk-in or we can book them and we can get things started and the ball rolling' (II.CR.NG).

This process was designed to facilitate preceptees' achievement of competencies. However, the CRNs perceived training preceptees out of their designated unit interrupted the relationship with their preceptors and reduced the opportunity to practice and/or observe events or skills relevant to their own clinical domain. Consequently, such action disrupted their integration into and familiarization with the unit's daily routine, as well as the opportunities to administer direct and indirect patient care.

We are taking them out of the clinical area for a period of time just to do their competencies. This is disruptive whenever they should be with the preceptor doing a procedure they cannot attend because they have to go out to finish their competencies' (FG.CR.AB).

This latter idea was supported by one of the preceptors when reflecting back on her own experience as a preceptee and was taken out of her allocated unit to perform one of the required competencies:

'They take you out of your safe area and put you like here in ER... I had to do cannulation (smile) I was so nervous because [I] didn't know anybody. Yes, I found that very difficult' (FG.PR.DT).

Despite preceptees' efforts to complete their clinical requirements by the end of the eight shifts/ten days, this limited timeframe put them under considerable pressure and made it difficult for them to focus on the important things as pointed out by one nurse manager:

'I think they [preceptees] push themselves to get all those things done during their supernumerary period. OK, that might be considered a positive aspect, but they don't get time to focus on what they are doing. They focus on this a little, on that a little and we have got to do all by eight shifts... The pressure of having to meet [the] deadline of the competency dates ... really puts a lot of pressure on them, especially in the first week, and you must pass them before you can do anything else' (II.NM.LI).

One preceptee when asked to explain what it felt like trying to do everything in the eight shifts said:

'I am struggling with my competencies... I have to do this as well as I have to work in the ward and I have to learn all the APPs¹⁴, the IPPs' (FG.PE.Sh).

Failure to achieve the generic competencies within the eight shifts/ten days similarly affected the preceptees' ability to work independently. Hence, it was vital that each preceptee finished the latter by the end of the eight shifts as one nurse manager pointed out:

'It is very important to finish in eight days. Right now I am facing a problem. I have a nurse. She finished her eight shifts the day before and she [is] supposed to take five patients, but how is she going to take five patients or how is she going to get an admission [while] she hasn't done physical assessment yet. She has not given IV medication. If one of those five patients requires IV medication she can't give it because she hasn't signed it off yet. So that is a problem we have' (II.NM.SA).

Consequently, there was consensus between each of the participant groups that eight shifts were insufficient to enable completion of the preceptorship requirements, especially for preceptees who were new to Saudi. Yet for some, it was not always the competencies they found difficult to achieve as the following preceptee points out:

'The work is easy but what make it difficult are the things they want you to memorise, for example the IPP, the APP' (FG.PE.Vi).

¹⁴ APPs: Administrative Policy and Procedures

Lack of time was also identified as one of the major reasons why preceptees had insufficient information to prepare them to work safely as illustrated by the following CRN:

For me, the major problem ... is not enough time for the new nurse to have enough knowledge, [they are] under stress because [by the end of] the eight shifts [they] have [to look after] five patients. [So, they become] confused between the patients' (FG.CR.RD).

Conversely, some preceptees, especially those who worked with good preceptors and were able to manage their time well, perceived eight shifts could be enough for the completion of generic competencies. For example, one preceptee said:

'[For] the generic competencies [it] is OK. Unit-specific [competencies] will take time because some of the [procedures] may not be possible to complete. Insertion of NG tube is not a frequent procedure. It may not be in our time. If we are lucky enough, we get it' (II.PE.SU).

To achieve the requirements within the expected timeframe, CRNs and nurse managers tried to find alternative times for preceptees to fulfil any outstanding competencies prior to commencing their clinical patient workload. This extra time often encroached into the preceptee's off duty periods. However, preceptees did not find this an acceptable alternative and perceived it to be unfair practice because it negatively impacted on their performance and job satisfaction as indicated by a nurse manager and preceptee respectively.

In a busy area it is very difficult for them to finish all their competencies if they do not come in on a day off, they would not be able to do the physical assessment' (II.NM.SA).

I was trying to do physical assessment but having never done or seen one before. At home it's the house officer's job.... we will see if we can get you signed off here ...they wanted me to arrange for the next one in my own time. ...that was my second night shift, I was already two hours into my own time, and I was tired. I felt I was being bullied and at that point, I just went home and cried ... I just wanted to get on a plane and go home' (FG.PE.RE).

Thus, CRNs, nurse educators, preceptors and nurse managers agreed that the eight shifts/ten days for completing the preceptorship period was not enough time for preceptees to settle down and integrate fully into their new clinical domain. Furthermore, they considered the preceptorship timeframe to be one of the factors that affected the overall success of the programme. For example, one CRN perceived the healthcare system in the study setting was more advanced compared with other healthcare systems. In addition, one of the nurse educators expected preceptees who came to Saudi would face difficulties settling down because she believed the

preceptorship programme did not take into account all the factors that were needed to ensure preceptees integrated easily into their clinical domain. Accordingly, both of the above participants agreed that eight shifts were not enough as the following quote illustrates:

'The system here, I can say is [an] advanced system. Some of the nurses [preceptees] come from [a] completely different system so that I don't believe that eight shifts are enough to let them know everything. 8 shifts for me are not enough to let them work alone' (FG.CR.RD).

Another CRN thought the three-month probationary period would be enough for the majority of preceptees to adjust to the new role.

'I think the 3 months are 90% enough to help the people [preceptees] adjust to the place. Maybe the distribution of the timeframe within the three months should be reconsidered to support the [preceptees' adjustment] in a good manner to the place' (FG.CR.GW).

The following preceptee expressed a similar opinion. However, she believed her own integration was much faster because of the similarity between the new clinical domain and the one to which she had been accustomed at home.

'I think it will get me into the system fast because other places I've work are the same. You have around two weeks to get used to the unit after then [you work] on your own.....So, I do see similarity. So, just getting used to the process here. Yes, I am lucky; I came from a similar system. [So,] it was easier for me to catch on. There is another nurse from Finland [who had difficulty settling down] because the system she was used to was different, [so,] she could not catch on' (FG.PE.AK).

Furthermore, another preceptee believed that as soon as you understood how to do the paper work; other nursing tasks were similar to anywhere else in the world. Thus, integration was felt to be easily achieved.

'One is to understand the paperwork because here it seems that it's a terrible ... lot of paper work. But once you get into that, the job is very much the same wherever you are in the world' (FG.PE.RR).

Although most preceptors gradually exposed preceptees to the work routine of the unit and patient care as part of the preceptorship period, preceptees did not always fully integrate into the unit's routine, and frequently felt confused, even when they actually began their independent practice. Therefore, according to one preceptor, integration of preceptees into the team was not easy, especially for preceptees working in Saudi for the first time, as they needed to adapt to the language, the Saudi culture as well as to nurses from other countries working in their clinical area. In addition, they also had to adapt to the work practice of a diverse range of doctors

and other members of the multidisciplinary team. Hence, the participants emphasized that the preceptorship period was not enough for preceptees to settle into their new role as one nurse manager pointed out:

We [have] got lots of staff who [are] leaving their family and are looking to adjust. But we do not really give them that time to settle down' (II.NM.BE).

Thus, participants concluded many preceptees did not begin to integrate into the clinical team until much later as illustrated below.

For myself, I [began to] find my feet by the end of the 5th month, which was last month where it started to fall into place' (FG.PR.DT).

She added that:

'Our preceptee is still struggling with a few things, because she never did physical assessment back [during the preceptorship period] and I have not done any of the competencies with her. Most of the competencies [were] done in [another] unit' (FG.PR.DT).

Furthermore, when the preceptee referred to above was asked if she had settled down in her new unit, she agreed with what her preceptor had said.

'For now, not really. I am just confused because I have to learn a lot of things. I still have to learn a lot of things' (FG.PE.Sh).

As a result, nurse managers, preceptors, CRNs and nurse educators alike all perceived the preceptorship programme should be longer to enable preceptees to settle down gradually, rendering the adjustment process less challenging or stressful.

For example, one CRN said:

'A longer period [of preceptorship] is motivating and challenging [for the preceptee]. But if [it] is shorter [the preceptee] feels intimidated' (II.CR.NG).

'Tak[ing] into consideration this is a new place, especially if it is the first time in Saudi, they need to adapt to the language, the culture, with the different nationalities. So, I think even after 3 months they are still confused. they need 6 months to get on track. That is my experience with all new staff [preceptees] that came to our ward' (FG.PR.CS).

Furthermore, there was total agreement among participants that introducing a notion of flexibility in respect of the time available to complete the preceptorship programme would enable individual differences to be taken into consideration as the following quotes demonstrate:

'Not everybody develops at the same rate. ... you have to take into account that everybody is different. You cannot expect that I will reach that stage at that time' (II.NM.SM).

I think it should be more flexible.....The organization should say like look 8 supernumerary [shifts] is the minimum but you can extend [it] however you see fit up to a certain timeline' (FG.CR.GW).

Accordingly, the following CRN considered that the current preceptorship programme was not really a success:

'[The preceptorship] programme is not successful. [Because it] is very restricted and it stands like a rigid peeler. It could be a success if [the time period] was not restrictive' (II.CR.NG).

In summary, the duration of the preceptorship programme and the need of preceptees for teaching to complete specific components within a specified timeframe were considered important factors needing to be borne in mind if the preceptorship process were to be a success. Confusion around the preceptorship period and the restricted time allocated to staff in which to complete the preceptorship programme in the study setting impacted on the success of the preceptorship process. Accordingly, the ability of newly hired experienced nurses to settle down in the clinical domain severely hampered their ability to administer effective clinical nursing care, a feature that will be examined in the following section.

4.4 Theme three: The impact of preceptorship on clinical nursing care

4.4.1 Introduction

Providing appropriate training and support for newly hired experienced nurses (preceptees) in the early stages of their employment through an organized preceptorship programme has been considered as a way of assisting such nurses develop their professional and clinical skills and, potentially improve patient care (Harbottle 2006, Charleston & Happell 2004). This section aims to explore the impact preceptorship had on clinical nursing care from the perspectives of those involved in the preceptorship programme, as this was an area of concern for study participants. Hence, in order to address the theme in detail, the section has been divided into two sub-themes regarding the impact the preceptorship process had on the preceptees and preceptors' clinical performance.

4.4.2 Preceptees' clinical nursing care

Some participants felt that preceptorship had no effect on preceptees' clinical performance because they were already experienced, knowledgeable and skilful nurses in their respective field of nursing. Hence, the preceptorship programme was

perceived simply as a programme of study designed to assist preceptees to become familiar with their new roles, routines, rules and regulations as the following CRNs commented:

I do not think nurses improved their clinical performance. We exposed them to the new system ... but with regard to clinical work [the] nurses came with their own clinical experience, sometimes maybe more than expected' (FG.CR.RD).

'Some preceptees have the skills and they just need to be adjusted to the place' (FG.CR.GW).

The following preceptee comment concurs with the above illustrating her experience from the outset had involved taking on a full caseload of patients in keeping with the notion of an experienced practitioner as illustrated below:

For me, I always had [a] full patient load (six patients) since my first day of preceptorship. My preceptor was there but I gave all the meds for all [the] patients, I did all [the] charting. So, pretty much I was doing everything' (FG.PE.AK).

Similarly, the nurse educators also believed the aims of the preceptorship programme were not designed to improve clinical performance as indicated below:

I don't think our aim should be to improve clinical performance [during] preceptorship' (FG.NE.SG).

Perhaps more fundamentally, delivering effective, efficient clinical care was thought to be dependent on the preceptee's personality and psychological status regardless of the quality of his/her relationship with the preceptor. For instance:

If you are depressed, you can imagine you are coming to work, and you have all these things and you cannot cope. Already you are negative. But if you are positive you know you will have [a] positive outlook. So, it does affect performance. If you can make the preceptees feel comfortable, they will feel comfortable in their work environment and that will definitely improve their performance' (II.NE.SE).

One preceptee reinforced this point by saying:

It depends on the individual and his learning ability, because someone could have the preceptor that I had and not do very well, because when I had my preceptor, she did not have time to teach me. She just showed me things and I had to catch on very fast to the routine. But it is easier for me to learn things on my own, if I had a preceptor that did not let me have any patients I would find it harder to follow' (FG.PE.AK).

Although the following CRNs tried to emphasise the idea that preceptees were experienced practitioners in their own right and preceptorship had no effect on their clinical nursing care, the CRNs' comments indicated preceptees still lacked the necessary knowledge and confidence to pass the required competencies and/or to work independently.

'Actually his performance was really above average. His clinical experience was good. The only thing that he has not passed [is] the physical assessment competency' (FG.CR.RD).

'His performance since starting is OK; he managed to finish all his competencies in the timeframe. But the first day of his own independent work [after preceptorship], was too difficult [for him] to adjust' (FG.CR.AB).

The CRNs perceived that preceptorship could potentially facilitate skills acquisition. Hence, its' impact on improving clinical performance was dependent on various factors: the preceptees' previous experience and clinical background being one of them. For example, preceptees who lacked knowledge or were unskilled in a particular procedure and were exposed to such skills during the preceptorship period via training/teaching until they became competent, could potentially improve their clinical performance as indicated below:

'It depends on the preceptees' previous experience. Some [have] never [been] exposed to the equipment [we have] here. Getting enough training and teaching of specific procedure that they know nothing about till they become competent in doing it might enhance preceptees performance' (FG.CR.RD).

More importantly perhaps, the impact preceptorship had on clinical care was largely dependent on the preceptee's commitment to the role and what was expected from them as postulated by the following CRN:

'It depends on the preceptees' experience and their commitment to what they are here to do. There are people who do not like what they are doing, so if you don't like what you are doing, irrespective of what the preceptor does; it is not going to save the situation. So, some got benefit while some [did] not, not because of the preceptorship programme but because of the preceptees themselves' (II.CR.NG).

Additionally, the preceptees' clinical performance was also linked to their ability to settle down in their new role as the following nurse educator pointed out:

'If the preceptee does not settle down you can see it affect their performance in a certain way' (II.NE.SE).

Nevertheless, only four preceptees felt the preceptorship programme had a positive impact on their clinical nursing care. The latter was felt to be largely due to their preceptor having been a knowledgeable role model with whom they had established a good relationship. A situation that helped the individual gain knowledge and improve her practice as the following suggests:

'Definitely it helped to improve my clinical experience, because [on the] first day they taught us how to do the procedure, such as cannulation or phlebotomy. The second day we were practicing and they were supervising [and] if there were any mistakes they corrected us. Also they asked some questions. So, we got more knowledge from them. Sometimes we don't know how to do [a procedure] or maybe our answers are different so they are

correcting [us at] the same time. I think preceptorship is very important for our clinical experience' (II.PE.Mi).

Another preceptee indicated that the preceptorship experience had helped her gain insight into ICU:

'how the skills and procedures are done. It allowed me to practise these easily and safely.... especially [since] I come from India, [which] is [a] totally different background' (FG.PE.SU).

One of the preceptors, when reflecting on his previous experience as a preceptee agreed that preceptorship did have an impact on his clinical care:

'Yes it has [an] effect on the preceptee's performance, because it shows him how to do things in [a] safe way, and it happened to me when I came to this place for the first time. Let's give you an example, Zantac, in ER back home we dilute it in 80 ml and we give it IV slowly. Here the system is different, we have to dilute it in 50 ml and infuse it over 20 minutes. Therefore, if I do not show him this [although] he will not harm the patient but he [would make] a mistake because he [would not have] followed the policies of the hospital' (II.PR.TS).

One of the nurse managers also indicated that preceptorship had an impact on patient care as it precepted preceptees to the work routine, rules and regulations and guided their practice to help avoid making clinical mistakes. Hence, they were better able to deliver safe care to patients.

'Just think! If we did not have a preceptor programme the nurse would be lost because they come from a different country. Therefore, she needs to know [the] routine of our organization, [the] rules, regulations and policies to guide them and help them [to do] the right things and it affects patient care' (II.NM.SA).

Consequently, there was consensus among the study participants that preceptorship played a key role in helping preceptees gain confidence in their work and become competent in clinical practice.

'Preceptorship helped me a lot by orienting me to the ward; [it] showed me [the] unit routine step by step. I got confidence also, because my preceptor is very organized and he taught me everything. It really helps me a lot emotionally and physically.... I became competent in dealing with the doctors and carrying out their orders because my preceptor gave me a system, like a style to work properly without being stressed' (II.PE.AE).

4.4.3 Preceptors' performance

The impact preceptorship had on preceptors' clinical nursing care was clearly stated by all participants. Being a role model for preceptees encouraged preceptors to be theoretically and practically prepared for the role, adhere more closely to clinical

policies and procedures and deliver a high quality nursing care as the following quote illustrates:

'My performance improved because I have to be more focused, I have to do things well at least 99.9 % if not 100% because somebody is observing me... I have to be a role model, because what I am doing, he will do in the future so I have to teach him the right things, so it has an effect' (II.PR.IA).

Another preceptor reinforced this stating:

'of course [it] helps in contributing to good performance on the ward, especially for the preceptor' (FG.PR.CH).

The following nurse manager believed that preceptorship would enhance preceptor performance as the preceptor-preceptee relationship enabled the preceptor to exchange knowledge with the preceptees who were also considered experienced nurses. In essence, being a preceptor encouraged those carrying out the role to correct any mal-practices and discover new ways of working or develop new practices based on their interaction with preceptees.

'It [preceptorship] could enhance preceptors' practice because preceptees are experienced nurses. So, when the preceptors listen to the voice of experience, they could both ask and learn from each other, there is no harm in that. In this way, preceptors might get new skills' (II. NM. SM).

Another preceptor agreed with the above comments by saying:

'I have demonstrated to her [preceptee] what I did to the patient, and then asked her to tell me what is wrong with it or how I can improve it. So, I could evaluate her and exchange experiences' (FG.PR.DT).

Conversely, preceptorship also had the potential to negatively impact on the preceptors' ability to deliver the expected patient care because, during the preceptor individual and focus group interviews, preceptors perceived the time that was supposed to be spent with their assigned patients was required to be split between patients and preceptees. Therefore, it was difficult to juggle giving care with teaching within the time available.

'Really you have to do a lot of jobs, it [preceptorship] is very challenging job for us as preceptors, very challenging because meanwhile you need to take care of your patients and you have to see that everything is done for those patients at the same time you need to guide her [preceptee] in every little thing. So, it needs a lot of energy as it is difficult to effectively do that within strict time [limits]' (FG.PR.EP).

Other participants perceived that it was impossible to deliver the required level of care because of the workload and the fact that preceptors did not received support or

help from their peers in order to distribute the responsibilities, which made them feel guilty.

'Actually this is the problem, ICU is a very busy unit and preceptorship means additional responsibility. Sometimes I can't provide my patient with the care that is needed because I am busy teaching my preceptee and nobody can replace me which makes me feel guilty' (FG.PR.JT).

As a result, one preceptor suggested reducing the patient workload for the preceptor in order to carry out her/his dual role effectively, as illustrated below:

I agree with her, it is additional responsibility. So maybe we can suggest that whoever is doing the preceptorship might take only minimum patients' (FG.PR.EP).

4.5 Summary

In this chapter, three themes and their related sub-themes generated from the participants' individual and focus group interviews have been reported. The themes were: the meaning of preceptorship; time as a confusing and restrictive concept and the impact of preceptorship on preceptees' and preceptors' clinical nursing care.

The findings of this chapter demonstrated universal agreement from participants that preceptorship was a useful supportive, educational programme for newly hired experienced nurses. It helped to facilitate their integration and enhance their confidence within the new health care system. However, divergent views existed amongst all groups regarding what preceptorship really meant and how long it should continue due to the existence of confusing and ambiguous timescales being outline in the various policy documents. The findings illustrated that preceptorship was implemented and applied differently in the study setting for the following reasons:

1. Confusion regarding the meaning of preceptorship.
2. Confusion around the preceptorship period and its restrictive timeframe.

The notion of confusion regarding the meaning of preceptorship existed across all participant groups. Furthermore, some participants used the term preceptorship interchangeably with that of mentorship, while others used the term orientation. Given the interchangeability between the terms 'preceptor' and 'mentor' and 'preceptee' and 'orientee', confusion emerged regarding the role and responsibilities

of each party involved, with the exception of the role of nurse managers. Consequently, each member of the preceptorship team engaged in the required activities based on his/her own understanding of what preceptorship was deemed to constitute. This highlighted inconsistencies in terms of what programme stakeholders each expected from preceptees and what preceptees expected from programme stakeholders. In fact, the findings revealed that all preceptees expected to be taught about the required skills and procedures in order to be able to carry these out successfully.

As a result of the ambiguities that arose concerning the meaning of preceptorship, confusion emerged across all participants with the exception of preceptees regarding its duration, in terms of when preceptorship began and ended. In the policy documents, the official pre-determined preceptorship period was identified as eight shifts for shift workers and ten days for regular hour's workers. However, the policy documents referred to the latter as the supernumerary period.

The time available for preceptorship was perceived by all participants as restrictive and insufficient for building a trusting preceptor-preceptee relationship. However, it was unclear whether the time allocation was enough to meet the preceptorship requirements. The stated duration for some participants was enough while for others it was not. This latter notion was based on the following factors:

1. Ward needs and requirements (location)
2. Preceptees level of experience
3. Preceptees' needs and expectations
4. Expectations of programme stakeholders
5. Preceptees being new to the health care system
6. Preceptors role
7. Workload

Consequently, in the current study the time factor was seen as a complex phenomenon as there was no definitive answer regarding what participants felt the precise duration of preceptorship should be. This severely affected the potential for some preceptees' to achieve their needs, expectations and preceptorship objectives as well as working independently. Likewise, time was seen to affect all programme

stakeholders' abilities to carry out their role effectively. The reason for the latter deficit in practice was solely attributed to the time allocated for preceptees to complete a set of mandatory objectives prior to engaging in independent practice, as many participants considered this extremely restrictive.

Finally, as a consequence of participants' confusion regarding the nature of preceptorship in the study setting, some including preceptors, nurse managers, CRNs and nurse educators were unable to perceive whether preceptorship actually had any impact on the preceptees' clinical performance as this depended on the preceptees'

1. previous experiences and background
2. commitment to the new role
3. ability to settle down and integrate into the new system

Nevertheless, the findings indicated that preceptorship contributed to enhancing preceptees confidence and competence: in fact, some preceptees perceived the impact on care flourished when preceptees had a good relationship with their preceptor, as they tended to receive teaching and clinical guidance that was more appropriate from their respective preceptors. This latter action enabled preceptees to be both corrected and directed in their practice to act in accordance with the stated policies and procedures, which helped them, provide safer patient care. Conversely, a few preceptees, CRNs and one nurse educator expressed that preceptorship had no impact on preceptees' clinical performance as the latter namely the CRNs and nurse educator believed the goal of preceptorship was not focused on improvement of performance but rather on orientation and facilitating the preceptees' integration.

All participants agreed that preceptorship could positively influence the preceptors' clinical nursing care as they were seen as a role model for preceptees. Conversely, preceptorship also had the potential to negatively impact on the quality of care delivered by preceptors as preceptorship was seen to require preceptor's to split their time between patients and preceptees.

The consequences of all this confusion and inconsistency among the participants' perceptions was that the preceptorship programme in the study setting was not implemented as effectively as expected by the organisation. The programme's impact on the enhancement of the quality of nursing care in general was not always evident. Finally, it was concluded from the study findings that providing a concise meaning of preceptorship and clear statements regarding the roles and responsibilities of programme stakeholders as well as assigning sufficient time for preceptorship were important components for effective preceptorship.

In the following chapter, the three remaining themes are reported, which explore the factors affecting the success or failure of the preceptorship programme/process.

Chapter V
Factors Affecting Success or Failure of Preceptorship

5.1 Introduction

This chapter presents the remaining three themes generated following analysis of the individual and focus group interviews. The study participants highlighted these three themes as the most important factors influencing the success or failure of the preceptorship programme in the study setting. As a result, they have been included under one chapter entitled factors affecting the success or failure of preceptorship as they each inter-relate.

These themes include *Recruitment and its role in the success/failure of the preceptorship programme*, which comprises two sub-themes

- a. Adjustment to a new culture and
- b. Matching preceptees experience with the unit needs

The second theme highlighted encompassed *Preceptor preparation and selection*, which has also been further subdivided into two elements.

- a. Preparation and
- b. Selection of the preceptor.

The third aspect included *Support for preceptorship*, which examines the perception(s) of each group regarding the support they received from senior management/educators and/or colleagues and how this support influenced the preceptees' clinical performance. This theme similarly includes two sub-themes

- a. Nature of the support provided and
- b. Recognition and rewards.

As in the previous chapter, selected quotations from individual and focus group interviews have been presented as part of the findings to illustrate and give credence to the interpretations presented.

5.2 Theme four: Recruitment and its role in the success/failure of the preceptorship.

5.2.1 Introduction

During the individual and focus group interviews, recruitment was one of the topics raised by all participants without exception. Study participants perceived the recruitment process to be a factor, which affected the success of the preceptorship

programme. The following section explores the participants' experience of recruitment and the impact this had on the success of the preceptorship programme. This theme has been divided into two sub-themes: adjustment to a new culture and matching the preceptees' experience with the unit's needs.

5.2.2 Adjustment to a new culture

New staff were required to think about what was going on in the new culture as well as balance the situations they observed with the reasons they had for working in a new cultural environment. Consequently, they needed to decide whether they could adjust to the new clinical area by working effectively with other nationalities from the new culture and being able to transfer their experiences from one culture to another in order to become an effective member of the organisation.

The issue of adjustment to a new culture explored in this section is mainly focused on international nurses becoming aware of the Saudi context thus facilitating their adjustment to the culture and its health care system before their arrival. This sub-theme represented the participants' perceptions of the recruitment process in the Saudi context as this was felt to have a lasting legacy for staff retention.

The findings illustrated that all participants believed providing preceptees with important information about the new culture facilitated their effective integration and adjustment into their new role as one CRN pointed out:

'There is a culture perspective. So, it depends on the recruitment personnel, if they provide them [preceptees with] clear information about what is happening here, the newcomers will have no problem during the orientation week. So, recruitment has a big influence on the preceptees' passing or failing' (FG.CR.GW).

Sending accurate information to applicants before they arrived in Saudi was felt to be necessary to build up a better picture and more thorough understanding of the Saudi culture and healthcare system, to minimise the potential for culture shock. Thus, participants suggested that a reliable person who was knowledgeable about the Saudi culture should give this information to new recruits. One nurse manager expressed her experience as follows:

'When I first came, I had no idea about the dress code [of Saudi women], I know they wore abaya, but I didn't know how it looked. In my country it's coloured and we have Muslims as well but they are different. So, it took me a while to get accustomed to that. The other was the information I got back home [such as] they will not allow you to look

at or touch a man. These things were told to me by people who didn't have a proper understanding of the Saudi [culture], which starts from the recruitment agents. So, when I got here, as soon as I saw [a] male I would turn my head on another side because I was so afraid. But there was nothing wrong in talking to colleagues To tell you the truth, I had to bring water from home, I brought cornflakes and I was so ashamed because this is what I was informed and you wonder ... So, when I came here I already had a perception of it. So, the incorrect information has a certain degree of impact on your adjustment. That's something which must start from the recruitment' (II.NM.BE).

Consequently, it was suggested that such information should be well organised, be in written format, and distributed to applicants by the overseas recruitment agents as:

'... Resource material, booklets or something to say this [is] how the hospital is, because there are a lot of questions and there is no consistency in the answers given by many staff' (II.NM.BE).

Failure to provide preceptees with the necessary information regarding the work environment also had a potential impact on preceptees' adjustment to the setting as one nurse educator demonstrated when outlining the reaction of a preceptee when she informed her about the vacation policy.

'[I] told the preceptee "it's required to give 60 days' notice [before you apply for annual leave]". The preceptee said, "I have to give 60 days' notice before I can go on annual leave? Well if I had known that I would never had come." ... this person was really negative in class; took her negativity to the clinical area and informed every person she met on the corridor "Do you know I have to give 60 days' notice". So, it's just one example [of how it] affects the adjustment process' (II.NE.SG).

Consequently, all participants considered that providing such information about the organisation, its culture and the role requirements was the responsibility of the recruitment agents. Therefore, the recruitment process was perceived as one of the factors that influence the preceptees' ability to pass successfully the preceptorship requirements.

'If the recruitment has been done appropriately, then the person will probably pass. If the information has not been given to the preceptee and whatever factor has not been done, the person would have a most difficult time to pass the requirements, some would still pass but they would have a more difficult time. So, it depends on the recruitment and quality of information that they provide to the preceptees about the organization and everything here, including [the] culture' (FG.CR.GW).

Finally, matching preceptees' experience with the unit's needs was perceived by the participants as another responsibility of the recruitment personnel. This was considered by the participants as one of the factors that impacted not just on the success of the preceptorship programme in the study setting, but also its ability to retain recruits as revealed in the following section.

5.2.3 Matching preceptees' experience with the unit's needs

As indicated in chapter four, preceptees were recruited from various countries, some of which operated different healthcare systems and technologies from those followed in Saudi, and more specifically in the study setting. Furthermore, role requirements and job descriptions also varied from those preceptees were familiar with, in their home country. For example, UK nurses were not responsible for undertaking physical assessments for patients, while in the study setting, each nurse was expected to be competent in assessing her/his patients' physical status. Therefore, recruitment personnel needed to have considered the clinical background, professional skills and qualifications of preceptees. Matching preceptee qualifications and experiences with the clinical unit's needs was considered an important issue for the success of the recruitment process.

When this match was not achieved, the preceptorship process was disrupted prolonging the time needed to train those preceptees who lacked one or more of the nursing skills required as such skills had not been part of their natural repertoire in their previous employment. In such cases, either the CRN or the preceptor needed to rectify this skill deficiency. This type of training process was time-consuming for preceptees, preceptors and CRNs alike. However, had the preceptee's background been considered during recruitment, it is likely time would have been saved as the following CRN pointed out:

'They didn't consider that they hired her from a country where they don't cannulate and she came to the country where they cannulate. But if you look to the preceptorship period, part of it went in training her on cannulation and ensuring that she could cannulate' (II.CR.NG).

Furthermore, failure to consider the preceptees' clinical preference affected their psychological status, which challenged their confidence when performing clinical skills. Hence, the latter was a factor that subsequently affected their ability to integrate into the clinical domain and/or their new role. To reinforce this point, the following participants explained their experience with the recruitment process as follows:

'The person ticks and said my first preference is outpatient but they get recruited to another unit. If you find a person who had 10 years ICU experience recruited to a general unit, the morale of that person [would be challenged and], make him feel bad because he thought this was not what I am used to do. That really affects the preceptorship' (II.CR.NG).

I have been a dialysis nurse for three years and ... they allocated me to staff health. I am very upset, especially when I saw something I used to do... Dialysis unit is a big difference. I really want [to go to the] dialysis unit' (FG.PE.Sh).

I am a paediatric nurse. I should not be sent to adults because it is so different. I think they need to modify the recruitment system' (FG.PR.CS).

Assigning preceptees to a domain that did not match their clinical speciality or experience affected their ability to deliver the required nursing care, which subsequently influenced staff turnover, as the following nurse manager suggested.

Don't take nurses from staff health and make them work in theatre and ask them to scrub for a doctor. They are not going to stay. No matter how many preceptors they have, it is not going to work. Put the nurse to the job that they have been trained for. Don't assign them somewhere where they are not skilled or confident [to] carry on. I am here in staff health getting sick everyday because I don't like the department I am working in' (II.NM.SM).

Furthermore, lack of congruence between the clinical area's specific requirements and the preceptees' unique experience affected the preceptee's ability to fulfil the required competencies during the preceptorship timeline as expressed by following nurse manager.

I had 4 nurses who had no ER experience at all. ... they could not really [finish the] required competencies. The reason behind this was lack of knowledge and skills in some of these competencies regardless of the [clinical] experience they had. Some of those who actually failed to finish their competencies; they had no adequate experience in ER.... How has nursing recruitment recruited and assigned them to work in ER?' (II.NM.AM).

Another nurse manager recommended that the recruitment office should instead

'... Look at the way of recruiting nurses in terms of specialty and qualification, because when they accepted them, [there is] no way to reject them. They need to see how they can match the orientation and recruitment in order to help newcomers adapt easily to the system' (II.NM.AM).

As the effective recruitment of preceptees is important for developing efficient staff nurses, so proper preparation and selection of preceptors for guiding, teaching and supporting the preceptees are also important issues that need to be considered by the health care organisation if successful integration of preceptees is to be attained. Preceptor preparation and selection is therefore the next factor to be discussed below.

5.3 Theme five: Preceptor preparation and selection

5.3.1 Introduction

Preceptor preparation and selection was a further concern for study participants and was raised by them as one of the factors that impacted on the success of the preceptorship programme. Hence, the current theme examines in detail how preceptors in the study setting were prepared and selected for their role. Participants' perceptions of the quality of the preparation and selection process and factors affecting the preceptors' preparation and selection based on the participants' own experience are described in detail. In order to address all issues raised by participants the theme has been split into two sub-themes to address 1. Preparation and 2. Selection of preceptors.

5.3.2 Preparation of the preceptors

5.3.2.1 Educational preparation

According to the hospital's nursing administration department taking on the preceptor role was a responsibility that all nurses across the organisation were expected to fulfil (IPP 1). Therefore, each nurse was expected to be a preceptor to any new nurse allocated to his/her clinical area.

Preceptorship is a very good thing. But then everybody should be able to precept' (II.NM.SM).

'They [nurses] should all be preceptors. It's a teaching hospital; we knew that before we came here. So, they should all attend the preceptorship workshop and they should be prepared to work with the new nurses, they have got to be ready to [be a] preceptor' (II.NM.LI).

It [The preceptor role] is part of our responsibilities' (FG.PR.EP).

However, in order to have a general understanding of the nature of the preceptor role potential preceptors were required to attend a one-day preceptorship workshop. A booklet which the potential preceptors needed to read before they attended the workshop was sent from the nurse education department to each registered nurse one week before the workshop. During the one-day workshop, nurse educators

'...went through what they [preceptors should] have read in the book [to] teach them about precepting, [such as] the responsibilities of preceptors, preceptees, CRN, NM and nurse educators. We do role-playing at the first meeting about what we would like them to discuss... to improve their communication. [In the] afternoon we spend a lot of time on evaluation and when I do that I make a list of the things/areas they need to [focus on] during the preceptees' performance evaluation' (II.NE.SE).

By the end of the workshop, the nurse educator expected each nurse who attended to:

Feel confident when [they worked with] preceptees and not be scared because they lack knowledge, use the human resources [such as] CRN and NM to build up their knowledge. They should know the unit-specific procedures that preceptees should do... [The] preceptorship workshop helps them to become aware of what they are supposed to be doing; [therefore], all staff should attend it' (II.NE.SE).

Some participants acknowledged the benefit of the preceptorship workshop as it provided them with the necessary knowledge to help them successfully fulfil their role.

'[The preceptorship workshop] was very interesting; it gave us some information when we have new staff coming to the ward' (II.PR.IA).

It's [a] really helpful workshop, it gave a very good direction to the preceptors' (II.NM.AM).

However, one preceptor perceived the one-day workshop to be unhelpful as it lacked much of the information preceptors needed to understand what the preceptorship process was expected to achieve and the preceptor's role in that the latter as each preceptor followed her/his own preferred system of engaging with preceptees, as illustrated below:

It was one day, talking about preceptor and preceptee definitions but it was not going through the forms that we have to fill in or how they should be completed. They don't cover the system that we are doing here, how to receive the preceptee, what we have to do for them during the 8 shifts. We are not following the same system. Each [preceptor] receives the preceptees in a different way and follows his/her own preferred system and most of the time the preceptor faces difficulties about the forms that s/he has to fill in. So, I think [the workshop content] should be reviewed to give specific points and not teach everything in the same minute' (II.PR.TS).

Although the workshop was conducted for all nurses in the hospital, it was not available on a regular basis, which resulted in many nurses being unable to attend. Therefore, according to the policy, they were not qualified to take on the preceptor role.

My problem in OPD was that not all nurses had attended the preceptorship workshop because they don't run it too many [times] and whenever there is a slot it is fully booked' (II.NM.BE).

No-one can be [a] preceptor except if s/he has [attended] the workshop in the hospital' (II.NM.AM).

Furthermore, attending the preceptorship workshop on only one occasion affected the success of the preceptorship programme as most of the preceptors, CRNs and nurse managers had forgotten the preceptorship programme's requirements and related policies whenever they had subsequent preceptees.

I cannot remember how frequently we have to meet the preceptees because I took the preceptorship workshop in 2006¹⁵' (II.PR.IA).

Consequently, preceptors acknowledged their need to re-attend the workshop to update and refresh their knowledge in order to be a successful preceptor.

It was quite a long time [ago] and I need to repeat it again' (FG.PR.CH).

The following nurse manager therefore suggested that each nurse should attend a preceptorship workshop on a regular basis, for example annually and the content should always be updated to fit the needs of the preceptor, preceptees and organisation.

Instead of [attending] the workshop [once only]... It needs to be yearly and updated [because] times change, people change' (II.NM.SM).

Another nurse manager concurred with the above saying:

We need all staff to be involved in this [preceptorship workshop] and it should be done as a refresher course, [to] show the preceptors what it is all about' (II.NM.BE).

Accordingly, the preceptorship workshop was considered one of the factors that affected the success of the preceptorship programme as it was felt to be the first level of preparation for nurses' taking on the preceptor role.

To have a successful preceptorship programme, the preceptors have to attend the workshop. Don't get someone who hasn't done the workshop to be a preceptor because s/he would [not] know what is expected of her/him' (II.NM.SA).

5.3.2.2 Clinical preparation:

Clinical preparation was the second phase of preceptor preparation. Therefore, for the preceptor to be clinically and psychologically ready to receive her/his preceptee, preceptors should be informed by the nurse managers, before the preceptee arrives, that s/he had been selected to preceptor a new preceptee. Each nurse manager then discuss with the preceptor the preceptee's background and qualification(s), and provide him/her with the necessary information to enable him/her to carry out the preceptor role effectively and efficiently so that:

¹⁵ The fieldwork of this study was undertaken in year 2008

'Once the new nurse comes to the nursing education [department], they will call the preceptor to introduce [themselves] to each other. Then, they will give us all [the] checklist, report [forms], timeline of meeting AD¹⁶, CND¹⁷. They will tell us we will meet after 36 days, 56 and follow up. The CRN should be there' (FG.PR.CS).

Some preceptors acknowledged receipt of the above information from their nurse managers.

My nurse manager [has] already spoken to me that I will preceptor someone and he is from [the] Philippines' (II.PR.IA).

However, others were assigned a preceptee without having been informed, as the following preceptor indicated

I didn't actually realize that I was responsible for her until she asked me about the report that I have [to] write and I said "well if I don't see you do anything with me, I can't comment on anything" I just realized along the way, oh! I am responsible for this girl for the month that has passed and I didn't even know it. I was not appointed' (FG.PR.DT).

As a result of such actions some preceptors felt they were not properly prepared for their preceptor role. Furthermore, they recognized the need for further knowledge and information regarding preceptorship in order to fulfil their role.

Preceptors need more education [about] how to do [the] preceptorship summary [report]' (II.NM.SA).

I need more knowledge and information about preceptorship' (FG.PR.CH).

Accordingly, all participants perceived that inadequate or insufficient training for the preceptor was a factor that adversely affected the success of the preceptorship programme, as the one-day workshop was not enough to make them an effective preceptor as emphasised by the following nurse manager.

Lack of proper training for preceptors was a factor affecting the success of the preceptorship. You need to think, is one day enough to train a preceptor? Is one day enough¹⁸?' (II.NM.LI).

5.3.3 Selection of the preceptors

In the study setting, there were no specific criteria identified on which to base the selection of appropriate preceptors. Each nurse manager used her/his own judgment

¹⁶ AD: Associate Director

¹⁷ CND: Clinical Nursing Director

¹⁸ Underlined text indicates the participant's concern and emphasis (see appendix E, page 388)

to assign a suitable preceptor for each prospective preceptee. For example, one nurse manager believed that:

'When you choose the preceptor you really need to find somebody who has all the skills. For me the main thing I really want in the preceptor [is] to be supportive, very fair and honest, to look at the preceptee as a member of the team and to provide [an] honest and realistic report [on the preceptee's performance]' (II.NM.BE).

Others perceived that performance differences were important factors to consider during preceptor selection. However, implementation of these selection criteria depended on the availability of qualified nurses.

'Although preceptors have the same job description and the same responsibilities, they varied in performance. So, I need to look at all these aspects to assign those who I feel are very effective in the precepting so they will be [a] good preceptor. [Whereas], if I have less qualified nurses available for preceptorship, I have no choice but to [maximize my effort] to make sure that the preceptorship is doing fine for this particular preceptee' (II.NM.AM).

Whereas, the following preceptee believed that:

'The preceptor should have complete knowledge regarding the routine, [be] experienced and [able] to teach you the good things' (II.PE.AE).

Furthermore, some nurse managers perceived that the sound criteria for selection of a good preceptor were that the candidate had attended the preceptorship workshop and also possessed the knowledge and ability to teach.

'I choose a preceptor who has attended the preceptorship workshop, is able to teach, is knowledgeable and who could be a good role model' (II.NM.SA).

Conversely, some nurse managers considered that each nurse in their unit could be a preceptor and one stated that:

'[it was] not necessary for all preceptors to have attended the workshop' (II.NM.AN).

This resulted in two nurses in her wards included in the study being selected to be preceptors, even though they had not attended the preceptorship workshop. Nevertheless, some preceptors who had the required clinical skills did not have the necessary teaching skills to teach preceptees effectively, as indicated by the following nurse educator comment:

'Nursing administration feel everyone should be a preceptor. But, not all nurses are able to be preceptors; some do not have good teaching skills, they are not aware of all aspect of preceptorship' (FG.NE.SG).

Additionally, some preceptors were not willing to precept, as the preceptor role was an extra burden for them. Hence, when coupled with the limited amount of time

allocated to preceptorship and the requirement to retain a normal clinical workload, the task was considered unduly onerous.

I hate it [the preceptor role] because it's a burden, especially if you have your own things to do and you have specific time to finish these things. So, to be a preceptor was very difficult' (FG.PR.CS).

'Actually this was the problem, we don't have time to teach the preceptees, especially in ICU, it's [a] very busy unit. We can't teach them' (FG.PR.JT).

Conversely, others were happy to act as a preceptor especially if they had enough time to teach, as indicated below:

I like to teach, but [only] if my time allows' (FG.PR.BP).

Selection of multiple preceptors to look after one preceptee was another issue that impacted on the preceptorship process. According to the policy, two preceptors should be selected for each preceptee so that the second preceptor could cover the main preceptor in case of an emergency, as pointed out by the following nurse manager:

'Usually I select two preceptors in case the [first] one has to be away or was sick so the preceptee has somebody to fall back on' (II.NM.AN).

Nevertheless, the fact that two preceptors were used simultaneously to precept the preceptee disrupted some preceptees' learning. Moreover, some preceptees had three preceptors, which confused them even more as each taught the same procedures using slightly different techniques as the following participants highlighted:

'Staffing is not enough, we always tried to put at least 2 preceptors as back up' (II.CR.NG).

I have 3 preceptors' (FG.PE.Sh).

'What I found is 3 of us taught her the same thing but everybody has different techniques and this confused her. So, it would be better if there was one person teaching her the correct technique' (FG.PR.DT).

Shortages of qualified nurses also impacted on the preceptorship process. Hence, increased turnover was a further obstacle leading to inappropriate selection and/or preparation of preceptors. As the shortage of nurses is likely to escalate in the future in parallel with the unit's workload, more preceptors without the necessary educational preparation and teaching skills are likely to be selected to fill this position as the following quotes illustrate:

Nurses left all at one time and others were coming towards the end of their contract. So, when nurses were brought in, basically, there were only 4 experienced nurses in the unit. So, if there are 4 experienced nurses and there are 6 being replaced who need to be preceptored, [together with] interns and student trainees ... sometimes you can't give the trainees what they really deserve' (II.CR.NG).

I have 7 left, 2 on leave so I have 5 [on the floor], I have got 4 coming next month so I have 1, 2, 3, 4 and the 5th person is probably the one that has got the intern and I will be on leave next month. Who is going to be there to facilitate all of their needs, to do their mid probation report, to make sure they are on track, to decide this preceptee needs a development plan? When I come back the report is going to be due. We don't have enough qualified nurses to do that.... I mean how are you going to assign 5 nurses to 10 people? How are you going to assign all these grades to the 5 staff you have? The manpower is not there and you don't have the CRN in this ward because the CRN is busy in another ward. The programme would work better if there were more [human] resources available in the units' (II.NM.LI).

It [attending the workshop] depends on the time and the staff I have. Those [nurses] who had attended may have left the hospital and I [am] left with nurses who don't have a chance to attend because the preceptorship workshop is not something that happens every 2-3 weeks and neither do the staff get time to attend because if I am short [of staff] I cannot allow so many nurses to go. Some nurses just do it because they want the 8 hours study ...or a certificate out of it, while they don't use it effectively' (II.NM.AN).

In summary, all key stakeholders as well as some preceptees highlighted preceptor preparation and selection as a significant problem requiring the attention of the organisation. Thus, participants perceived preceptor preparation and selection as an important factor for ensuring effective implementation of the preceptorship programme. Hence, the study findings illustrated that most preceptors were not adequately prepared either educationally or clinically for the preceptor role due to a shortage of qualified nurses associated with high turnover. The content of the preceptor preparation workshop was also not adequately organised as it did not pay sufficient attention to preceptee, preceptor and/or organisational needs.

The findings also revealed that no specific criteria were used to select preceptors and some even lacked the necessary teaching skills. Within the literature there appears to be consensus that the role of the preceptor includes the need to teach and shape the preceptees learning during the preceptorship period to help them settle down in their new role (Gleeson 2008, Hardyman & Hickey 2001). This role needs the preceptor to be adequately prepared clinically, theoretically and psychologically (Kaviani & Stillwell 2000), although from the evidence presented here this did not always take place in the study setting. However, in order for

preceptors and other members of the preceptorship team to carry out their role effectively they also felt they needed considerable external support from other team members as revealed in the following section.

5.4 Theme six: Support for preceptorship

5.4.1 Introduction

Support is one of the essential elements for successful preceptorship (Duffy 2009). Therefore, an unsupportive preceptorship programme could be an unrewarding experience for both preceptees and preceptors (Myrick & Yonge, 2005). This theme aims to explicate the participants' experience of the support they received from their colleagues and senior personnel during the preceptorship period in the study setting and how this support impacted on them. Accordingly, two sub-themes are also discussed. These are the nature of the support provided and the rewards and recognitions associated with the preceptor role.

5.4.2 Nature of the support provided

The study participants strongly believed that support was important for the success of the preceptorship programme. More importantly, they perceived administrative and peer support for preceptees and preceptors inspired them to achieve their role effectively, as illustrated below:

'The thing that makes the programme successful was the support from higher [personnel]. Support from the people around you and from your big, big boss make the people, especially preceptors and preceptees, work hard' (FG.PR.CS).

'Actually, both of them [preceptors and preceptees] need support' (FG.CR.RD).

During the fieldwork, it was possible to identify different types of support demanded by preceptors and preceptees during the preceptorship period. First, administrative support from clinical nursing directors (CND) was required, to let those engaged in preceptorship feel that someone was concerned about them, recognized their role and appreciated their presence. Second, support from nurse managers was also considered valuable as a backup and/or reference point in the event of any clinical, financial and/or social problems that may emerge. Third, educational and clinical support during the preceptorship period was required from CRNs, peers and fellow preceptors, in order to help the allocated preceptor carry out his/her role effectively, facilitate the preceptees' training and enhance their integration into the clinical area within the assigned timeframe. However, CRN support for preceptors and

preceptees was not seen as limited to educational support, but the management of conflict, which constituted psychological support, especially

'when a misunderstanding, disagreement or problem [arose] between the preceptor and preceptee, I offered my support, tried to [get it] sorted out before it [went a] step higher' (FG.CR.GW).

5.4.2.1 Support for preceptees:

Emotional support was recommended for preceptees by all participants, given they were new employees who had left their families to engage in a very different culture and health care system. Some preceptees had no friends or relatives to talk to especially when experiencing difficulties or depression; so, emotional support was identified as the most common form of support offered to preceptees during the preceptorship period.

'Emotional support was the best support I gave. Because I have experienced that, if I felt depressed, I felt awkward. So, for me the best support during preceptorship was moral and emotional support' (II.PR.CH).

'During orientation, we supported the preceptees emotionally, we sat with them and talked, especially if it was their first time, they were overwhelmed with all the information, with the culture, and traditions. So, we have had coffee during break time. I gave them my number to call me if they need anything at any time. I asked them if they have other people living with [them] such as friends to go for shopping as a group. If no, I offered my services. So, when I went somewhere I asked them to come along so we can go together like that. Really they need help' (II.NE.SE).

Emotional support for preceptees was provided by letting them feel accommodated, accepted as a staff member, and that somebody was there to help them feel comfortable in their clinical environment, especially when dealing with colleagues or their preceptor as demonstrated by the following comment:

'[I] opened discussions not related to work to let him feel close to me, made him understand that I am here to help him not to judge him. I am here to show him the way, to let him break the ice between me and him. This was the best support that I [gave to] the preceptee' (II.PR.TS).

The following preceptee acknowledged the importance of the emotional support she received from her preceptor, CRN, and nurse manager:

'They were very supportive, very welcoming and they gave you a better feeling about going into work. When I started work my manager has been supportive... If you need something she runs off and finds it. As a new member of staff it's nice that people actually know that you are there. Yes, she has been lovely' (FG.PE.RE).

Furthermore, one preceptee acknowledged the nurse manager's awareness and appreciation of the preceptee's feelings as new employees, and clear direction from the CRN was a useful support mechanism by increasing the preceptee's confidence.

My nurse manager was very supportive; she understood that I am a new nurse in the Kingdom. She gave me [the] confidence to do my job when I talked to her. She was very supportive, very supportive. My CRN [helped] us, understood what [to] expect and how [to] deal with it' (FG.PE.Vi).

Moreover, frequent checking and follow-up by preceptors, nurse managers and CRNs made preceptees feel emotionally accommodated, as well as clinically and educationally supported. Nevertheless, not all colleagues were helpful as indicated in the preceptee comment below:

'.....Colleagues, I can tell you frankly, we have our own different behaviours, some of them supportive, some not. Some of them are pretending [to be] busy while some were really busy and can't help' (II.PE.AE).

Although the following preceptee recognized his nurse manager's administrative support, he claimed that he received no educational support from his CRN.

'The nurse manager has been helpful in more than one way, helping to sort out salary and also was supportive with any issues I have had. CRN hasn't really taught me anything' (FG.PE.RR).

The above claim was confirmed by the following CRN who said that due to a lack of human resources, preceptees did not always receive as much support as they should have.

'I am sure there is more [that] could be done for them. It's easy to support people when there are resources. We are trying our best but' (II.CR.NG).

5.4.2.2 Support for preceptors:

As stated earlier, heavy workloads prevented preceptors from carrying out their role as effectively as possible. Patient workload, managerial responsibilities and the limited preceptorship period were all factors impacting on the quality of the preceptor-preceptee relationship and with it the teaching and learning process. Therefore, providing appropriate support for preceptors in order to fulfil the preceptees' learning needs was crucial. To achieve this, preceptors:

Need[ed] to have more time and take on less acute patients so they can spend time with the preceptees. [For example] if the preceptor had a very sick patient, she may not have time to spend with or assist the preceptee. So, by assigning her to the [less acute] patients where she can spend more time, it might help them focus on what they want to do and may

encourage them to be more vocal to tell you what is going wrong and to have a better interaction between both sides' (II.NM.AN).

One preceptee agreed with the above suggestions.

Preceptors need ... just a couple of patients so she has that free time to go through the boxes that we are supposed to know and get all that work done' (FG.PE.RE).

Hence, one CRN felt it was important to offer her support by being

'available in the unit. So, [I] assisted them [preceptor and preceptee] in the procedures, [helping] the preceptor to relieve some of the stress from their shoulders and to support the preceptee, especially [since] some of the preceptors were in-charge, so they couldn't give all their time to the preceptee' (FG.CR.AB).

Moreover, educational support in the form of updating preceptors about new policies, guidelines or information, which could help them in their role, was felt to be important. For this reason, some preceptors valued the managerial, educational and clinical support received from their managers, CRNs and peers as outlined by one of the preceptors:

In our unit, our nurse manager, and CRN helped a lot. During preceptorship, they gave me one patient. So, I could have more time for teaching my preceptee. My colleagues also tried to help in teaching the preceptee, especially procedures' (FG.PR.JT).

Conversely, some preceptors perceived the support they received did not match their demands or expectations since they needed practical support to help them pursue their preceptor role and facilitate the preceptees training rather than simply providing verbal support.

We receive support by words, no practical support. Like taking [fewer] patients to find time to orient the preceptee. So, I can't say that I received support because when I was [a] preceptor nobody [helped] me to train my preceptee effectively, neither nurse manager nor CRN nor colleagues' (II.PR.TS).

For me I didn't feel any support from anyone' (FG.PR.BP).

Moreover, support for preceptors from nurse educators during the preceptorship period was also not always apparent, as exemplified below:

I haven't received any support from nurse educators since the first time in my role as preceptor' (II.PR.IA).

5.4.2.3 Support for CRNs and Nurse Managers:

CRNs and nurse managers as members of the preceptorship team also needed support, in this latter case, from Clinical Nursing Directors (CNDs) in order to facilitate their roles and responsibilities towards preceptees and preceptors.

'The nurse managers and CRNs need support from CNDs; you know things change from one month to another. For instance, paperwork, forms, everything changes' (II.NM.SA).

CRNs and nurse managers verbally acknowledged support received from their CNDs, although this only seemed to be available upon request. Despite this verbal acknowledgement of support, during the interviews participants' non-verbal cues such as head shaking, questioning of other participants by raising eyebrows while another talked about the support received, indicated the opposite, suggesting that in reality support was not received. For example, the CRNs and NMs pointed out that there were no regular meetings with CNDs to discuss issues related to preceptorship or preceptee progression and there were not provided enough time to teach, observe and assess preceptees performance. Yet this lack of dialogue with CNDs had a negative impact on preceptees' feelings of security and success as the following CRN and nurse manager pointed out:

'Whenever we have a preceptee, we don't have a standard to meet regularly to make sure that everything is going fine and discuss the preceptee's progression. Therefore, whenever we meet, the preceptee [is] scared; s/he feels there is something wrong and might not pass the preceptorship period' (FG.CR.AB).

'You know...the problem is that I don't have enough time to be with my preceptees to observe and evaluate the progress of her/his clinical performance. I need the CND's support to give me enough time to do all these stuff effectively and then sign off the required evaluation documents' (II.NM.SM).

However, one CRN not only experienced good levels of support from the nurse manager and CND but also from the physicians.

'In my unit, there is [a] good relationship between the nurse manager, [and we] had [a] weekly meeting regarding preceptees. Physicians ... also supported me and they did in-service with me. I also have had support from CND' (FG.CR.MB).

Contrary to the above, another CRN perceived that CND support did not exist since they tended not to be

'actively involved when we have preceptees. I think [it] would be best if we could sit together and everybody voiced what was going on' (II.CR.NG).

'The clinical nursing director just signed the final probationary report. There was no way to have an appointment and say I just need to hear from you how you feel' (II.NM.BE).

5.4.2.4 The impact of support on preceptorship:

There was agreement amongst the majority of participants that support contributed to the preceptorship programme's success, particularly if it met preceptee's needs:

'Support will contribute to the success of preceptorship if it matches the requirements of the preceptee. But if the support does not match, that means the results will be negative' (II.NM.AM).

Support from the preceptees' perspectives included encouraging them to become actively involved in the system by asking questions; participating in open discussions and verbalizing their needs. This helped them integrate into their new role, enhance their clinical performance and, subsequently, reduce turnover as the following quotes illustrate:

'I felt somebody was there, so I asked questions and got help if there was a problem' (II.PE.SU).

'When I asked my nurse manager 'what is this? What is that?' [He] said relax, take it easy. So, I felt that they were there to support because the way he spoke encouraged me to work much better' (II.PE.AE).

Although peer support had an impact on the preceptees' and preceptors' performance, their negative criticisms or judgments had the opposite effect as the latter were considered to be destructive factors that impacted negatively on performance and made individuals feel less confident, as the following participants pointed out:

'[The] support of my colleagues really makes a lot of difference [to] me. But their criticisms disappointed me because they underestimated me ...' (FG.PE.Sh).
'Some of them annoyed me, they observed me as if they were just looking for my mistakes, [I] was disappointed and [it] made me afraid' (II.PR.TS).

Likewise, the impact of support from the CRNs could be both negative or positive experiences; the positive aspect has been highlighted above. The negative impact is explored below in that the CRNs felt the negative aspect of support made preceptees more dependent on the CRN and thus less responsible and accountable.

'If you follow and support the preceptee for [a] long time, they take it that whenever they have to do any procedure you have to be beside them... Have someone with them, they feel confident but they can't do it alone' (FG.CR.AB).

'... Some people really got intimidated by the presence of another person. But some get benefit from that because they think that any problem shared by two is a problem halved' (II.CR.NG).

5.4.3 Recognition and rewards

Rewarding preceptor's clinical expertise and the contribution they made to the success of a preceptorship programme by training and supporting preceptees was felt to be a form of support the organisation needed to recognize (NNRU 2009). Recognising and rewarding preceptors in the study setting was discussed and recommended by all participants as a way of making preceptors aware of their value to the organisation and that they were appreciated as the following CRN and NM indicated:

I would really like to see the preceptor appreciated, because precepting a person is not such a burden, if you feel you have done something that someone else appreciates, it boosts your self-esteem and it really makes you feel 'I am a better person' and that is what you want to create' (II.CR.NG).

It [the organisation] needs to highlight preceptors and recognize what they are doing. Recognize that they are valuable, because they are the first real support link in the unit. So, they need to be recognized more. I mean not only a certificate; it should be more' (II.NM.LI).

However, for the preceptors to be rewarded with even a certificate from the organisation would have been enough for some as a token of appreciation.

I think for preceptors, I think they [the organisation] should give some sort of appreciation like a certificate which I don't think they have ever done. This gives you a good motivation. No doubt it's only paper, but it means a lot for us and it goes into your file which is good' (FG.PR.EP).

Another preceptor concurred with the above

I agree with EP, I can't count how many appraisals I got for the 6 years that I have been working here. But I have never been appreciated even when recently re-contracted never ever mentioned even verbally. For me just a certificate, so that when I get out of the place I have something in my file' (FG.PR.CS).

The first preceptor quoted above explained her feelings when her nurse manager recognized her efforts towards the training of the preceptee and the impact this had on her morale and self-confidence, especially when the nurse manager complimented her in front of the CND.

My nurse manager said 'I am very proud of you because your preceptee is very happy with you and she has told this to the CND. So, that [boosted] my morale very much... that is good motivation and it's good to have an appraisal that boosts your morale' (II.PR.EP).

In summary, support was emphasised by all study participants as an important factor for making the preceptorship programme successful. Although each group highlighted their need for support, they all stressed the importance of supporting

preceptees and preceptors. The importance of rewarding preceptors and recognising their role in the preceptorship programme was strongly underlined and seen as vital to the success of the preceptorship process by each of the key stakeholders within the study setting. Similarly, the notion of support it was similarly emphasized within the literature as important not only for the success of such programmes but also for facilitating staff retention and improving recruitment rates (DeCicco 2008; Nelson *et al* 2004).

5.5 Summary

In this chapter three themes relating to factors affecting the success or failure of the preceptorship programme in the study setting as illustrated by the participants, have been examined. Recruitment, preceptor preparation and selection, support for preceptorship have been explored. Findings are summarised as follows:

1. An effective preceptor workshop was one of the components felt to be necessary for the successful preparation of preceptors, as it guided, taught and directed each prospective preceptor as to the nature of his/her role in the programme. However, for most stakeholders, the content of the current workshop was too broad and not focused on the preceptors' role or needs, and one day of preparation was not felt to be enough to comprehend the role successfully. This affected the ability to build trustful relationships with preceptees or provide the necessary training and education to secure the success of the preceptorship programme.
2. Clinical experience of the preceptor alone was not enough to prepare nurses to be effective preceptors, as the ability to teach was also necessary. Some preceptors in the study setting were felt to lack the necessary teaching knowledge and skills, which impacted negatively on the preceptorship process.
3. For most preceptors, a shortage of qualified nurses and insufficient time to fulfil the preceptor role gave rise to a reluctance to assume the preceptor role and negatively influenced the success of the preceptorship process.

4. The absence of specific criteria for allocating preceptors to preceptees rendered the allocation process *ad hoc* and inconsistent.
5. All participants perceived that preceptors needed more support and direction in the clinical area in order to be clinically prepared to receive and work with their respective preceptee. Additionally, the preceptor role needed to be consistently recognised and rewarded by the organisation.
6. Although preceptees in the study setting received emotional and psychological support, the clinical and educational support needed to prepare them to work independently and facilitate their integration into the new role was lacking. Such support was absent for several reasons:
 - a. lack of human resources resulting in heavy workloads for both preceptors and preceptees;
 - b. a limited preceptorship period; and
 - c. lack of understanding of the term preceptorship by participants, coupled with a lack of role clarification.
7. Each party involved in the preceptorship programme needed support from their senior personnel in order to perform their role effectively and efficiently. Preceptees, as newly hired experienced nurses, need emotional as well as educational support. According to some preceptees and preceptors, support was not effectively delivered, or did not always meet their needs.
8. Recruitment, unexpectedly, was found to impact negatively on the success of the preceptorship programme. Preceptees' lack of awareness regarding the Saudi culture, coupled with a lack of accurate information about the culture before their arrival, severely impacted on the preceptees' ability to settle in. The factor that had the greatest impact on a preceptee's ability to accommodate to the new culture, however, was whether the recruitment agent ensured that there was a match between the preceptee's area of clinical expertise and their allocated work domain on arrival at the hospital.

Consequently matching unit needs with the preceptees' experiences and qualifications was considered vital for the preceptees' successful development

and subsequent job satisfaction. Hence, this factor exerted a significant impact on the preceptees' willingness to learn, which subsequently influenced their ability to integrate into the new role and ultimately to be retained in the new healthcare system.

5.6 Overarching summary of the two findings chapters

This study aimed to explore the nature of preceptorship and its impact on clinical nursing care as perceived and experienced by four groups of nurses: preceptees, preceptors, nurse managers, clinical resource nurses and nurse educators. The study highlighted:

1. what took place during the preceptorship programme;
2. what preceptorship meant to participants;
3. what participants expected of preceptorship;
4. what factors influenced the success or failure of preceptorship; and
5. what impact preceptorship had on the preceptees' or indeed the preceptors' clinical nursing care.

The analysed data from individual and focus group interviews revealed six major themes relating to the participants' perception of the experience of preceptorship. The study findings revealed that all participants considered preceptorship important, as it enabled them to gain the requisite knowledge and skills regarding their new role to help them settle down in an unfamiliar environment and safely perform their new role. Furthermore, prior to the preceptorship programme, preceptees expected to receive appropriate support, teaching and guidance from their preceptors and nurse managers to facilitate their integration into the ward team.

Although all participants acknowledged the importance of preceptorship, seeing it as a supportive, educational programme, lack of clarity regarding the meaning of preceptorship was manifest amongst all parties with the exception of preceptees. This affected the understanding of the roles and responsibilities participants were each expected to play. In the study setting, 'preceptorship' was used interchangeably with the terms of 'mentorship' and 'orientation', despite differences between the three terms in relation to the objectives, duration and focus/purpose of the

preceptorship programme. Furthermore, participants showed confusion regarding the duration of the preceptorship period.

Restriction of the preceptorship period regardless of the preceptees' needs, in addition to increased workload and a shortage of nurses made some participants feel insufficient time was allocated for the fulfilment of the preceptorship requirements. Hence, some preceptees needed more time in order to gain basic competence and complete her/his new role independently and safely.

The limited time period that was officially allocated to the preceptor-preceptee relationship was considered by all participants to be inappropriate as it influenced the preceptors' and CRNs' ability to offer the type of effective education and teaching, they felt each preceptee deserved. Thus, not all preceptees were able to work independently by the end of the designated preceptorship period. Conversely however, others felt their expectations were fulfilled as they had been lucky having experienced good teaching, guidance and support from preceptors, nurse managers and colleagues; a factor that was seen to impact positively on their clinical nursing care.

More worrying perhaps was the notion that some preceptors themselves did not feel prepared for their role as they lacked the necessary knowledge, teaching skills, and educational support from nursing educators to prepare them for the role. More specifically the preceptor role was considered by some to be a burden, especially when appropriate support from colleagues, managers, the organisation or all three were lacking. Hence, issues related to staffing and workload was seen either as factors that contributed negatively or positively to the preceptorship programme in the study setting.

However, a key factor identified as negatively affecting preceptorship was the efficacy and quality of the recruitment process. The latter was an unexpected finding that ultimately needs to be considered by the organisation, as it was felt to have the potential to exert a significant impact on the preceptees' ability to learn, integrate into the new clinical environment and provide the level of nursing care that the organisation expected. Hence, this study has exposed a previous gap in the existing

literature by exploring how newly hired experienced nurses and programme stakeholders perceived preceptorship, and by examining the impact preceptorship had on the clinical nursing care provided by both experienced preceptees and preceptors.

In the following discussion chapter, the study findings are discussed in relation to other research in order to derive and identify areas of similarity and difference and finally to discuss the study's trustworthiness and limitations.

Chapter VI
Discussion

6.1 Introduction

In this chapter, the main study findings regarding key factors considered crucial for ensuring the effective implementation of a preceptorship programme are presented and examined in relation to the research questions. The findings will also be compared and contrasted with the existing literature regarding the preceptorship of newly qualified and new graduate nurses. Social learning theory has also been used as an explanatory framework for better understanding of the findings that related to the preceptorship process and the extent to which it enabled newly hired experienced nurses (preceptees) to develop their professional practice by drawing on the participants' perceptions. In addition, as part of this discussion, the potential impact of this study within a wider theoretical context has been examined.

The reason for choosing social learning theory as an explanatory framework for understanding of the study findings was derived from the fact that learning, in both social learning theory and preceptorship, is perceived as a social activity. In both cases this social activity is shaped by modelling and the principles of vicarious learning to bring about cognitive and behavioural modification in learners (preceptees) (Kim 2007, Bahn 2001, Bowen & Carline 1997, Bandura 1977). Social learning theory was felt to be the most appropriate explanatory framework to draw on in order to illuminate how preceptees integrated into the new setting, learnt new knowledge and developed new behaviours via observation and interaction with role models. Thus, in order to set the scene for this chapter the following section provides a brief overview of social learning theory.

6.2 Social learning theory

Social learning theory has its origin in behaviourist theories, originally developed by James in 1890 (Smith *et al* 2003, Chadee 2011), it was considered a mainstream learning theory by the 1940s. Theorists had begun to criticise behaviourism for its inadequate explanation of the learning process (Smith *et al* 2003, Chadee 2011). Thus, social learning theorists highlighted that people learn by observing others' actions, which is then reinforced by observing the outcomes of these actions following interaction with the environment itself (Miller & Dollard 1941). In addition social learning theorists also recognised the role of motivational factors, which include internal factors designed to encourage individuals to imitate the action observed

when similar situations were encountered in the future. Hence, social learning theorists focused on cognitive-behavioural approaches, by examining the interaction between thoughts and actions (Bahn 2001).

The most well known social learning theorist is Bandura hence; it is his theory that has been drawn on as part of this thesis. Although social learning theory has developed over time, initially it focused on learning acquired via imitation before being broadened out to incorporate cognitive concepts (Braungart & Braungart 2008). More recently, the theory has been developed further to incorporate the impact of socio-cultural aspects (Braungart & Braungart 2008). Essentially therefore, social learning theory combines elements of behaviourism and cognitive psychology, which comprises three central concepts: role modelling, reinforcement and cognitions (Braungart & Braungart 2008, Bahn 2001, Bandura 1977). These concepts are explored individually in the next sections.

Role modelling

Role modelling is one of the central concepts of the theory (Braungart & Braungart 2008). Social learning theorists suggest people learn through observing others' attitudes and behaviours, and by assessing the consequences of such behaviour in order to inform their future actions (Abbey *et al* 2010, Bandura 1977).

Role modelling, in social learning theory consists of a four-stage process, which ultimately determines whether learning is effective (Bahn 2001, Bandura 1977). These steps are:

1. **Attention:** in order for people to learn, they need to pay attention to the modelled behaviour. This process involves both the intake of sensory information and self-directed exploration (Bandura 1986). However, various factors may enhance or diminish a learners' attention which in turn may positively or negatively impact on the modelling process. For example, high status, competent role models are more likely to be observed and thus taken notice of. However, the learner's needs, competence and self-esteem may also play a more important role in bringing about a change in behaviour (Braungart & Braungart 2008). In addition, in the context of nurse

education, Hislop *et al* (1996) outlined the significance of competing demands in respect of the learner's attention within the ward setting, in particular, where the demands of a ward's routine lead to a learner focusing on practical tasks rather than exploration.

2. **Retention:** in order to learn, people also need to retain information. Retention works by using words, labels or imagery to code the modelled behaviour, in order to enable the individual to hold it in his/her memory before it can be reinforced by rehearsal and repetition (Bandura 1977). Nevertheless, retention is affected by a series of intrinsic and extrinsic factors. For example, the learners' perceptions of the relevance of a particular behaviour may affect retention and with it learning. In addition, retention of the modelled behaviour is thought to be more effective if learners code the input whilst observing it, rather than just watching or being involved in other activities (Bandura 1977).
3. **Reproduction:** in order to learn, coded information needs to be converted into tangible actions if the learner is to be able to copy the observed behaviour in the future, and not have to be repeatedly shown what to do. The use of mental rehearsal, immediately copying the behaviour and constructive feedback all strengthen the reproduction of learning (Braungart & Braungart 2008). Thus, for behaviour to be reproduced, corrective, informative feedback from the role model is important because individuals cannot observe their own performance and therefore they need information in the form of feedback so that self-corrective adjustments can be made (Bandura 1977).
4. **Motivation:** the individual needs to be motivated to learn and imitate the modelled/observed behaviour. This motivation can be either intrinsic or extrinsic. The latter infers performing an activity for external rewards and implies a lack of personal interest. When extrinsic reinforcement is the primary mode of reinforcing the message there is a possibility that this might reduce intrinsic motivation (Bandura 1977). Hence, reinforcement and

punishment play a significant role in whether a learner wants to learn or opts out of the learning process.

Reinforcement process

Reinforcement is the process whereby people develop an internal representation of what behaviours should be engaged in, to bring about learning, and with it a change in behaviour via a process of observation. In order for observational learning to take place however, social learning theory suggests that there are three methods of reinforcement: direct external, self-administered and vicarious (Bigge 1982, Bandura 1977).

1. **Direct external reinforcement** occurs when people regulate their actions based on direct feedback. Hence an action may be enhanced or eradicated depending on what outcome an individual experiences whilst engaging in the new behaviour (Bigge 1982, Bandura 1977).
2. **Self-administered reinforcement** occurs when individuals regulate their own behaviour based on the outcomes they generate for themselves, responding to their own actions by self-rewarding or self-punishing (Bigge 1982, Bandura 1977). The ability to develop self-administered reinforcement is considered to give the capacity for self-direction (Bandura 1977).
3. **Vicarious reinforcement** is the process of changing behaviour based on the observed actions of others and on the perceived outcome of such behaviour: namely whether this is seen as a reward or punishment (Braungart & Braungart 2008, Baggie 1982, Bandura 1977). Thus, the person engaging in the observation uses his/her judgement to decide whether or not to emulate the observed behaviour in a similar situation depending on their incentive and motivation and on what they see as the probable consequences of repeating a given behaviour. Accordingly, social learning theorists concluded that learning via direct experience could occur by watching others' behaviours and making a note of the consequences such behaviours invoke to either reinforce or eradicate what has been learned.

Cognition

Social learning theory also has a cognitive purposive focus based on two cognitive principles (Sinclair & Ferguson 2009, Braungart & Braungart 2008, Bandura 1986). These are: self-regulation and control, and self-efficacy.

1. **Self-regulation and control** is the process through which people can control their goal-directed behaviours. This process involves three steps: self observation, judgement and self response (Bandura 1986, 1977). In self observation, people look at their action and keep track of their behaviours in order to maintain standards, which can either be externally or internally reinforced. In making a judgement about how to behave, people contrast the self-observed behaviour with the standards/rules that are usually set by the organisation or by themselves. Self-response is the process of self-administered reinforcement described above (Bandura 1986, 1977). For example, a person is able to control his/her behaviour in an appropriate way via a process of self-regulation after having observed behaviours that have been deemed appropriate in a given situation. These observed behaviours can later be drawn on in order to reproduce those behaviours perceived to produce the desired consequences or achieve the stated goals.
2. **Self-efficacy** plays a key role in social learning theory; this refers to an individual's sense of self confidence towards the learning process and the learner's ability to perform certain actions. Hence, it is the process whereby behaviour changes in small stages to guarantee achievement (Sinclair & Ferguson 2009, Braungart & Braungart 2008, Bandura 1986). Self-efficacy is usually strengthened by personal, emotional and physiological factors and by feedback from others (Sinclair & Ferguson 2009).

Social learning theory attempts to explain how people learn by viewing the learning process as a continuous reciprocal interaction between personal, behavioural and environmental factors (Abbey *et al* 2010, Sinclair & Ferguson 2009, Staddon 1984, Bandura 1977). Nevertheless, the relative influence of each interdependent factor varies across different settings. Thus, the same behaviour may produce different outcomes, depending on the time, place and persons involved (Bahn 2001, Bandura

1977). In addition, the outcomes of behaviour have different functions in that they are able to:

(1) impart information as a guide for action; (2) provide the intervening influence of thought; (3) motivate the person through their incentive value; (4) provide anticipatory benefits and averters of future trouble; (5) bring remote consequences to bear through the person exercising anticipatory thoughts; and (6) give rise to examples and precepts that delineate standards of conduct that serve as a basis for self-reinforcing actions (Bigge (1982) p.161).

Social learning theory has been applied in various nursing educational studies (Sinclair & Ferguson 2009, Kane-Urrabazo 2006, Goldenberg *et al* 2005, Maag 2004) as it helps to explain student behaviours and understand how self-efficacy, confidence and the ability to perform nursing care can be enhanced through social interactions that place during vicarious learning processes.

Social learning theory is therefore, a useful means of exploring the social aspect of nurse education as much of the learning that takes place in nursing occurs within a social environment. Nevertheless, although social learning theory has been acknowledged as recognising the complexity of both the learning environment and the learner; it has been criticized by others (Braungart & Braungart 2008, Bahn 2001, Callery 1990, Staddon 1984). These criticisms have suggested social learning theory is difficult to apply when attempting to analyse the interaction between an environment and the persons operating within it (Callery 1990); more specifically models of interaction are poorly defined (Staddon 1984); and the theory is difficult to action, assess and measure (Braungart & Braungart 2008). Despite these criticisms application of social learning theory within the context of this study has enabled me to explore and explain the reasons why the preceptorship programme was experienced in the way it was by participants.

Thus, the chapter has been sub-divided into three interrelated sections based on the thesis questions. These are: participants' perceptions and expectations of preceptorship, the factors influencing the success of preceptorship, and perceptions of the impact of preceptorship on clinical nursing care. Finally, the chapter will close with a discussion related to trustworthiness and study limitations as well as the contribution this study has made to the body of knowledge. The first section addresses the participants' perceptions and expectations of preceptorship.

6.3 Participants' perceptions and expectations of preceptorship

The study findings highlighted some degree of confusion and a lack of clarity regarding the meaning of preceptorship amongst many of the study participants. These findings reinforced the inconsistencies that have been highlighted globally and recognized in a wide range of literature related to the preceptorship of newly qualified and new graduate nurses (Duffy 2009, NNRU 2009, Beecroft *et al* 2008, Gleeson 2008, Nisbet 2008, Scells & Gill 2007, Wood's 2007, Harbottle 2006, Charleston & Happell 2004, Griffin *et al* 2002). More clearly, in the wider literature, confusion regarding the term 'preceptorship' existed between studies as opposed to within one study *per se* as the role and definition of preceptorship varied from one study to another based on what each organisation meant by the term 'preceptorship' and to whom it was offered. Consequently, despite each study examined as part of the literature review having a clear definition of what each particular organisation meant by the term 'preceptorship', when these definitions were collated as part of a cumulative process, this clarity of meaning evaporated. However, in each of the studies all parties seemingly understood what the term preceptorship meant and acted accordingly.

In contrast to the above, in my own study, this confusion regarding the meaning of preceptorship abounded both amongst and between the study participants themselves. This latter finding essentially made comparison between the current study and the wider literature difficult to establish, given that confusion between participants regarding preceptorship was not something that had been highlighted previously. If we explore this notion of confusion within a social learning framework, it could be argued that when preceptees enter a new culture as those in my study had done, it is appropriate to expect that at the outset each person entering the setting would hold their own definition of the term preceptorship. Hence, it would also be reasonable not to expect to have convergence of understanding regarding how the organisation might conceptualise the term preceptorship at this preliminary stage of the preceptorship process.

Conversely, however, it would be reasonable to expect that each of the key stakeholders involved in preceptorship, would share the same understanding of the term preceptorship and how it should be executed within and across the organisation

at the end of the process. Thus, it would be reasonable to expect that this shared understanding should be similar to the definition outlined in the organisation's policy documentation. From a social learning theorist's perspective therefore, one would have expected that following a period of social interaction between preceptees and other members of the preceptorship team (preceptors, CRNs, nurse managers, and nurse educators) a change in the preceptees' perceptions and expectations of the preceptorship process should have taken place. Hence, the preceptee and other team members should theoretically have each exhibited the same understanding of the term preceptorship and what was expected of each party involved by the end of the preceptorship period.

Despite the above, in my study this change in behaviour did not take place, in particular, preceptees not only began their learning from a confused standpoint, demonstrating an unclear understanding of what to expect but continued their learning within a confused and confusing environment. In particular, other members of the preceptorship team did not fully appreciate or understand what was expected of them as part of the preceptorship process or what their role in the preceptorship process encompassed. Consequently, whilst the organisation expected all preceptees to achieve a convergent understanding of the term preceptorship, which also reflected that outlined in the relevant documentation by the end of their engagement with not only the policy documents and stakeholder groups; preceptees remained confused about the term 'preceptorship'. In fact, in the context of my own study, everyone involved in the preceptorship programme appeared confused about what it meant and/or involved.

Nevertheless if the modelling process had worked properly, namely that the three interrelated elements of observational learning (live, verbal and symbolic modelling) had converged enabling learning to occur, then a change in behaviour should have ensued. However, due to ambiguity in the way the term preceptorship was articulated within the organisation's policy documents (symbolic model) preceptors, CRNs, nurse managers, and nurse educators (live model) similarly held an unclear perception of preceptorship.

Consequently, preceptees were unable to change their previously held perceptions of preceptorship, as the original message stored in their memory from observing and listening to the live models, and policy documents within their previous organisation was not clarified within the new setting. This lack of clarity perpetuated participants' confusion regarding their role and the preceptorship process *per se*. Confusion regarding the meaning of preceptorship manifest regardless of what role each member of the preceptorship team was expected to undertake. Thus, each member involved in the preceptorship process acted in accordance with his/her own understanding of the term and which led some preceptees expectations not being met while others were exceeded.

However, this difference between preceptees' needs and expectations cannot be fulfilled if they have no clear understanding of what preceptorship is or means from the outset (Myrick & Yonge's 2005, Oermann & Garvin 2002, Downes 2001). Thus, in response to this lack of clarity the UKCC (2001) emphasised the importance of providing clear written documentation for preceptees and preceptors. Hence, Bahn (2001) highlighted the necessity of using consistent language for facilitating preceptees' and indeed preceptors' understanding of their respective roles and responsibilities. Thus, before learners can engage in the learning process effectively, they need to have a clear overview of what the learning process is about (Abbey *et al* 2010, Bandura 1977). Hence, in the present study context, although there were policy documents stating what preceptorship meant, to guide participants' practice and outline the roles and responsibilities of each member involved in the preceptorship process, conflicting language used within the documents made them difficult to interpret and comprehend suggesting the documents were not fit for the purpose intended.

Furthermore, lack of clear guidance in the clinical setting stating how the preceptorship programme should be implemented similarly hampered its success. A conclusion reflected by Diehl-Oplinger & Kaminski 2000) given that '*written guidelines contribute to making preceptorship programmes positive experiences for everyone and help orientees, preceptors, and nurse managers understand their role in the orientation process*' (p.46). Equally, Billay & Yonge (2004) have also emphasised that if effective application of the preceptorship process is to take place, it is important for those nurses involved in the

process to have a clear understanding of what preceptorship means across an organisation so they can act not only effectively but consistently.

Ridge (2005) and O'Malley *et al* (2000) concur with the above and add that regular updates and/or revision of the preceptorship process based on evaluation by all those involved is also vital. However, this requirement for regular review by all parties involved in the preceptorship process was also lacking in my own study setting. Although a review of the process did take place, it only involved nurse educators and did not include other programme stakeholders. Actively involving people in the evaluation and restructuring process can act as an extrinsic motivational force (Bahn 2001). Involving all programme stakeholders in the development, revision and updating of the preceptorship process would encourage them to discuss, share and clarify ideas and thereby generate a common understanding of the preceptorship programme within the study setting.

Although there is consensus in the wider literature supporting the notion that when those involved in preceptorship have a clear understanding of the concept, successful implementation of the process is more likely to occur; time and the quality of preceptors are also important factors to take into account when considering its successful implementation (NNRU 2009, Harbottle 2006, Myrick & Yonge 2005). These additional factors were raised by my participants as reasons why the organisation's preceptorship goals were not achieved in some clinical areas. In the following section, the factors, which influenced the success or failure of the preceptorship programme from the perspective of the participants' involved, are discussed in more detail.

6.4 The factors influencing the success of preceptorship

According to Bandura (1977), awareness is a powerful facilitative factor for changing a learner's behaviour, but it is not the only factor, as there are other external and/or internal forces, which also contribute negatively or positively to a learners' ability to learn and acquire new behaviours. This notion helps explain why some preceptees in the study context were unable to learn and successfully integrate into the new context. For example, if learners perceive factors such as the length of preceptorship and choice of preceptor positively they will benefit from the learning process.

However if these aspects are viewed negatively then they are less likely to derive any benefit from the learning opportunity. In this study, extrinsic factors such as the preceptorship period, preceptor preparation, and efficacy of the recruitment process were perceived by the study participants as having the capacity to exert an influence on the success of the preceptorship programme. These factors will be discussed in the following sections.

6.4.1 Restrictive time versus individualisation

In terms of time, Kelly *et al* (2002) and Kaviani & Stillwell (2000) believe successful integration of the preceptee cannot be achieved without establishing an effective preceptor-preceptee relationship over time. However, if the timeframe is not clearly identified, well managed, too short or is not clearly understood, integration of the preceptees will not occur and both the preceptor and preceptee will be put under unnecessary stress. More specifically time has the potential to impact on the preceptee's ability to work independently and safely (DeCicco 2008, Ross & Clifford 2005, Ohrling & Hallberg 2001, Kaviani & Stillwell 2000, O'Malley *et al* 2000).

In this study, it was clear that sufficient time was not always available to enable preceptees to discuss issues of concern, listen to and observe others' actions and practice what they were taught. In particular, the eight shifts/ten days allocated as supernumerary practice were not always protected, as preceptors had to juggle their normal patient caseload with the preceptor role. Furthermore, there was a lack of time for preceptees to familiarize themselves with the clinical routine. The latter circumstances therefore prohibited the ability of preceptees to identify their weaknesses and act on their strengths in order to fulfil all the necessary preceptorship requirements within the timeframe allocated within the organisation. In this latter context when preceptees were expected to work autonomously, they were not always able to provide the expected level of nursing care confidently and/or independently. Hence, facilitation of the preceptees' integration into the clinical setting was not always achieved and for this reason, the preceptorship programme in this case did not achieve the goals set out within the policy documentation.

The reason the preceptorship programme failed to attain its goals was identified by most participants as being related to the fact that insufficient time was assigned for

preceptees to interact with members of the preceptorship team, particularly preceptors. More specifically, there was a perception that time was too short for the preceptorship programme. Therefore, the notion of time was perceived as restrictive, as it did not allow all preceptees to fulfil the preceptorship requirements successfully. Similar findings have been highlighted in studies about the preceptorship of newly qualified nurses (Duffy 2009, Gleeson 2008, Hautala *et al* 2007, Kim 2007, Scells & Gill 2007, Harbottle 2006, Davis *et al* 2004, Allen 2002, Jarvis 2000).

Despite the above, some study participants perceived the preceptorship period was long enough as they were able to fulfil all the necessary requirements within the time allocated, mainly due to the preceptor's capabilities. This latter finding was similar to those of Allen (2002) who highlighted that preceptees were able to fulfil their preceptorship requirements within the timeframe specified. However, in the study setting, it is not possible to state categorically that the preceptorship programme was totally unsuccessful as it was perceived to be effective for some participants, while not for others. However, this lack of achievement could be related to motivational factors.

Social learning theorists argue that learners learn at different rates (Bandura 1977). Therefore, time as an extrinsic factor might encourage some learners to perform better than others. As learning in the clinical setting is a socially contexted process the influence exerted by time will differ according to the setting and the personalities of those involved. Thus, in real life practice, it is normal to find differences between learners' performance as the successful execution of a task depends on the ability of each learner, the surrounding environment and the power of incentives (Bahn 2001). For example, persons working with role models who had heavy patient and unit workloads, as in this study, tended to need more time than those who worked with role models in a less pressured environment. In this case, workload could be considered an external inhibitor, which impacted on a person's ability to learn or engage with the clinical setting within a pre-determined timeframe, thus it is necessary for those involved in teaching preceptees to consider that one preceptee might require more time than another in order to achieve the preceptorship goals and practice safely.

Social learning theorists argue that learning varies from person to person based on each learner's personality and the environment. However, in the study setting, this individualisation of learning was not an acknowledged part of the preceptorship process. It was expected that all preceptees would fulfil all the necessary requirements, particularly the generic competences, within eight shifts/ten days. This was a fixed time period with no consideration given to those preceptees who came from different backgrounds, some of whom had more experience than others in respect of their ability to perform clinical skills such as venepuncture or history taking. Additionally, no account was taken of the fact that some preceptees might have previously worked in similar health care systems while others were used to totally different systems. More importantly, factors such as preceptee stress and/or preceptor workload were also not taken into consideration when allocating a timeframe to the preceptorship process.

Thus, from a social learning theorist perspective, if the learning process had been more conducive to learning; in that social interaction between the preceptee and other programme stakeholders has been successfully achieved, each preceptee would have been provided with an opportunity to observe, model and gain supervised practice in his/her professional role within the new cultural domain over a more flexible timeframe. In this way learners could have been furnished with an opportunity to learn new clinical skills, enhance their cultural understanding and professional attitudes while interacting with patients and other members of the multidisciplinary team (Johnson & Wilson 2009). Thus, by having a more flexible timeframe within which to complete the preceptorship process each preceptee's needs could have been more appropriately taken into account (Clark & Holmes 2007, Lockwood-Rayermann 2003, Ohrling & Hallberg's 2001).

Nevertheless, this notion of flexibility in relation to time creates a further dilemma in terms of how much time should be devoted to this process particularly in relation to newly hired experienced nurses. The existing preceptorship literature relates only to newly qualified nurses and has reported an overwhelming demand for the duration of such programmes to be between four and six months (Beecroft *et al* 2008, Wood 2007, Carroll *et al* 2005, Myrick & Yonge 2005, NMC 2002, Hardyman & Hickey 2001, Diehl-Oplinger & Kaminski 2000). Thus, the latter would suggest that newly

hired experienced nurses would not need this length of time to work with a preceptor as they already have practical experience on which to base their development. However, the nurses in this study were newly hired experienced nurses who had moved to a new cultural domain, which in effect rendered them equally if not more vulnerable than newly qualified nurses.

Thus, if the previous notion is explored within a social learning theory framework it could be argued that preceptees in this study setting were expected to engage in a new learning process and not simply transfer previously acquired skills to the new setting. This is because the study setting could be considered a new social context where new knowledge, skills and ways of working needed to be acquired by preceptees. These skills might or might not be similar to those acquired in previous clinical contexts. In order to acquire the new skills and modify their previous experience to fit the new setting's standards of care, preceptees needed to interact not only with programme stakeholders but other colleagues and patients within the new social context in order to carefully observe the latter groups' behaviours, listen to and analyse their language and actions. If such learning is to be successful, programme stakeholders have to facilitate an appropriate social learning context in order to eliminate those factors that would detract the preceptees' attention away from observing or listening to relevant role models. Furthermore, preceptees also require time to retain the newly acquired information and behaviours via a process of reflection because without retention meaningful learning cannot be achieved (Sincero 2011, Abbey *et al* 2010).

Time is also required to demonstrate new procedures in order for preceptees to be confident in performing them when required to practice unsupervised and for preceptors to be able to evaluate preceptees' performance and provide them with the necessary feedback. However, the amount of time needed in this case, might differ from person to person as some preceptees might need to observe role models again given they may not be able to retain information and/or some preceptees might be unable to practice the skill immediately following the first demonstration and need to repeat the procedure. Accordingly, similar to newly qualified nurses when four to six months is considered an appropriate length of time to engage in preceptorship newly hired experienced nurses in the study setting were found to need an equivalent

timeframe. However, not all preceptees will require this length of time and so it might be more appropriate to inject some degree of flexibility into the process, where the duration of the preceptorship programme is expressed in the form of a minimum and maximum timeframe, taking into consideration the ward's needs, workload demands, and the preceptees' individual learning needs.

In the following section, preceptor preparation a further extrinsic factor perceived by study participants' to impact on the success of the preceptorship programme is discussed from a social learning theory perspective.

6.4.2 Preceptor preparation

The principle of role modelling is to allow learners to interact with trained role models, enabling them to develop professionally by observing behaviours and experiencing day-to-day actions associated with the particular role (Johnson & Wilson 2009). This is not limited to learning clinical skills, but includes learning about professional attitudes, by interacting within multidisciplinary teams and engaging with patients (Abbey *et al* 2010, Bahn 2001). In practice, the preceptorship process is seen as part of adult socialisation where the influence of the role model (the preceptor), is considered vital for the success of the learning process (the preceptorship programme). The influence of role models in clinical learning environments have been similarly highlighted by Henderson *et al* (2006), NMC (2002), Hardyman & Hickey (2001) and strongly reinforce the findings of this study. However, if role models are to exert a positive influence on the learning process, preceptors need to be well prepared for their role (Henderson *et al* 2006, NMC 2002, Hardyman & Hickey 2001).

In the study setting, the policy documentation stated that preceptors should themselves be prepared for this role. However, the preceptors who participated in this study felt insufficiently prepared for their role even though they had attended a mandatory preceptorship workshop. This lack of preparation has also been reported in the literature (DOH 2009, NNRU 2009, CNA 2004, Hardyman & Hickey 2001, Almada *et al* 2004, Charleston & Happell 2005). Consequently preceptors felt that the preparation to enable them to carry out their role effectively was severely limited in the study setting, due to lack of clarity concerning what they were required to achieve

and/or what the role actually entailed. This lack of clarity impact negatively on the preceptees' learning and with it their ability to engage successfully with their new role.

If we explore the notion of preceptor preparation in more detail it could be argued that since preceptees learn by observing and interacting with competent role models (preceptors, CRNs, nurse managers and nurse educators as well as other ward staff), selected preceptors should be well prepared for their role. The reason why it is vital for role models to be competent is largely related to the fact that they are required to provide learners with the necessary knowledge, and skills while also drawing on appropriate teaching and learning principles to assist them in their teaching and thus facilitate effective learning (Bahn 2001, Bandura 1986, 1977). Hence, preceptors need to be both clinically experienced and effective teachers if valuable learning is to take place (Murray & Main 2005, Kaviani & Stillwell 2000). In practice, preceptors are expected to be able to interact successfully with their preceptees, provide them with appropriate learning to enable them to demonstrate positive behaviours and facilitate skills acquisition (Bahn 2001).

For effective role modelling to take place, preceptors should first be aware of their role and responsibilities. The latter is particularly important given that social learning theorists suggest that if role models have no awareness of what is being reinforced, they will generally not exert any influence on individual's learning or cognitive development (Bigge 1986, Bandura 1977). Furthermore, preceptors should also be prepared to notify preceptees about what skills or clinical activity they are going to demonstrate in advance, so that preceptees will know exactly what to focus on (Bandura 1986, 1977). From the organisation's perspective, competent preceptors would also normally be expected to inform preceptees that, once the skill had been demonstrated, they would be expected to perform the observed behaviour competently under supervision, before being allowed to engage in autonomous practice. For such interactions to be effective it is expected that preceptors would encourage their respective preceptees to engage in a process of self-monitoring and self-assessment in order to improve their performance and enhance self-confidence. Consequently, preceptors need to know how to build a trusting relationship with each of their respective preceptees. Following on from this, the new mode of doing

things not only needs to be observed and practiced *in vivo* but also discussed both by the preceptee and preceptor for further clarification as part of a reflective learning process (Murray & Main 2005, Bahn 2001, Bowen & Carline 1997).

Hence, it could be argued that in order to have effective preceptors who are able to carry out all of the above actions, they should attend a preparation workshop to enable them to engage with the learning process. Almada *et al* (2004), Hancock (2002), and Hardyman & Hickey (2001) have all identified the need for preceptors to attend preparation programmes in order to enhance their knowledge of adult learning styles, communication techniques, personality characteristics and conflict resolution. Furthermore, Gleeson (2008) highlighted the need for preceptors to be good teachers as well as experienced nurses, emphasising the fact that adult learning principles are central to preceptorship. The latter was further emphasised by Farnell & Dawson (2006), who indicated the type of educational strategies adopted by those running preceptorship programmes contribute directly to its success or failure.

However, this study found that when preceptors did not attend preparation workshops, they lacked the necessary preparation. Therefore, it might be expected that the preceptees ability to learn vicariously would have been negatively affected (Murray & Main 2005, Bahn 2001). For example, in my own study, when preceptors did not attend preparatory workshops they tended to demonstrate clinical skills and behaviours unrelated to the competences required, as they were uncertain of what needed to be demonstrated or reinforced. As a result, preceptees' observed potentially inappropriate behaviours or skills and were taught on an *ad hoc* basis, as opposed to the teaching constituting part of a planned educational process. The latter clearly has the potential to challenge the preceptee's ability to work independently. Despite the above, in the study setting, the majority of preceptors did not attend the preparatory workshops; one reason for this was because their nurse managers did not consider it necessary for them to attend as they were already experienced clinically. However, although they undoubtedly had clinical experience, they lacked the necessary skills to be able to teach and pass on their knowledge and skills to others. Consequently, it could be argued that attendance at a preceptor preparation workshop should be a pre-requisite for being appointed as a preceptor.

A further reason why preceptors failed to attend the preparation workshop was that it was perceived as unhelpful as it discussed too many issues in one day and the content was not standardised. Furthermore, it did not address information deemed by preceptors to be necessary regarding the nature of the preceptor role and the way in which it should be carried out. Additionally, the workshop did not occur on a regular basis which resulted in many preceptors being unable to attend. Gleeson's (2008) study revealed similar findings to this study, in that one day was considered insufficient to prepare preceptors for their role, considering the amount of data they needed to be aware of if they were to be effective. From a social learning theory perspective, if the learning process is to be conducive to learning and the preceptor preparation successfully achieved, then the content of the preparation workshop needed to be more focused on issues considered important to preceptors, rather than addressing generic content (Gleeson 2008, Bahn 2001).

Similarly, DeCicco (2008) and Cavanaugh & Huse (2004) suggested that preceptor preparation programmes needed to be standardised and conducted over a two-day period by a registered nurse educator. Phillips' (2006) and Allen's (2002) studies both added that it is important to update the content of a preceptor preparation programme and to offer it to all involved parties in order to meet the needs of preceptees, preceptors and the organisation. Feedback related to the efficacy of preceptor preparation programmes from programme stakeholders in an ongoing, open and supportive manner are also seen as necessary to ensure improvements (Henderson *et al* 2006). In addition, it is also essential to allocate sufficient resources to the development of well-prepared preceptors (DeCicco 2008, Cavanaugh & Huse 2004, Speers *et al* 2004).

From a social learning perspective, if an individual's achievement brings about a sense of failure and self-dissatisfaction, the individual will tend to evaluate their own actions in order to correct them and bring about feelings of personal satisfaction (Braungart & Braungart 2008, Bandura 1986, 1977). In the study setting, the preceptors' sense of unhappiness regarding their performance as role models made them realise that they needed to update their knowledge by re-attending a preparation workshop. They felt that without this they would be unable to practice as effective role models, which has the potential to impact negatively on their

preceptees' ability to work autonomously. This is supported by Allen (2002) and Cavanaugh & Huse's (2004) who stated that continuous updating of skills means that preceptors need to receive ongoing support, education and mentoring from a clinical educator. The latter type of support from organisational personnel was openly requested by my study participants in order to be able to perform their roles accurately.

Furthermore, preceptors who took part in this study also requested the introduction of a reward system for all stakeholders. This also ties in with social learning theory, which suggests rewarding role models, (in this case preceptors), for good achievement, is a factor likely to enhance performance (Bahn 2001, Bandura 1977). Similarly, Neumann *et al* (2004), Stone & Rowles (2002), and Greenberg *et al* (2001) also indicated that developing a recognised reward system was a way of making nurses aware of the value of the preceptor role. The success of the preceptorship process is, therefore, dependent on nurses becoming knowledgeable and skilled in the delivery of clinically based teaching (Myrick & Yongue 2005). Hence, although preceptors were often senior experienced nurses, it is still necessary to prepare them for the role and provide them with the required support, perhaps even more so when precepting newly hired experienced nurses as opposed to newly qualified nurses. In addition, when they are well prepared to become good role models, preceptees have a greater potential to subsequently become more effective preceptors for others in the future, a fact supported by the work of Lee *et al* (2009).

6.4.3 Recruitment process

A surprising and unexpected finding headlined as part of this study was the significance of recruitment in relation to preceptorship. In particular, participants strongly argued that ineffective recruitment processes; where there was a mismatch between a unit's needs and the staff member's clinical experience, negatively impacted on the success of the preceptorship programme. The impact of recruitment on the success of preceptorship has not been raised or discussed in any previous study. While there is general agreement in the pre-existing literature that effective preceptorship enhances staff recruitment and retention (DOH 2009, Lee *et al* 2009, Leigh *et al* 2005, Singer 2006, Myrick & Yonge 2005, O'Connor *et al* 2001) there is no evidence to suggest that recruitment impacts on preceptorship. However, Almada *et al* (2004) claim that a positive preceptorship experience culminates in

increased job satisfaction and decreased staff turnover and with it fewer vacant positions. A view similarly supported by Singer (2006) who indicated that preceptorship programmes render the work environment more attractive for experienced employees, promoting morale and potentially increasing retention rates.

Although social learning theory does not address recruitment, social learning theorists suggest self-efficacy is stronger when supported by positive external reinforcement (Braungart & Braungart 2008, Bahn 2001, Bandura 1977). Thus, from a social learning theory perspective, it could be argued that the quality of the recruitment process, in terms of matching preceptees' needs, qualifications and clinical experience with the ward requirements can be considered an external factor which enhances preceptees' self-efficacy. This in turn impacts on the success of the preceptorship programme. Because of the reciprocal interaction between preceptees and the environment, enhanced self-efficacy helps them to adjust quickly into the new environment (Bahn 2001, Bandura 1977). Thus, from a social learning theorist perspective, learners have needs that should be considered if the learning process is to be successful (Sinclair & Ferguson 2009, Bahn 2001, Bandura 1977). These needs work as internal incentives, encouraging learners to actively interact with the social environment during the learning process in order to achieve their goals.

In the context of this study, one could argue that when nurses apply to work in a country other than their own, they tend to seek greater personal safety or freedom, good working conditions and better a income for themselves and their families. Such nurses often decide to leave their families behind to secure a good education and/or life by working abroad (Kingma 2006). This decision is not an easy one to make as it means abandoning social and cultural commitments including, sometimes, caring for children (Habermann & Stagge 2010). However, the fact that this is a high stakes decision means immigrants (in this case preceptees) are deeply committed to achieving their goals. However, as Murray & Main (2005) state, preceptees need the right environment in which to grow psychologically (and in this case one could argue - clinically).

Recruitment procedures, therefore, undoubtedly have the potential to impact positively or negatively on clinical practice. For example, when new recruits

(preceptees) are allocated to a familiar environment, one that matches their clinical expertise they observe role models performing similar skills and procedures to those already known. As a result, there are two potential outcomes in this scenario. Firstly, there is self-administered reinforcement leading to enhance self-efficacy and secondly, in practical terms, an awareness that they need only to adjust what they already know in order to fine tune their otherwise competent performance.

Thus, when there is a good match between preceptees and the allocated clinical environment there is more chance for any interactions that take place with the learning process to be effective, given that the learner will demonstrate greater interest when observing role models and listening to instructions that are familiar to them, in order to engage in a more effective analysis of the educational content to put into practice what they have learned (Eccles & Wigfield 2006, Bahn 2001, Bowen & Carline 1997, Bandura 1977). Consequently when preceptees are assigned to a clinical setting they expect to work within, they are more likely to be motivated to demonstrate competence, and engage in additional ward related projects, to enhance their sense of belonging. Thus, in the latter circumstance, the preceptee's socialisation into the multidisciplinary team will be accelerated and their integration into the new setting/role similarly enhanced (Bahn 2001, Bandura 1986, 1977). In essence, all of these factors working together have the potential to have a positive impact on the success of the preceptorship programme thereby enhancing the preceptee's ability to integrate into the new clinical environment and become an effective member of the ward team.

In contrast to the above, some preceptees within the study setting were not assigned to a clinical area matching their previous experiences. For those preceptees assigned to "alien" clinical environments it was considerably more difficult for them to integrate and accommodate to the new setting, modify their previous experiences and acquire new skills. In the latter circumstance, when preceptees observed role models' behaviours they often felt de-skilled, lacking in knowledge and generally uncomfortable when working in a setting outside their area of expertise. Consequently preceptees felt unable to regulate and control their behaviour to integrate within the clinical domain. Two preceptees in this study were assigned to areas where they had no previous experience hence they were unable to achieve the

required competences in the time allowed despite not being allocated to high pressure environments. In this context, it could be argued they lacked the necessary motivation to engage in learning and for this reason they did not develop as hoped due to the fact that they were internally dissatisfied as a result of feeling that they were in the wrong place (Bahn 2001, Bandura 1977).

The main reason for the above problem was due to recruitment personnel hiring internationally targeted experienced nurses simply to fill vacancies and meet the growing demand for high human resources. This process was undertaken without considering the needs of preceptees or the clinical setting. However, from a social learning theory perspective, although those assigned to “alien” domains were experienced nurses when they were assigned to an area outside their sphere of competence, dissonance arose between preceptee and key stakeholder expectations. This dissonance, had a significant impact on the preceptee’s ability to actively engage with the learning process and by default the success of the preceptorship process due to lack of confidence, lack of motivation and lack of fit with the environment.

The latter not only impacted on the preceptees concerned but also had the potential to affect recruitment and retention rates and with it patient safety, due to their being too few staff to meet patient demands. This latter hypothesis has been reinforced by Habermann & Stagge (2010) and Chesnutt & Everhart (2007), who stated that failure to assign the right nurses to the right place severely impacted on their ability to learn and address patient safety issues. Similarly, Ang *et al* (2007) added that assigning employees to inappropriate clinical areas inhibits their ability to cope and effectively engage with the novel work setting, such as that presented in Saudi Arabia.

More specifically in this case, preceptees were not provided with detailed information about their new setting before their arrival and these study findings reflecting those of Plum (2007), who found that preceptees needed this information in order to be able to engage effectively with the new setting. Access to such information is important in order to avoid problems arising within the environment after the new recruit’s arrival which further factor that has the potential to negatively influence learning and with it the individual’s ability to adjust to the new environment (Shermont & Krepcio 2006). Arguably, a learner’s prior awareness of the learning

environment permits them to assess their capability and interest in experiencing the new culture before arrival, and facilitates social interaction with both the environment and the people involved on arrival, thereby increasing the chances of a successful learning experience taking place (Braungart & Braungart 2008, Bahn 2001, Bandura 1977). Therefore, it seems that, on a global level, recruitment personnel need to provide prospective preceptees with the necessary information about working in a multicultural context prior to their arrival, as well as matching their qualification with the requirements of the clinical setting in order to have a fully functioning workforce.

6.5 Perceptions of the impact of preceptorship on clinical nursing care

Preceptorship programmes have been developed and implemented by most health care institutions world-wide with the aim of facilitating new nurses' integration into a new role. This integration is achieved by promoting the acquisition of clinical skills and knowledge to enable new nurses to meet the needs of patients and deliver safe, competent nursing care at the bedside (Kuroda *et al* 2009, Lee *et al* 2009, Ashurst 2008, Mills *et al* 2008, Nisbet 2008, Scells & Gill 2007, Hautala *et al* 2006, Jasper 2006, Almada *et al* 2004, Mohanna *et al* 2004, Griffin *et al* 2002, Diehl-Oplinger & Kaminski 2000, O'Malley *et al* 2000).

Although preceptees in this study were considered "competent practitioners," they were still new to the rules, regulations, policies and procedures of the clinical setting, hence they lacked the necessary skills to enable them to work effectively within the organisation. Thus, as part of the preceptorship process, preceptees were expected to adapt and develop their clinical skills within a restrictive timeframe, to enable them to achieve both their own and the organisation's goals, namely to deliver safe, competent nursing care. In the study setting, two different perceptions regarding the impact preceptorship was felt to exert on clinical nursing care which were identified as a positive or negative impact on care. First, concept to be explore will be related to how preceptorship was felt to have a positive impact on nursing care.

6.5.1 Positive impact

All preceptors and nurse managers in the study perceived preceptorship had a positive impact on preceptees' clinical performance, a perception reinforced by

almost half of the preceptees, who felt, by the end of the preceptorship programme, their confidence and competence to deliver safe nursing care had been enhanced. These findings are in agreement with other studies that indicated preceptorship had the potential to have a significant impact on the quality of care delivered to patients in a new clinical setting (NHS 2010, Clark & Holmes 2007, Myrick & Yonge 2005, O'Malley *et al* 2000, Bain 1996). A reason given for these perceptions of enhanced skills competence and confidence following the preceptorship programme emanated from having interacted with knowledgeable, competent role models (preceptors), and having developed a good relationship with them. Findings consistent with those highlighted in early studies (McGowan & McCormack's 2005, Orsini 2005, Messmer *et al* 2004, Nelson *et al* 2004, Hancock 2002, Beecroft *et al* (2001).

If we explore this finding further, it could be argued preceptees' clinical nursing care improved after having received the necessary educational input in the form of successful observation and interaction with competent preceptors who were able to provide appropriate information and who were themselves oriented to overtly guiding preceptees clinically. Furthermore, confidence increased further when educational input was followed by positive feedback regarding the preceptees performance either from preceptors, other programme stakeholders or both (Bahn 2001, O'Malley *et al* 2000).

In some studies, participants acknowledged the value of formal evaluation and frequent meetings with their respective managers as it enabled them to gauge how their clinical performance was perceived by others (Farnell & Dawson 2006, Guhde 2005). In the current study, preceptees commented on the usefulness of correction and having been questioned about how to improve performance when carrying out new procedures. Furthermore, nurse managers in particular, considered preceptorship to be valuable because it enabled them to assess the new nurse's clinical strengths and weakness and identify their training needs before the individual commenced his/her independent practice, a factor supported by Guhde (2005). According to social learning theory, such feedback enables learners (preceptees) to be both corrected and directed in their practice. In the context of my own study, such feedback enabled learners to act in accordance with the stated policies and procedures, which in turn, helped them to provide safer patient care within a

relatively short timeframe (Finkel 2003, Diehl-Oplinger & Kaminski 2000, Bahn 2001, Grusec 1992, Bandura 1977).

However, the impact of preceptorship on clinical nursing care was perceived not to be limited to preceptees but to also encompass the preceptors' clinical performance. Consequently, given the social nature of the learning process, arguably preceptors and preceptees had a daily opportunity to learn from, with and about each other and their peers (Bandura 1977). During such interactions each member involved had a chance to discuss and share his/her ideas, listen to other opinions and accordingly modify and share good practice, which had the potential to enhance the quality of care each party was able to deliver (Bahn 2001, Bandura 1977). As a result of these interactions preceptors in the current study felt their own clinical nursing care improved concurrent with the preceptees. In the latter context it could be argued the preceptors level of commitment and general sense of responsibility encouraged and enabled them to focus on improving their own knowledge and clinical behaviour in order to become a more affective role model. Additionally, praise received from nurse managers regarding their performance as preceptors increased their confidence and self-esteem, which in turn augmented their satisfaction with the teaching role. A finding similarly reported by others (Lee *et al* 2009, Mills *et al* 2008, Green & Puetzer 2002, Charleston & Happell (2004).

6.5.2 Negative impact

In the literature, no empirical evidence was found highlighting the negative impact of preceptorship on clinical nursing care. However, in the study, most preceptors were aware of the possibility that preceptorship could impact negatively on both preceptees and their own clinical nursing care, due to workload pressures. In the study setting, preceptors perceived that their dual teacher/carer role made them feel overwhelmed. As a result, they expressed reluctance to participate in future preceptorship programmes, suggesting that how it was currently organised negatively influenced their beliefs about their own abilities, limiting what they tried to achieve and how much effort they put into their performance (Grusec 1992, Bandura 1977). Conversely, effective support and guidance for preceptors was felt to enable them to be more productive in their role (Wood 2007, Guhde 2005).

In practice, working in a busy ward, while simultaneously acting as a preceptor for one or more preceptees, not being given sufficient time, or the chance to accept or reject the extra responsibility, increased not only the workload but also the work related stresses experienced by preceptors. The latter had the potential to lead to burnout particularly when individuals lacked the support they need to perform the preceptor role; a factor which also had the potential to impact negatively on their ability to deliver the level of care required (Henderson *et al* 2006, Myrick & Yonge 2005). These findings reflect those of Yonge *et al* (2002) and Duffy (2009), who both argued that preceptors needed considerable support from management, administrative personnel and colleagues, to enable them to feel less stressed and to perform their dual roles effectively.

Although participants in this study were aware of the increase in workload which accompanied being a preceptor, they also perceived there was a lack of support from peers or nurse managers. In essence what preceptors craved was to be given some assistance by having some of their responsibilities redistributed enabling them to carry out both the caring and teaching role more effectively. Hence, what preceptors wanted most of all was to have a reduced patient workload for the duration of the preceptors programme. This finding is also consistent with others who highlighted that preceptors needed practical support to reduce their workload if they were to fulfil their role effectively (Duffy 2009, Hautala *et al* 2007, Henderson *et al* 2006, Cavanaugh & Huse 2004, Speers *et al* 2004).

6.6 Trustworthiness of the study

Assessment of the quality of qualitative research has been a hotly debated and contentious issue amongst qualitative researchers. Some have proposed that the quality of qualitative studies can be judged by adopting validity and reliability constructs normally used in the quantitative paradigm (Morse *et al* 2002). However, others have argued that rigour in qualitative research cannot be measured by criteria set for quantitative research, because of the differences between quantitative and qualitative paradigms, their respective implications and outcomes (Burns & Groves 2007, Sandelowski & Barroso 2002, Sandelowski 1986, Lincoln & Guba 1985). Nevertheless, Rolfe (2006) disputes the abandonment of 'epistemic criteria' in favour of judgement '*according to aesthetic considerations*'. In contrast, he argues that the

appraisal of each study must be based on its own merits using unique criteria. As a result, large numbers of different criteria have emerged.

Sandelowski (1993) linked validity in qualitative research to 'trustworthiness' whereby the naturalistic inquiry becomes visible and auditable. The notion of auditability was used by Sandelowski (1986) as an alternative term for reliability; while credibility and fittingness are alternative terms for internal and external validity respectively (Sandelowski 1986). According to Lincoln & Guba (1985) the trustworthiness of qualitative research should be measured by alternative criteria because the notion of reliability, validity and generalisability as referred to in quantitative research is inappropriate for use in naturalistic approaches as the social world in qualitative research is naturally changeable.

Additionally, unlike quantitative research, the researcher's role in qualitative research is acknowledged as constituting one of the data sources and in effect, s/he can be considered as one of the research tools (Erlandson *et al* 1993). Trustworthiness of qualitative data is '*associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data and consideration of all of the data [generation, interpretation and presentation]*' (Burns & Grove 2007, p.91). Accordingly, trustworthiness of qualitative studies should be measured using criteria appropriate to the study philosophy, together with its purpose and the questions researchers look to answer (Burns & Grove 2007, Sandelowski 1993). Lincoln & Guba (1985) presented other criteria which are: credibility, transferability, dependability, confirmability. These criteria equate to the notion of internal validity, external validity, reliability, and objectivity criteria as used within the quantitative research paradigm.

As this study has adhered to the naturalistic inquiry paradigm, it was appropriate that the study's rigor be examined according to the naturalistic process criteria of trustworthiness. The four criteria (credibility, transferability, dependability and confirmability) outlined by Lincoln & Guba (1985) have been used to ensure trustworthiness of the current study as outlined below.

6.6.1 Credibility (internal validity)

Credibility examines how convincing the study findings are (Erlandson *et al* 1993). Findings represent the themes and sub-themes that emerge from the data collected (Erlandson *et al* 1993, Lincoln & Guba 1985). Gaining a comprehensive interpretation of the constructed perceptions as reported by the participants is a major component when establishing credibility when using a naturalistic paradigm. One of the techniques that helped to ensure credibility of the current study was the prolonged engagement with participants in the study context, in order to minimise the distortions generated by my own bias and the impact I was able to exert on the study arena (Erlandson *et al* 1993).

The nine years spent working as a preceptee, preceptor, and clinical resource nurse in the study setting, coupled with my four months continuous exposure in the field during the data collection period, allowed me to uncover what preceptorship meant for the nurses who participated in the study (Erlandson *et al* 1993, Lincoln & Guba 1985). Preceptorship stakeholders (clinical resource nurses, nurse educators, nurse managers and preceptors) who participated in the study were also known to me as I had previously coordinated the preceptorship programme for newly hired nurses in addition to having facilitated workshops which the above staff had attended. My ability to develop a professional relationship with preceptees was more limited as it comprised the four months of field work.

Dealing with participants openly and honestly, demonstrating that I valued their ideas and opinions via active listening and by helping them to become inculcated into Saudi society, enabled me to cement feelings of trust between the study participants and myself. This emerging trust enabled participants to reflect on their preceptorship experiences more openly. In addition, participants encouraged each other to talk about their experiences despite my presence. More specifically they were interested to receive my report on the study findings. By the end of each interview, participants were eagerly offering their help by saying: *we will contact you if we remember further issues about preceptorship that might help in your study*. Spending time with participants to get to know them better helped me to gain more in-depth data, and thus to understand their perceptions of the preceptorship concept more fully and appreciate what impact it may be able to exert on clinical nursing care (Erlandson *et al* 1993).

Conversely, I considered the negative impact of this engagement with the participants in terms of reporting bias. Therefore, regular meetings and discussions with the co-researcher during the data collection and analysis phases were conducted to avoid any such bias and achieve credibility of the findings. In addition, data generated were reviewed and double-checked with both the co-researcher in order to clarify my interpretation, uncover any biases and increase theoretical sensitivity.

Credibility was also achieved in this study by using different sources of data (nurses from different grades, who had different roles within the preceptorship programme), and implementing multiple methods of data collection (interview including individual and focus group, in addition to documentary review). In essence the latter strategies enabled me to identify divergent perceptions regarding preceptorship and to cross reference the data obtained by comparing the content of each element for consistency, similarities and/or differences. This triangulation technique helped to provide completeness and improve the clarity or precision of the research findings. Likewise, using different data collection resources provided diverse ways of looking at the study phenomena (Ritchie & Lewis 2003, Erlandson *et al* 1993, Lincoln & Guba 1985).

Credibility was also achieved through thick description of the phenomena, hence, data were collected and analysed concurrently. Finally, as illustrated earlier in the data analysis section, obtaining consensus from two independent parties (co-researcher and I) as well as my study supervisor regarding the identified themes and sub-themes also helped to reinforce the creditability of the coding system (Burnard 1991).

6.6.2 Transferability (external validity):

Transferability is concerned with how the study findings could be implemented in other contexts or with different participants (Lincoln & Guba 1985). Naturalistic researchers believe that study findings should be transferable to settings that have similar characteristics to those manifest in the study context (Erlandson *et al* 1993). In this study, transferability criteria were achieved via the collection and provision of thick descriptions regarding the participants' demographic data, by giving a clear explanation of the sampling methods - in this case purposive and convenience sampling strategies - and comparison of the study findings with other literature.

Furthermore, by using *verbatim* transcripts as part of the study report, readers and other researchers will be empowered to decide for themselves if the study findings can be applied to either their own or other study settings (Speziale & Carpenter 2007, Erlandson *et al* 1993, Lincoln & Guba 1985).

6.6.3 Dependability (reliability)

Dependability refers to the consistency and stability of the study findings, which means, that if the study were to be repeated in the same context with the same participants, the same findings should emerge (Lincoln & Guba 1985). According to Erlandson *et al* (1993) dependability as well as confirmability can be achieved by the researcher leaving a clear audit trail. In the latter context, the research process needs to be clearly outlined using a systematic process to allow an external auditor to check the process by which the study was implemented (Kilcullen 2007, Erlandson *et al* 1993). In this case, the research process has been identified by describing the data collection methods and the data analysis process in considerable detail.

During the line-by-line analysis of the interview data, and subsequent generation of the major and sub-themes nothing was discarded. Moreover, appropriate exemplars have been used in the text to support and highlight the study findings. Data were collected and analysed via a systematic, supervised process. The natural context of the data was maintained by conducting the interviews in the hospital and during the duty hours of the participants. Therefore, I believe that the data used to present the findings are not only dependable but also original.

6.6.4 Confirmability (Objectivity)

Verbatim transcriptions of the individual and focus group interviews have the potential to enable the reader to confirm the authenticity of the data collected. In addition, double-checking the data with a co-researcher helped to confirm the accuracy of the data and facilitate the generation of a clear data audit trail (Burnard 1991, Lincoln & Guba 1985). Throughout the research process, I kept my self close to the data by constantly listening to the tapes and looking at the transcribed version of the data which helped the interpretation process. Moreover, I tried to include in the findings chapters as many quotes as appropriate to support my interpretations in

order to provide evidence that the study findings were derived from the participants' own words.

In summary, the techniques used to ensure the robustness and trustworthiness of the study were chosen, as it was felt these techniques best served my study aim and reflected the underlying philosophy of the methodology, in this case a qualitative descriptive method based on naturalistic inquiry.

6.7 Limitations of the study

As with all studies, this thesis comes with its own limitations. The study included only literature pertaining to preceptorship published in English which discounts all other literature, with the potential for me to have missed important information related to the topic. Comparing the findings of this study with the existing literature was difficult due to the number of various preceptorship definitions and because preceptorship has largely been studied in relation to newly qualified nurses.

Furthermore, the inclusion of only one Saudi hospital as the sole research site has no doubt reduced the diverse experiences and/or perceptions potentially obtained from other participants if different sites had been used. This limits generalisability of the findings regarding the experiences of all the preceptorship programmes' stakeholders, including newly hired experienced nurses, across Saudi Arabia. However, the findings may be transferable to settings that have similar characteristics to those manifest in the study context within Saudi Arabia.

Moreover, there was also the potential to introduce sample bias by including only those preceptors, CRNs, nurse managers whose preceptees were interested and decided to participate. The inclusion of patients' perceptions might therefore have enhanced my study findings by providing another point of view. Furthermore, I did not differentiate between the perceptions of Saudi and non-Saudi participants as the number of Saudi nurses (three) were too small in comparison to the non-Saudi nationals' voice, which could constitute another study limitation.

6.8 The contribution of the thesis

Although some of the study findings mirror those reported in earlier studies, they can still be considered as adding to the body of knowledge. In particular, this study is the first, to the best of my knowledge, to examine preceptorship in relation to newly hired experienced nurses as opposed to newly qualified or new graduate nurses. It is also the first study to look at preceptorship in a Saudi context. Therefore, this study contributes to filling a gap in knowledge about the nature of preceptorship in terms of how it is understood and implemented in the context of newly hired experienced nurses in Saudi Arabia. Hence, the findings of the study provide valuable insight for others planning to implement preceptorship programmes in the future as a means of helping to shape the attitudes and behaviours of preceptors, clinical resource nurses and nurse managers towards the teaching and training of newly hired experienced nurses.

Similarly the thesis contributes to the wider body of literature related to preceptorship as it provides decision makers and programme developers with new knowledge and insight into what newly hired experienced preceptees expect or need in order to be able to integrate and settle into their new environment. Thus, it provides programme planners with new insight into the factors that impact negatively on the preceptorship programme of newly hired experienced nurses. Furthermore, there are three specific contributions this study has made to the existing body of knowledge not highlighted in the previous studies. These include the following:

1. That when experienced nurses relocate to a new cultural setting as newly hired nurses, they need to be treated and supported in the same way as new graduate and newly qualified nurses entering the work place for the first time. Therefore, orientation alone is insufficient to meet the needs of newly hired experienced nurses particularly if they are working in a different cultural context. Furthermore this latter group of nurses need to engage in a comprehensive preceptorship programme through which they can be introduced to the new culture, work routines, rules and regulations as well as trained to work with patients and staff from a different culture. Additionally, they need to be educated in order to help them adapt their existing skills and

knowledge and acquire new skills and procedures to be fully competent and confident in the new clinical practice.

2. The role that recruitment appears to play in the success of preceptorship programmes. This adds to the body of knowledge as it has not been highlighted in previous studies. Thus, this study has revealed the importance of matching the clinical area with a preceptees' clinical qualifications and experiences. Assigning a preceptee to an area which does not fit his/her previous qualifications, skills and/or interest may lead him/her to feel deskilled and demotivated to participate in a preceptorship programme and disinclined to integrate into the new role.

3. The influence that success of the preceptorship programme exerts on preceptors and preceptees clinical nursing care as perceived by the participants themselves. This aspect adds to the body of knowledge as it has not been highlighted in previous empirical studies from the perspectives of newly hired experienced nurses. This study has tentatively indicated that effective preceptorship programmes for newly hired experienced nurses have the capacity to impact positively not only on the preceptees' but also preceptors' clinical nursing care.

6.9 Summary

In this chapter, social learning theory has been used as an explanatory framework for better understanding of the study findings and for discussion of their wider significance. The discussion has examined the importance of the social elements of learning within the context of the preceptorship programme. Furthermore, the study has revealed how important this social learning process is for newly hired nurses to engage in particularly those who move from one culture to another. Despite the above, ambiguities and confusion amongst all the study participants regarding the meaning of preceptorship and its interchangeability with the term 'mentorship' reinforce the findings of other researchers (Beecroft *et al* 2008, Gleeson 2008, Nisbet 2008, Scells & Gill 2007, Wood's 2007, Harbottle 2006, Charleston & Happell 2004). However, my own participants' lack of awareness regarding the meaning of preceptorship was exacerbated further due to the elusiveness of a clear definition

regarding the process extant within the organisation's policy documents. This confusion hampered preceptees learning and with it their ability to achieve their learning needs and expectations. In contrast, the notion of confusion extant within the wider literature only existed when studies were compared and contrasted with each other given that each individual study had its own definition of the term preceptorship underpinned by a clear set of guidelines and policy statements.

This discussion section has also examined the restrictive preceptorship timeframe which participants perceived as an external factor impinging on their interaction with preceptors and clinical resource nurses preventing them actively engaging in the learning process. Similar to the present study, previous studies' have considered allocating sufficient time for preceptorship to be important for the success of the programme, which also needs to be tailored to both the preceptees' needs and a given unit's specific requirements. More importantly, the study revealed that because newly hired experienced nurses were new to the culture, they required a preceptorship programme similar in type and purpose to that offered to newly qualified nurses. In this way, newly hired experienced nurses can be enabled to engage their new role more effectively by inducing greater feelings of confidence and thereby increasing their clinical competence.

Despite the above the discussion highlighted feelings of disquiet given that the preceptorship programme was considered inadequate as preceptors felt they needed more focused preparation and regular updates. However, in addition to being adequately prepared preceptors also identified the need for external rewards and recognition for their role in order to ensure the effective application of the programme.

A rather unexpected finding emergent from this research was the role played by recruitment in the success or failure to the preceptorship programme. This reciprocal relationship between preceptorship and the recruitment process identified a need to match a specific unit's needs with the qualifications of the newly hired experienced nurses (preceptees). The latter was also identified as a vital element for enhancing not only preceptees self-efficacy, but also to integrate into the new setting. As a consequence, preceptees felt that it would have been helpful to be provided with

information about the culture prior to making an application to hasten their cultural awareness and with it their subsequent integration into the new culture.

Although the social and interactive nature of the preceptorship programme was felt to have a positive impact on preceptors' and preceptees' clinical nursing care. The latter appeared to be influenced by the quality of the preceptor; the preceptor-preceptee relationship and the level of reward and reinforcement received by both parties during the preceptorship process. Nevertheless, this needs to be investigated further as the interrelationship between such factors cannot be fully understood from the limited findings of this study alone.

Finally, trustworthiness of the study was assessed in the closing aspect of this chapter by drawing on the criteria outlined by Lincoln & Guba (1985) namely, credibility, dependability, confirmability and transferability. Limitations and the significant contributions of the thesis to the existing body of knowledge were also discussed. In the closing aspect of this thesis the conclusions and considerations for education, management, clinical practice and research will be examined in turn.

Chapter VII
Conclusion and Considerations

7.1 Conclusion

This study aimed to explore the nature of preceptorship and its impact on clinical nursing care from the perspectives of all stakeholders within a Saudi context. Hence, four groups of participants (preceptees, preceptors, nurse managers, and clinical resource nurses and nurse educators) were purposively and convenience sampled to participate in the study. Unlike other studies however, preceptees, in this case, were newly hired experienced nurses¹⁹ as opposed to newly qualified nurses. The study itself was conducted using a generic qualitative approach drawn from the theoretical perspectives of naturalistic inquiry. Adopting a generic qualitative approach was considered appropriate as it helped to achieve the aim and objectives of this study. Furthermore, it helped to find answers to the research questions and facilitated the acquisition of more diverse data in order to develop an overview of what preceptorship in the Saudi context constituted and how it might influence the clinical nursing care of both preceptees and preceptors.

Semi-structured focus group and individual interviews as well as a review of the policy documentation were the methods applied to generate the study data. Data were analysed using thematic analysis. Applying these data generation and analytic techniques allowed me to gain rich insight into newly hired experienced nurses and other programme stakeholders' perceptions of preceptorship. The findings of this study provided greater insight into how the preceptorship programme in the study setting was perceived by all those involved. In particular, it explored what the newly hired experienced nurses both needed and expected to achieve by the end of the programme and how the programme was actually implemented on the ground. In addition, other factors that were seen as influencing the success or failure of the preceptorship process were also articulated.

The study findings highlighted that the preceptorship programme in the study setting was not consistently implemented by those involved. The reason for this was that considerable confusion existed around the meaning of preceptorship, which reflected the inconsistent language used in the policy documentation as well as the lack of clear written guidelines showing how the programme should be implemented.

¹⁹ See page 9

This confusion and inconsistent application of the preceptorship process resulted in the needs and expectations of some preceptees not being accurately assessed and therefore not completely met. Conversely, for other preceptees, these needs were met in their entirety. The differences in participants' views regarding the impact of preceptorship on clinical nursing care in respect of both preceptees and preceptors; enhancement of clinical nursing care was felt to be dependent on how successful the preceptorship programme was. This included the need to appropriately assign qualified preceptors to preceptees, having a flexible timeframe for preceptorship, building trusting preceptee-preceptor relationships and providing clear, understandable guidelines regarding the roles and responsibilities of each party involved.

The findings also indicated that inaccurate information received by prospective employees during the recruitment process may have contributed to the failure of the preceptorship programme. More importantly, failure to match nurses' experience with the wards' needs and vacant positions was also found to have had serious ramifications for the preceptorship process. Furthermore providing appropriate emotional, and needs-based educational support during the preceptorship period was also seen as a major motivator encouraging preceptees to integrate more easily into their new role. Focused preceptor preparation, managerial and peer support coupled with rewards and recognition for each member involved in the preceptorship programme were also perceived to be essential factors for promoting success of the programme by helping to meet nurses' individual needs.

The main study findings have been examined by reflecting on the research questions and using social learning theory as an explanatory framework to enable me to explain why specific factors impacted impeded or enhanced the preceptees development by drawing on the participants' perceptions. This latter action helped to provide a more meaningful explanation of the participants' behaviour during the preceptorship process and enabled me to generate significant conclusions from the data. Hence, this thesis provides useful insight into those factors that need to be taken into consideration when planning and implementing a preceptorship programme for newly hired experienced nurses as it has raised a range of issues that relate specifically to the preceptorship of this unique group of nurses in the Saudi context. Although

some of these findings were similar to what have already been highlighted in the literature, other aspects are different. This is because to the best of my knowledge no study has previously examined the preceptorship needs of newly hired experienced nurses and neither has any study looked at this in a Saudi context. Hence this study contributes to the body of existing knowledge by highlighting significant factors that have not previously been examined in the preceptorship literature.

Hence the knowledge regarding preceptorship that this thesis adds to that already extant in the literature is that preceptorship programmes need to be provided for newly hired experienced nurses, particularly those who move from their own known culture to one that is totally different. The reason for the latter is that; although such nurses are highly experienced, because they are suddenly acculturated moving from the familiar to the unfamiliar they are often just as, if not more vulnerable, than newly qualified nurses particularly when they first arrive in the new setting.

Finally, participants perceived the effect of the preceptorship programme on the clinical nursing care of both preceptees and preceptors was based on the quality of preceptors, the preceptor-preceptee relationship and the level of reward and/or support received from the supporting personnel. However, this is an area that needs to be investigated further in the future.

7.2 Considerations

The considerations outlined here have been generated in light of the study limitations identified in section 6.7 and are based on the discussions outlined in the thesis thus far. Consequently these considerations address factors emergent from the study in relation to recruitment, clinical nursing education, nursing management, clinical practice and future research.

This study has helped to identify issues that need to be considered when supporting newly hired experienced nurses in any setting. The importance of preparation and support for all parties involved in the process and access to standardised programmes has been identified as an important consideration for organisations. Whilst the preceptorship programme is an important instrument for nursing

development, further work is needed to demonstrate its actual benefits to patients and the care they receive. Thus, my considerations are as follows:

7.2.1 Considerations for recruitment

7.2.1.1 The process of adjustment into the new setting should be started and facilitated prior the preceptees' arrival by providing them with pre-arrival information about the relevant (Saudi – in this case) culture and health care system. Pre-arrival packages should include clear, appropriate and accurate information about the clinical setting, environment, health system and common terminologies used between patients and nurses to facilitate communication with people both internal and external to the hospital.

7.2.1.2 The pre-arrival information should be prepared in collaboration with the nursing education department, recruitment personnel and administrative department in the study setting. The nursing education department should provide a brief overview of the nursing services, business hours, nursing care standards, the organisation's mission and vision, the probationary period and in particular the content and expectation of those engaging in the preceptorship programme. In addition, the skills and procedures that need to be acquired by each new nurse by the end of the preceptorship programme also needs to be articulated to give a clear overview of the nurses' roles and responsibilities in the clinical setting in order to prepare them for their new role.

The administrative department should be responsible for providing precise information about the Saudi culture and health care system in the study setting including religious values and beliefs, food, sources of transportation, communication language, attractions, available resources and types of shopping, immigration policies and conditions of residency.

Recruitment personnel should then be accountable for providing the necessary information about nurses' rights including the policy for making annual leave applications, salary issues and qualifications required

for specific positions. The three departments should work as a team to develop, organise and update this information. The responsibility of the recruitment agencies thereafter should be to ensure that each applicant has one copy to read at the time of their application. If such a strategy were to be implemented then the amount of information required to be imparted during the orientation week would be reduced. Thus, more time could then be spent addressing other role requirements, in particular the generic and unit specific clinical competencies.

- 7.2.1.3 The recruitment process should be based on the quality not the quantity of nurses which means that recruitment officers responsible for hiring new staff need to be aware of each unit's requirements and match these with preceptee expertise. In addition, the recruitment office also needs to select the best-qualified nurses who are able to learn easily and quickly so as to be fully trained and prepared for their new role in a limited timeframe. In order to achieve this, there should be collaboration between those in the recruitment office and head nurses in order to update them regarding the latest clinical requirements so that these can be matched to applicants' CVs. Hence, nurse managers should also be involved in the recruitment process by reviewing applicants' CVs prior to interviewing applicants in order to assess their suitability for the position and to improve the quality of the recruitment process.

7.2.2 Considerations for clinical nursing education

- 7.2.2.1 Clear written policy documents stating the exact nature of preceptorship, its duration, the role and responsibilities of each member involved, and what the organisation expects by the end of preceptorship period should be developed. The supernumerary, probationary period and orientation programme should be clearly defined in order to clarify their meaning. In addition, how these concepts relate to each other in practice and how each one should be applied in the context of the organisation also need to be clarified. This would serve to remove any ambiguity, achieve standardisation of the preceptorship programme and ensure its effective implementation. Furthermore, such policies should also be reviewed and

updated every two years so they remain current and reflective of organisational needs and developments.

7.2.2.2 Clear written guidelines to help make the preceptorship programme a positive experience for everyone and help preceptees, preceptors, nurse educators, clinical resource nurses and nurse managers understand their roles in the preceptorship process should also be constructed. These guidelines should outline how the preceptorship programme should be implemented and enacted by each party involved in the process to generate a consistent approach to the execution of the programme.

7.2.2.3 A more frequent, standardised preceptor preparation workshop should be offered. This workshop should be mandatory for all programme stakeholders. Its contents should cover the roles and responsibilities of preceptorship, preceptees' needs, adopting the principles of adult learning, effective teaching, performance assessment and strategies for effective precepting and support.

7.2.2.4 Frequent meetings should be conducted to enhance communication between programme stakeholders within the organisation, particularly between preceptors and educators, in order to review and evaluate how the programme is progressing and to exchange experiences in order to prevent or at least reduce inconsistencies in the delivery and implementation of the programme.

7.2.3 Considerations for nursing management

7.2.3.1 Development of a reward system not only for preceptors but one that includes all those programme stakeholders who demonstrate best practice in order for them to feel more integrated and valued within the organisation. In this way, commitment to the programme can be enhanced and the importance of the preceptorship programme for improving the organisation should be stressed as a way of raising the profile of the preceptorship programme to effect greater engagement with the process.

7.2.3.2 The duration of the preceptorship programme should be flexible and allocated according to each preceptee's needs and each unit's requirements. Extending the preceptorship period should be considered by the organisation in order to provide enough time for the preceptees and preceptors to perform their role successfully. Therefore, it is recommended that the duration of preceptorship programme should not be less than four month and not more than six month as this timeframe was highlighted by the studies' participants as well as the UKCC as an average time for the preceptorship period of newly hired nurses to integrate fully into the new role.

The four month model could be considered the minimum period during which preceptees are assisted to integrate into their new role. If preceptees did not attain the necessary skills, then both the CRNs and nurse managers could support the preceptee via the development of an action plan. In this case, the allocated time could be exceeded for the preceptees to complete the preceptorship programme, which in essence encroaches into what would normally be considered to represent the newly hired nurse's probationary period.

7.2.4 Considerations for clinical practice

7.2.4.1 Study participants sometimes felt that time was wasted learning skills and carrying out clinical procedures not commonly practiced on their particular unit therefore it is recommended that the generic competencies addressed as part of the preceptorship process should be based on each unit's requirements.

Attention to and compliance with these considerations could potentially lead to the development and implementation of more efficient and effective preceptorship programmes in Saudi Arabia and elsewhere and a more positive outcome for all stakeholders involved in the process. Possible future research related to clinical practice could include the following topics.

7.2.5 Considerations for future research

- 7.2.5.1 In view of the study themes and considerations, research to explore preceptorship purely from Saudi nurses' perceptions might be useful to identify the preparation and support needs that might be required to prepare Saudi preceptors and preceptees for their role.

- 7.2.5.2 Examination of how Saudi nurses themselves perceive preceptorship should also be conducted to see how these compare with the views of international nurses. Gaining insight into this additional dimension of the workforce may identify different factors and needs that require consideration by educators when developing preceptorship programmes.

- 7.2.5.3 Research comparing the current study findings with other preceptorship programmes in Saudi Arabia to highlight any similarities and/or differences as well as exploring the potential for implementing a standardised preceptorship programme across the Saudi health care system would also be useful and help to raise the profile of preceptorship nationally.

- 7.2.5.4 Further research needs to be conducted to explore the impact preceptorship has on the quality of nursing care delivered by both the preceptees and preceptors. Additionally, research to explore patients perspectives regarding the quality of care received from preceptees before and after engaging in a preceptorship programme would be a further topic area that could be examined by researchers in order to objectively measure the impact of preceptorship on the quality of clinical nursing care by measuring patients' satisfaction with the competency level of nursing care received.

The above considerations would help to develop a better understanding of the preceptorship process by adding new data to the existing body of knowledge.

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Appendices

Appendix A

Critical appraisal of Environmental and Occupational Health Literature

Critical appraisal of Environmental and Occupational Health Literature

Introduction:

This is a guideline for the steps that should be followed in critically appraising the quality and validity of published literature. Although it is of some benefit on its own, it needs to be practised and applied a few times preferably under the supervision of an experienced mentor for maximum benefit to be attainable.

Title:

- Does this accurately reflect the main scope and nature of the work?

Abstract:

- Is this a well structured, accurate and balanced summary of the work?
- Does it distinguish between the results and the conclusions drawn?

Objectives:

- Are these clearly stated in the introduction?
- How specific are they?
- Have they been met?
- Do they raise hypotheses or test hypotheses?

Study Design, Methods, subjects etc:

- What approach has been used? e.g. case series, cross-sectional, cohort, case-control.
- Was it appropriate and could it reasonably be expected to fulfil the objectives?
- Cross refer to other teaching material in Epidemiology and Environmental Risk Assessment etc as appropriate.

Study "Populations" and Sampling

- Was the study "population" clearly defined?
- Is it representative of the group from which it is drawn?
- How satisfactory was its sampling?
- How was the sample size chosen?

Methods Used

- How has the information been obtained?
- Have sources of data been clearly described?
- Have they been validated?
- Are they reproducible?
- Could they have been biased?
- Is quality control of collection of information mentioned?

Remember: even a review article should have a method; including criteria for identifying, selecting, and evaluating original published work.

Controls

- Are these appropriate?
- How distinct from the cases were they?
- Could there have been misclassification?
- Has matching been carried out correctly?

Exposure

How well was this 'specified', (i.e. characterised as to its identity, and other relevant co-exposures assessed)?

Results

- Do these appear in enough detail to permit some checking for accuracy (between the text, tables, figures etc)?
- Are they consistent?
- Are they detailed enough to justify the conclusions?
- If appropriate, are they consistent with an exposure-response relationship?
- Cross refer to other teaching material in Epidemiology and Environmental Risk Assessment etc as appropriate.

Response Rates

- Are these quoted?
- Could a poor response rate hide the possibility of important bias?

Bias and Other Distortions

- What are the most important sources? i.e. interviewer, observer, recall, selection, response, etc.

Discussion and Conclusions

- Are the conclusions consistent with the reported results?
- Are they plausible?
- Were the sources, direction and magnitude of bias adequately discussed?
- Have the confounders been adequately considered?
- Could other conclusions be drawn from the same results? (e.g. if they rely on temporality alone).
- Has there been an adequate comparison with other relevant literature?

- How relevant were the study population and conditions of exposure to the conclusions drawn?

Authors and Citation

- Is the source of the reference clear?
- Are the authors and their affiliation clear?

- Where can further information be sought?

Other Points

- How differently would you have undertaken a study to fulfil the same objectives?
- Why did the authors not follow the approach you might have advocated?
- What other information would you seek about this particular study?
- What other information would you seek to corroborate or refute the conclusions of this particular study?
- Is this study likely to make a difference in relation to understanding or practice?

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You may also wish to consult a [companion page](#) on searching and appraising Environmental health information on the Internet.



Return to the alphabetical [Index of Resources](#), or to the [FAQs](#)

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Appendix B
Data Extraction Sheet

Data Extraction sheet

Quantitative studies		
No	Items	Details
1	Author/ Year	Charleston R. & Happell B./ 2004
	Title	Evaluating the impact of a preceptorship course on mental health nursing practice The title reflected the scope and nature of the study.
	Aims/ purpose	The purpose was to present an overview of the programme and/or workshops held for training preceptors; the findings emerged from an evaluation of this programme conducted between 2000 and 2002.
	Objectives	Not stated
	Research questions	Not stated
	Methodology	Quantitative, Evaluative design This was considered appropriate as it helped to achieve the research purpose by eliciting the participants' experiences of the programme and generated various areas for future development.
	Data Collection Methods	Evaluation instrument (questionnaire) consisting of two sections of closed and open-ended questions was used. The first section aims to capture participants' experiences of the preceptor programme by responding to 15 statements through a numeric value rating from 1 (strongly disagree) to 10 (strongly agree). The second section aims to identify areas for improvement and any further resources which could be provided by the Centre for Psychiatric Nursing Research and Practice to support the implementation of professional development activities within the workplace. Finally, the opportunity was given to preceptors to provide any relevant comments they considered important. The questionnaire was distributed into 154 nurses, 150 completed questionnaires were returned: a response rate of 97%.
	Data Analysis Methods	The numeric value of each statement of the first section was entered into an excel spreadsheet. The mean score was then calculated for each question. Content analysis was used for analysing data of the open-ended questions of the second section in order to identify the major themes.
	Sampling /setting	150 participants including primary mental health nurses and allied health and consumer consultants were included in the study. Study setting included large numbers of mental health services in both metropolitan and rural settings from most regions of Victoria, Australia.

Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - For the validity of the study, participants’ approval to participate in the study was obtained and consent form was signed by each participant. - Response rate was high. - Findings were presented briefly but were integrated with tables which allowed checking for accuracy. - Conclusions were consistent with the reported findings. - There was adequate comparison with other relevant literature. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Abstract was not well developed or structured. Methodology adopted was not stated. It did not distinguish between the findings and conclusion drawn. - Formal ethics approval was not obtained as this study was conducted as a Quality Improvement exercise. The guidelines as stated by the National Health and Medical Research Council were followed in conducting the study. - Study rigor was questionable as methodology, data collection, data analysis and sampling techniques were not clearly stated which made replication of the study impossible. - Although participants included nurses from different mental health services and settings, sample size is not sufficient to generalise the study findings to all mental health nurses. - Study population was not indicated clearly. Sample was not representative of the population. It is not clear how the sample size was chosen. It lacked randomisation. Setting was uncontrollable - The questionnaire was self-reported allowing greater risk of missing data and potential for response bias. - The questionnaire was not piloted which impacted on the validity and reliability of the data obtained and on findings. - The study setting was unknown; no clear detail regarding the settings or demographic characteristics of the participants added to difficulties of replication. - No specific framework adopted. - The magnitude of bias was not discussed.
Findings	<ul style="list-style-type: none"> - Data revealed that participants gave a high satisfaction score to the course overall. - A total of 244 comments were made regarding what participants liked best about the subject under study. These

		<p>comments include: having an opportunity to communicate, networking with other psychiatric nurses about preceptorship and enhanced knowledge about the preceptor role.</p> <ul style="list-style-type: none"> - A total of 92 suggestions for improvement of the preceptorship course were provided by the participants. ‘No change is required’ was the most common comment, while the other suggestions included increasing time for group discussion and revising the content of the programme to include effective strategies for providing feedback for the preceptees . - 182 comments were extracted from participants’ responses regarding how participation in the workshops may alter future practice. Enhancing preceptor awareness of preceptees’ needs and learning styles was the most frequent comment to be highlighted. A commitment to promoting the organisation of preceptorship and enhanced commitment to and understanding of preceptor role were other comments indicated. Finally, 70 additional comments were disclosed. Another common response highlighted indicated that the subject was relevant, enjoyable and well presented.
	Inclusion/ Exclusion Criteria	Although the inclusion and exclusion criteria were not stated, the study included all participants who completed the preceptor course.
	Clinical Implication	This study has an implication on nursing practice as it identified issues, such as preceptorship impact on preceptors’ knowledge and attitudes which could enhance nurses’ willingness to act preceptor role. Furthermore, importance of preceptorship for the recruitment process could be considered by the organisation personnel.

2	Author/ Year	Giallonardo M., Wong C. and Iwasiw C./ 2010
	Title	Authentic leadership of preceptors: Predictor of new graduate nurses' work engagement and job satisfaction. The title reflected the scope and nature of the study.
	Aims	To examine the relationship between authentic leadership of the preceptor, job satisfaction and work engagement from the perspective of new graduate nurses.
	Objectives/ hypotheses	The study hypotheses were formulated based on the Avolio <i>et al</i> (2004) theory of authentic leadership and a review of the literature. The author hypothesized that: 1) new graduate nurses' perceptions of preceptor authentic leadership could enhance work engagement and job satisfaction. 2) New graduate nurses' work engagement mediates the relationship between the perceptions of preceptor authentic leadership and job satisfaction.
	Research Questions	Not stated
	Methodology	A predictive non-experimental survey design was used to examine the relationship between the study variables This method was considered appropriate as it illustrated the relationship between the variables and helped to test the authors' hypotheses to achieve the study aims.
	Data Collection Methods	<ul style="list-style-type: none"> - Mailed survey. - Study variables were measured using three standardized self-report instruments. - New graduate nurses' perceptions of preceptors' authentic leadership was measured by using the authentic leadership questionnaire. The questionnaire consisted of 16 items, divided into four authentic leadership subscales: relational transparency, balanced processing, self awareness and internalised moral perspective. The validity of the four sub-scales was supported by confirmatory factor analysis. Items were rated on a five point likert scale ranging from 0=not at all to 4=frequently, if not always. The self report questionnaire (Utrecht work engagement scale) was used to measure new graduates' work engagement. It consisted of 17 items based on work engagement components: rigor, dedication and absorption. The latter three dimensions were supported by the confirmatory factor analysis. Items are rated on a seven point likert scale ranging from 0=never to 6=always, everyday. Part B of the index of work satisfaction instrument was used to assess job satisfaction among study participants. The instrument contained 44 items divided into six sub-scales: pay, autonomy, task requirements, organizational policies, professional status and interaction. Items were rated on a seven point likert scale ranging from 1=strongly agree to 7=strongly disagree. A demographic questionnaire was included by the

		researcher to identify demographic information regarding participants' age, gender, year of graduation, type of nursing programme attended, academic institution attended, length of employment in the current work setting, employment status, specialty area and preceptorship experience.
	Data Analysis Methods	<ul style="list-style-type: none"> - Statistical Package for Social Science (SPSS) version 16.0 was used for data analysis. Descriptive statistics were computed on all study variables. - Pearson's correlations, hierarchical multiple regression and mediation analysis were used to test the study hypotheses.
	Sampling/setting	Study sample contained 170 registered nurses. These nurses were selected randomly from the registry list of the College of Nurses of Ontario.
	Methodological Robustness	<p>The study strengths were that:</p> <ul style="list-style-type: none"> - Ethical measures were considered. Validity and reliability of the instruments used in the study were measured and stated clearly in the text which ensured the validity of the data obtained. - Abstract was well structured and developed. Findings were distinguished from the conclusion. - Theoretical framework was stated clearly and concepts were defined clearly. - Sample was randomly selected. - Complete demographic characteristics of the participants were presented and demonstrated in tables for checking accuracy. - Data collection and analysis methods were clearly stated as well as how the sample was recruited which could help other readers think about replication of the study. - Findings were adequately reported and integrated with tables for accuracy checking. - Conclusions were consistent with the reported findings. - Sources and magnitude of bias was adequately discussed. - The findings were adequately compared with the relevant literature. - The findings could be cautiously generalised to new graduate nurses working in an acute care setting in the province of Ontario. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - There was a potential for response bias as self-reporting questionnaires were used.

		<ul style="list-style-type: none"> - There was a possibility of missing somebody from the list as what was listed as ‘current’ was the previous study year’s registration list. Furthermore, some of the registered nurses indicated that they did not want to participate in any research. - Findings may be impossible to generalise to new graduates working in acute care setting because of the relative homogeneity of the sample, small sample size and low response rate.
	Findings	<ul style="list-style-type: none"> - New graduate nurses perceived their preceptor as having a moderated level of authentic leadership (M=3.05, SD=0.62). No direct comparisons could be made with other like groups as these groups have not been studied in authentic leadership research. - New graduates engaged moderately in this study (M=3.98, SD=0.61). ‘Dedication’ was reported as the highest engagement factor (M=4.53, SD=0.79) followed by ‘absorption’ (M=3.85, SD=0.71) and ‘vigour’ (M=3.77, SD=0.70). - Findings reported a moderate level of job satisfaction. New graduate nurses reported professional status (M=23.36, SD=5.00) to be the most satisfying aspect of their work, while the most dissatisfying was the pay factor (M23.36, SD=6.62) - No significant relationships were found between the demographic variables and the major study variables. - In relation to the test of the first hypothesis, findings revealed that work engagement and preceptor authentic leadership were both significant independent predictors of job satisfaction. Findings of the correlation between major study variables uncovered that new graduate nurses’ work engagement was positively related to new graduate perception of authenticity. - In relation to the second hypothesis, findings revealed a positive relationship between authentic leadership and work engagement. Authentic leadership was positively and significantly related to job satisfaction. Accordingly, work engagement was positively related to job satisfaction. The mediating effect of work engagement on authentic leadership and job satisfaction was significant. Thus, the second hypothesis was partially supported. - No significant differences were found in job satisfaction and work engagement of new nurses who took part in the preceptorship programme and those who did not. It was deduced that the quality of preceptorship relationship, as opposed to the length of time, may play a greater role in predicting work-related attitudes of new graduate nurses.

	Inclusion/ Exclusion Criteria	Registered nurses who had less than or equal to three years nursing experience and worked in an acute care setting.
	Clinical Implication	Implication for nursing management. Managers must be aware of the role preceptors' authentic leadership plays in promoting work engagement and job satisfaction of new graduate nurses.

3	Author/ Year	Hancock J./2002
	Title	Preceptorship on a Neonatal Intensive Care Unit: Evaluating effectiveness The title reflected the scope and nature of the study.
	Aims	The aim was to enhance the learning environment and support for new staff nurses.
	Objectives/ hypotheses	The objectives were to: <ul style="list-style-type: none"> - Investigate the effectiveness of this programme in relation to the support and integration of new staff nurses into new roles in a very different clinical speciality. - Explore what aspects had been positive for both the learners and the preceptors. - Identify outstanding needs and barriers. - Identify aspects that needed to be added to the existing programme.
	Research questions	Not stated
	Methodology	Quantitative evaluation methodology.
	Data Collection Methods	An audit questionnaire was distributed to the study sample. The questionnaire was developed following discussion with the clinical team; this included nursing staff, managers, the clinical leader and other clinical educators from neighbouring units. It was designed on the base of the Likert Scale, described by Bell (1999). The questionnaire contained four point scales which were used to force the respondents to provide a positive or negative response. The response rate was 87% for the preceptees group, 66 % for the preceptor group.
	Data Analysis Methods	It was not stated how the data had been analysed.
	Sampling/setting	Included 40 participants: 16preceptees, 24 preceptors and team leaders. The study was conducted in the neonatal intensive care unit at the Great Ormond Street NHS Trust; no additional detail on the setting was provided.
	Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - The results were presented with tables and figures to check accuracy of the findings. The weaknesses of the study were that: <ul style="list-style-type: none"> - there was no abstract. - Study rigor was questionable as no clear, adequate information regarding the study sample or how they were recruited. The questionnaire was not validated, data analysis method was not stated, all of which impacts on the

		<p>validity and reliability of the findings as well as on the study rigor.</p> <ul style="list-style-type: none"> - There was no adequate information about the demographic characteristics of the study sample and setting which made generalisation and replication impossible. - There was confusion between discussion, findings and recommendations sections as the discussion appeared as statements for recommendations only. - Findings were not discussed with the relevant literature.
	Findings	<ul style="list-style-type: none"> - Almost all the preceptees felt that they received a good (35%) or very high level (50%) of support in their first six months. - 58% of the preceptors evaluated the programme as being ‘good’ while 35 % of them evaluated it as ‘very good’. - The clinical skill log was rated as ‘very good’ by 62% of the preceptees and intravenous workbook as ‘very good’ by 77 %. - Comments were summarised according to the common themes but were not reported in the findings section.
	Inclusion/ Exclusion Criteria	<p>The included Criteria were:</p> <ul style="list-style-type: none"> - The new staff who had undertaken the preceptorship programme since February 2000. - The staff who supported the new staff - The team leaders who co-ordinated the support within their own teams on NICU <p>No exclusion criteria were specifically highlighted.</p>
	Clinical Implication	<p>Support from the preceptees, preceptors and team leaders is necessary for the success of any programme. This finding could be considered by the clinical practitioners including educators when they deliver preceptorship programme.</p>

4	Author/ Year	Hardyman R. and Hickey G./ 2001
	Title	What do newly-qualified nurses expect from preceptorship? Exploring the perspective of the preceptee The title reflected the scope and nature of the study.
	Aims / purpose	The aims of the study were to document the careers followed and to analyse the professional and personal factors that may influence careers. This paper presented the findings that explore newly qualified nurses' expectations of preceptorship.
	Objectives/hypotheses	No objectives or hypotheses were stated.
	Research Questions	What do newly qualified nurses expect from preceptorship and how satisfied they are with what they receive?
	Methodology	Longitudinal quantitative survey, pilot work This was considered appropriate as it helped to explore the nurses' expectations and answer the study questions over a long period.
	Data Collection Methods	<ul style="list-style-type: none"> - Data were collected using a postal questionnaire sent at qualification and 6 months after qualification. Each questionnaire was developed with a pilot cohort, qualified in the year preceding the main study cohort. 424 newly qualified nurses helped to develop the questions of the 'at qualification' questionnaire. - The piloting process of each questionnaire involved three stages. The first was semi-structured interviews with pilot cohort members regarding the issues for inclusion in the questionnaire. The second stage was questions developed from the first stage which were tested for clarity and relevance. In the third stage a draft questionnaire was sent to the sample to complete and comment on its structure and content. - The questionnaire concentrated on three questions: did respondents want a preceptor, how long did they want their preceptorship to last and how important did they consider various aspects of preceptorship to be?
	Data Analysis Methods	It was not clearly stated how the data were analysed.
Sampling/ setting	<ul style="list-style-type: none"> - The study sample was nationally representative and comprised 3476 nurses who qualified from all four branches of the nursing diploma course (adult, child, mental health and learning disabilities) between August 1997 and July 1998. This paper presented findings from the adult branch. - The primary sampling setting selected was a college of nursing which facilitate meeting students in pre-determined teaching groups. 	

	<ul style="list-style-type: none"> - Students were recruited by personal visit. A simple random sample from a single college sampling frame was taken. - The final sample for the adult branch comprised 2109 students which represented a sampling fraction of approximately one-third. 87% (1832) of those agreed to take part, of whom 87% (1796) returned the first questionnaire. 1512 nurses were asked about their expectations of preceptorship.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - How the samples were recruited was stated clearly. The sample was representative of the total population of newly qualified nurses from which it was drawn. This made the idea of generalisation possible to all newly qualified nurses. - Pilot work was detailed clearly which enhanced the validity of the data obtained. - Questionnaire was validated and piloted. Findings were reported in very clear detail and supported by the tables in order to check accuracy which enhanced the validity and reliability of the findings. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - a brief, balanced summary of the work was stated, but it did not distinguish between the conclusion and findings obtained. - Sources, direction of bias as well as limitations of the study were not discussed at all. - No discussion section. - Replication of the study could be done with some caution as the data analysis technique was not stated.
Findings	<ul style="list-style-type: none"> - 97% of respondents wanted a preceptor during their first nursing job. - 51% of those who wanted a preceptor wanted preceptorship for 6 months. - 91% considered constructive feedback on their clinical skills a very important aspect to be considered in the preceptorship period.
Inclusion/ Exclusion Criteria	Not clearly stated.
Clinical Implication	The study could has clinical implications for nurse educators and administrators when deliver preceptorship programme as it highlighted issues such as preceptorship time, period, when it should be conducted for the new staff and what these nurse expected from preceptorship.

5	Author/ Year	Kim K./ 2007
	Title	Clinical competence among senior nursing students after their preceptorship experiences The title reflected the nature and scope of the study.
	Aims	To explore students' perceptions of their competence.
	Objectives	To examine the perceptions of baccalaureate senior nursing students regarding their clinical preceptorship in relation to the degree of interaction with their preceptor and to evaluate their perceptions of competence in implementing the nursing process.
	Research Questions	<ul style="list-style-type: none"> - What are the perceptions of senior nursing students of their clinical preceptorship and relationship with their preceptor? - How competent do senior nursing students feel about implementing the nursing process at the end of the preceptorship experience? - Is there a relationship between the level of perceived nursing competence and the degree of interaction between the preceptors and senior nursing students?
	Methodology	Descriptive Correlational design. This method was considered appropriate as it helped to achieve the study objectives and examined the relationship between the study variables i.e. their level of competence in providing nursing care to patients and their degree of interaction with their assigned preceptor.
	Data Collection Methods	Self-administered 52 item questionnaire, using a five point Likert Scale was used to collect the data from the sample (students). It comprised two categories; the first consisted of opinion statements that evaluated the sample perceptions of their relationship with the preceptor. The second category contained competence-oriented statements to indicate the sample perceptions of their competence to perform the clinical skills in the clinical settings.
	Data Analysis Methods	SPSS and descriptive statistics included mean values, median values and standard deviations which were used to analyse the data in addition to cross-tabulations; percentage scores were calculated to analyse response differences between opinion and competence statements. Correlation coefficient was used to determine the relationship between sample perceptions of competence and degree of interaction with preceptors.
Sampling/ setting	- 92% (108) of the students signed the informed consent and completed the questionnaire, however only 102 students were included in the study as 6 did not fully complete the forms.	

	<ul style="list-style-type: none"> - The sample were recruited from various clinical areas (medical/surgical, paediatric, maternal-child, intensive care, emergency department and operating room) in one setting.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - The abstract was a well developed, structured and balanced summary of the work. It also distinguished between the results and conclusion drawn. - The conceptual framework was stated clearly and applied effectively for structuring and conducting the study, accordingly it helped to achieve its purpose. - Questionnaire content validity was achieved as its content was reviewed and analysed by the author and numbers of faculty teachers. The questionnaire was piloted and then revised to the format used in this study which enhanced the validity and reliability of the data obtained. - Ethical approval was obtained to conduct the study. - The study process was clearly detailed which enhanced the probability of replication of the study. - The findings were clearly stated and integrated with tables for data checking accuracy. This led to the drawing of a clear conclusion. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - The sample lacked randomisation as it is a descriptive study which made generalisation of the findings of all senior nursing students difficult. - The study used a self-reported questionnaire which enhanced the possibility of response bias. - There was a lack of complete demographic characteristics of the sample and clear description of the setting. It is difficult to assess how representative respondents are of the complete population and there was a lack of information about the sampling frame adopted - The setting was not controllable as the study was conducted in a natural setting. - There was no adequate comparison with other relevant literature.
Findings	<p>Findings were reported according to each research question. The findings of the first question indicated that 90 % of students perceived having a primary preceptor in a clinical setting was very important. The interaction with the preceptor were rated as highly important. The finding highlighted that preceptorship is a helpful process in identifying students' strengths and weaknesses. The findings of the second questions illustrated that 95% of the</p>

		students rated themselves as 'competent' to 'very competent'. 90% perceived that their competence increased with the preceptorship programme. In the third question, the findings indicated a significant correlation between student/preceptor interaction and student perceptions of nursing competency skills.
	Inclusion/ Exclusion Criteria	Inclusion criteria were senior nursing students who enrolled in the final clinical course of a baccalaureate nursing programme in northern California
	Clinical Implication	This study was considered unique as it illustrated the benefit of preceptorship programme from different perspectives. The findings have clinical implications for the educators of senior students.

6	Author/ Year	Kuroda T., Kanoya Y., Sasaki a., Katsuki T. and Sato Ch./ 2009
	Title	Relationship between educational programs offered at Midsize Hospital in Japan and novice nurses' anxiety levels. The title reflected the nature and scope of the study.
	Aims / purpose	The purpose was to describe the type of education for novice nurses and their level of anxiety in a midsize or local hospital.
	Objectives	Not stated
	Research Questions	Not stated
	Methodology	Approach to be adopted was not stated.
	Data collection methods	Two types of questionnaire were used to collect the study data; one for nurse managers and another for novice nurses. They were prepared based on previous study results. They were piloted and tested by five experienced nurses. A detailed description of each questionnaire, its aim, contents and number of pages was provided.
	Data Analysis Methods	Statistical analysis including the Mann-Whitney U test was used to compare scores for the Bedside Educational Programme. The t test was used to analyse the Stated-Trait anxiety Inventory scores. State Views 5.0 was used for all statistical analyses.
	Sampling/ setting	The sample consisted of nurse managers and novice nurses in 15 adult general hospitals with 150-200 beds in Chiba prefecture, located near Tokyo. The hospital was chosen from the hospitals' bulletin in Japan. 11 hospitals were included as they had novice nurses and nurse managers agreed to participate. 63 novice nurses agreed to participate in the study; one was excluded because s/he did not meet the criteria of novice. Accordingly, a total of 62 nurses and 11 nurse managers were included.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract was well structured, provided a clear summary of the study and distinguished between results and conclusions. - Ethical approval was obtained to conduct the study. - The content validity for the data collection tools was achieved which ensured valid data was obtained and thus ensured validity and reliability of the study's findings. - Detailed findings supported by demonstrating tables were illustrated which allowed for checking the accuracy and helped to draw clear conclusions. - Findings were compared with adequate relevant literature, leading to drawing appropriate conclusions. 	

		<ul style="list-style-type: none"> - The study was considered unique as it drew attention to the importance of preceptorship for the novice nurses and how such a supportive programme could impact on their anxiety level. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - There was a potential for response bias as mailed questionnaires were used and novice nurses responses regarding the programme's effectiveness could be affected by their relationship with the managers. - There was potential for selection bias as nurse managers were the ones who collected the envelopes and mailed them, so, it was possible they could have ignored some envelopes while returning others. - The study lacked information about the sampling frame adopted or how the sample was recruited. - Methodology and sampling frame were not known, so it was not possible to assess their appropriateness to achieve the aims of the study. - Sample size was small, and was recruited from one area which made generalisation of the findings to all novice nurses impossible. - Replication would be impossible as the study procedures were not stated in detail.
	Findings	<ul style="list-style-type: none"> - Response rate was 73.3 % - The findings showed that preceptorship was used in 8 of the 11 hospitals, while others used other types of training programmes. - The opportunity for learning experiences in hospitals with preceptorship was found to be greater than in hospitals without preceptorship. However, no significant differences between the hospitals were found for the other items. - There were no significant differences in anxiety score between the novice nurses who received preceptorship and those who did not.
	Inclusion/ Exclusion Criteria	<p>The study included:</p> <ul style="list-style-type: none"> - Novice nurses who had a nursing degree and worked in the chosen hospitals since April 2001. Thus they had approximately 5 to 6 months of experience. - Those who had experience from hospitals or other health care facilities but no nursing license (ie. clerks and nursing aids).

		The study excluded: - All nurses who did not complete their questionnaire.
	Clinical Implication	The preceptorship programme would be effective for novice nurses who have less experience. Further study is needed to examine this issue.

7	Author/ Year	Lee T., Tzeng w., Lin Ch. And Yeh M./2009
	Title	Effects of a preceptorship programme on turnover rate, cost, quality and professional development The title reflected the scope and nature of the study.
	Aims / purpose	The purpose was to: <ul style="list-style-type: none"> - Design a preceptorship programme - Evaluate its effect on turnover rate, turnover cost, quality of care and professional development.
	Objectives	Not stated
	Research Questions	How to improve nurses' willingness to stay in their jobs and reduce the high turnover rate Hypothesis was well designed preceptorship programme could possibly decrease turnover rates and improve professional development.
	Methodology	A quasi-experimental research design was adopted. This was considered appropriate as it helped to evaluate the programme and examined the relationship between the study variables.
	Data Collection Methods	Different instruments were used to collect the data. Patient satisfaction regarding the Nursing Care instrument was measured using a five point Likert scale which consisted of 10 questions. Internal consistency, reliability and content validity of the tool were measured. A 20-item questionnaire was used to measure preceptor performance. Internal validity and reliability were also tested. The 20-item preceptor perceptions questionnaire included a 4-point Likert scale and its validity and reliability were checked.
	Data Analysis Methods	Data were analysed using SPSS version 14.0. Mean, frequency, percentage and standard deviation measurements were used to analyse the findings. T test was used for evaluating the inferential statistics.
	Sampling/ setting	A convenience sample of 24 preceptors and 34 new nurses (preceptees) was included in the study. The setting was a 1,800 bed teaching medical centre in Taiwan
	Methodological Robustness	The study strengths were that: <ul style="list-style-type: none"> - Abstract was well structured and developed. It provided a clear balanced summary of the work and distinguished between results and conclusions. - Ethical approval for study conduction was obtained for study's validity - Adequate and detail demographic characteristics of the participants was provided for possible replication of the study.

	<ul style="list-style-type: none"> - Findings were stated clearly and supported by tables for checking accuracy. - All instruments used were valid and reliable which ensured valid and reliable data. - Findings were compared with adequate related literature, leading to clear conclusions. <p>The study weaknesses were that:</p> <ul style="list-style-type: none"> - It lacked information about the population which made judgment of how representative the sample is of the population difficult. - Sample size was small and the study was conducted in one setting which made generalisation of the findings to all preceptors and new nurses impossible. - Potential for selection and assignment bias of the sample may impact on the validity of the study. - Participants were aware that they were being measured which was a potential threat to external validity. - Replication might be difficult as the authors did not state the procedures used in the research in great detail
Findings	<ul style="list-style-type: none"> - Turnover rate was less than before with 46.5%. Turnover cost was decreased by US dollar 186.102. - Medication error rates made by nurses reduced from 50-0%. - All nurses were satisfied with preceptor guidance.
Inclusion/ Exclusion Criteria	<p>Inclusion criteria for preceptors included:</p> <ul style="list-style-type: none"> - An RN license, more than two years experience as nursing staff in the working unit. - Passing the nursing department's examination on educational training; quality control and administration abilities of the study hospital and a nursing level higher than N2. - A recommendation from the nurse manager of the working unit and participating in and passing preceptor training. <p>New nurses included those who were recruited between March-August 2006 and agreed on one-on-one preceptor instruction.</p>
Clinical Implication	<p>The study provided new information for the health care administrators regarding retaining nurses, controlling costs, improving quality of care and staff professional development. Additionally, it was made clear to clinical staff and administrators that supporting preceptors during preceptorship is important for the success of the role.</p>

8	Author/ Year	Leigh J., Douglas C., Lee K. and Douglas M./ 2005
	Title	A case study of a preceptorship programme in an acute NHS Trust-using the European foundation for quality management tool to support clinical practice development The title reflected the nature and scope of the study.
	Aims	<ul style="list-style-type: none"> - To discuss the results of the evaluation, assessment and effectiveness of the Trust-wide clinical practice development of a preceptorship programme for newly qualified nurses. - To apply the European foundation for Quality Management (EFQM) model as a tool for monitoring and assessing the performance of the programme.
	Objectives	<ul style="list-style-type: none"> - To assess the preceptorship training programme using the EFQM three results criteria of people, customers and society linked to key performance results relating to: 1. the competence, confidence and retention of newly recruited nurses.2. ward managers' perception of the programme.
	Research Questions	Not stated
	Methodology	Quantitative survey research design was adopted. This was considered appropriate as it helped to achieve the aims of the study.
	Data Collection Methods	Pre and post programme questionnaires were used to collect data from the preceptees and post programme questionnaire was used to collect data from ward managers
	Data Analysis Methods	Not stated.
	Sampling/ setting	<ul style="list-style-type: none"> - All preceptees who participated in the March 2002 programme and all respective ward managers were invited to participate. 34 nurses attended the programme, 27 nurses completed a post-programme questionnaire with a response rate of 79.7%. - 7 nurse managers out of 12 were included in the study. Response rate was 58%. - The study was conducted in Salford Royal Hospitals NHS Trust.
	Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Abstract provided a balanced summary of the study, it was well structured and developed and distinguished between the findings and conclusions successfully.

	<p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - It is difficult to assess how representative the sample was of the total population as there was no information about the population and no information about the demographic characteristics of the participants. - The study validity and reliability was questionable as there was no adequate information about the questionnaires used and whether their content validity and reliability were previously tested. - The sample size was very small; the study was conducted in one trust which restricted generalisation of the findings. - The authors did not provide sufficient details about the research process and the data analysis procedures used which reduced the possibility of replication of this study.
Findings	Recruitment and retention of staff increased after introduction of the preceptorship programme. Preceptees' level of confidence was also enhanced. EFQM tool provided the nurse managers and departments with the required information.
Inclusion/ Exclusion Criteria	Not stated.
Clinical Implication	The study made the preceptorship planners in Salford Trust look objectively at the current services and work to strengthen the weaknesses by identifying strategies for achieving the quality of services required.

9	Author/ Year	O'Connor S. E., Pearce J., Smith R.L., Voegeli D. and Walton P./2001
	Title	An evaluation of the clinical performance of newly qualified nurses: a competency based assessment The title reflected the scope and nature of the study.
	Aims	<ul style="list-style-type: none"> - To demonstrate the expected level of competency of newly qualified nurses as defined by senior nurses. - To demonstrate the actual level of competency of newly qualified nurses as assessed by preceptors at 8 weeks after employment in their first employment on qualifying in an acute general hospital - To compare the expected level of competency of newly qualified nurses with their actual level at 8 weeks of employment.
	Objectives	Not stated.
	Research Questions	Not stated.
	Methodology	A prospective comparative design. It was considered appropriate as it helped to compare the actual and perceived competency and achieve the aims of the study thereafter.
	Data Collection Methods	<ul style="list-style-type: none"> - A questionnaire with 5 Likert Scale, which was designed by the research team and piloted in the same hospital, was used to collect the data. Validity and reliability of the tool used were measured which ensured its appropriateness for the purpose for which it was designed. - Data was collected in two phases: scoring expectations of the qualified nurses (preceptors) of the newly qualified nurses and scoring of preceptors expectations of the newly qualified nurses at 8 weeks post employment. These two scores were then compared.
	Data Analysis Methods	T test was used to analyse the comparison between the expected and actual data. Frequency, mean and standard deviation were used for analysing the data.
	Sampling/ setting	<ul style="list-style-type: none"> - Two targets of population were discussed. The first was grade F and G grade senior nurses population within the acute hospital. Of those, 137 nurses were recruited (30% of the total population). The second was grade D or E nurse preceptors and newly qualified nurses. 113 of the total 169 newly qualified nurses were available to enter the project. - A convenience sample was adopted as most appropriate approach for recruiting the study sample as it would allow for detailed explanation of the rationale of the study and helped to obtain as much of the sample as available. - A total of 90 preceptors and newly qualified nurses agreed to participate in the study. 37 preceptors and newly

		<p>qualified nurses completed the project, giving a response rate of 41%.</p> <ul style="list-style-type: none"> - The sample was drawn from only one acute Trust hospital
Methodological Robustness		<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract provided a balanced summary of the study, but did not differentiate between findings and conclusions. - The content of the instrument used was valid and reliable which ensured the validity of the data obtained. - Findings were reported in detail and supported with tables for checking data accuracy. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Although authors tried to show how the sample was representative of the total population, the study lacked randomisation; sample size was small with low response rate and the study was conducted in only one hospital which made it difficult to generalise the findings to all newly qualified nurses or preceptors. - No adequate information was given about the demographic characteristics of the sample; method of data analysis as well as data collection was ambiguous which made replication of the study impossible. - There was a potential for response bias as the questionnaire seemed to be a self-reported tool and selection bias was a possibility as some nurses may have participated because a ward colleague asked them to do so. - There were no adequate relevant literature used in the discussion section - There was ambiguity between discussion and conclusions drawn. - Study limitations were not highlighted.
Findings		<p>Senior nurses have clear subjective expectations of the competence level of newly qualified nurses. These expectations were consistently lower than the actual level of competency shown by the newly qualified nurses when assessed by their preceptors.</p>
Inclusion/ Exclusion Criteria		<p>The study sample included:</p> <ul style="list-style-type: none"> - Senior nurses who attended their directorate senior nurses' meeting and were willing to take part. - Respondents who volunteered their time or were asked to do so by ward colleagues. - Newly qualified nurses who took up their first post-qualification posts within the acute Trust during the study period. - Newly qualified nurses who were diplomats of the University of Southampton School of nursing - Nurses who their ward had a formal preceptorship scheme and that ward wished to take part in the study.

	Clinical Implication	This study could be important for clinical practitioners in relation to the accurate evaluation of the newly qualified nurses and the importance of having accurate, valid and reliable tools for this purpose.
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Qualitative studies		
No	Items	Details
10	Author/ Year	Allen C / 2002
	Title	Peers and partners: a stakeholder evaluation of preceptorship in mental health nursing The title reflected the nature but not the scope of the study.
	Aims	<ul style="list-style-type: none"> - To explore the preparation and support needs of practitioners involved with preceptorship in pre and post-registration mental health nursing. - To identify how such needs might be met.
	Objectives	-Not stated
	Research Questions	-Not stated
	Methodology	Qualitative evaluation method was the appropriate methodology used as it reasonably fulfilled the study aims.
	Data Collection Methods	Data were collected using group discussions/meetings, individual semi structured interviews and team meetings. These techniques were described clearly and considered appropriate as they allowed the collection of detailed and comprehensive related data.
	Data Analysis Methods	Content analysis principles were used to analyse the data, these were appropriate as they helped to generate various related themes.
	Sampling/ setting	Non- probability, purposive, convenience and snowball sampling. Participants were 275 programme stakeholders (163 preceptors, 18 lecturers, 26 managers, 63 preceptees, 3 community practice teachers, 1 occupational therapy manager and 1 social work practice teacher), five NHS trusts which provided mental health services were included in the study.
Methodological Robustness	<p>The strengths of the study was that:</p> <ul style="list-style-type: none"> - The title reflected the nature of the work but did not indicate the scope of the study which focused only on support and preparation of the practitioners. - Credibility of data was ensured by using data triangulation technique (different data sources and two data collection methods) as well as data were collected and analysed concurrently. - Findings were checked by the stakeholders which helped to confirm the data generated. 	

	<p>The study weaknesses were that:</p> <ul style="list-style-type: none"> - The abstract was not well structured as it identified only the aims and method used for the study but results and conclusion were not stated. - Study setting and demographic characteristics of the participants were not fully described which could make the decision of transferability to another setting difficult. - Interview was transcribed by the stakeholders. This enhanced the probability of changing texts during the transcription process, which increases personal bias. In addition, interview was not recorded. This allowed the probability of missing some points which might be important for the study. Finally, the latter issues might impact on the quality of the data and affect confirmability. - There was a potential for reporting bias as the findings were presented in detail but were not supported by the participants' quotes which could impact on the credibility of the findings.
Findings	Preceptors were not adequately prepared. The preceptor orientation package needed to be strengthened in order to fulfil the needs of preceptor preparation. The preceptor role needed to be acknowledged by the organisation and administrative personnel. Reward and recognition of the preceptor role might enhance preceptor commitment to the role and accordingly contribute to the success of preceptorship which in turn enhances the quality of care. Lack of time and workload were two reasons which made stakeholders unable to fulfil the requirements.
Inclusion/ Exclusion Criteria	Inclusion criteria included stakeholders who agreed to participate in group discussions or individual interviews by networking within the organisation. Exclusion criteria were not stated.
Clinical Implication	Preceptorship should be integral to the role of the nurse. All stakeholders and organisations, in a relationship of peers and partners, should seek to ensure that preceptors are adequately prepared to support learning in the clinical environment in order for preceptees to achieve fitness for the purpose and practice and enable them to meet the needs of mental health users. Findings of this evaluative study provide a future for clinical education and practice. The education providers have accordingly been awarded pilot-site status for the revised preceptorship programme. This provides an opportunity for revising the mental health curriculum and provides for better structured clinical placements. The preceptor role has been acknowledged with a pledge from the centre to enhance the status of those who provide practice-based teaching.

11	Author/ Year	Bourbonnais F. and Kerr E. / 2007
	Title	Preceptoring a student in the final clinical placement: reflections from nurses in a Canadian Hospital The title reflected the nature and scope of the study.
	Aims	To capture personal reflections on being a preceptor and to identify the supports and challenges to performing the role.
	Objectives	<ul style="list-style-type: none"> - To describe personal reflections on being a preceptor. - To identify common beliefs about what a good preceptor experience is as viewed by the preceptor. - To list the types of support that facilitates the preceptor role. - To explore the challenges that impact on the role of preceptor.
	Methodology	Qualitative method. As it was not specified which qualitative approach was adopted, it is difficult to decide the appropriateness of the methodology used for conducting this study.
	Data Collection Methods	One-to-one interviews were used to collect the data. This could be considered appropriate as the study followed general qualitative principles.
	Data Analysis Methods	Thematic analysis using Burnard's method. This is considered appropriate as it helped to uncover different themes related to the phenomenon under investigation.
	Sampling/ setting	Eight full time female preceptors from a variety of units agreed to participate in the study. Study took place in a Canadian hospital.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract was well developed; it provided a balanced summary of the study and distinguished between findings and conclusions. - Ethical measures have been considered. - Detailed description of the findings was presented and supported by participants' quotes which enhanced the credibility of the findings. - Findings were compared to adequate relevant literature which helped to draw clear conclusions. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Study findings may not be generalised to the preceptors of other institutions as the study was limited to the experience of the preceptors at one study setting; this setting was not fully described and it was not known of 	

	<p>what population this sample was representative.</p> <ul style="list-style-type: none"> - Response bias may have been introduced to the sample as only those interested decided to contribute to the study. - Data collection and data analysis techniques were not fully described. There were no adequate demographic characteristics of the sample or description of the setting which may impact on dependability and transferability of the study.
Findings	<p>An overriding theme entitled ‘safe passage’ emerged, under which two categories: role and process were revealed. Findings of this study revealed that safe passage for the preceptees and patients was accomplished through the process of initial and continuing assessment of the preceptor role and clear understanding of that role. Lack of recognition by nursing staff and administration as well as lack of support from faculty advisors were the challenges that affected the preceptor role.</p>
Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - All full and part time preceptors were employed at the hospital during the field work period of the study. - Preceptors all able to speak English.
Clinical Implication	<ul style="list-style-type: none"> - Preceptor role plays an important role for training new nurses. Adequate recognition, resources and support of preceptor should be ensured by both hospital and educational institutions.

12	Author/ Year	Carroll M., Daly D., Higgins A. and Begley C. / 2005
	Title	Supernumerary preceptorship - the key to learning midwifery skills in a direct-entry programme in the Republic of Ireland. The title reflected the scope but not the nature of the study.
	Aims	To report on the evaluation of a supernumerary preceptorship period introduced to support students undertaking a pilot 'direct entry' midwifery programme in the Republic of Ireland.
	Objectives	To explore stakeholders' perceptions of the supernumerary preceptorship programme.
	Research Questions	Not stated.
	Methodology	Case study research design was adopted. This design is considered appropriate as it helped the researcher to describe, explore and then provide explanations of single or multiple cases.
	Data Collection Methods	Data were collected in three stages: at mid-point (after 9 weeks), at the end of supernumerary preceptorship period and at the end of the programme. A questionnaire was distributed to both the preceptors and midwifery students at both mid and end-point of the supernumerary preceptorship period. The questionnaire contained mainly open-ended questions. At the end of the programme two other methods were used to collect the data. These were: closed-ended structured questionnaire was distributed to the key stakeholders and then focus group interviews were conducted for key stakeholders.
	Data Analysis Methods	Quantitative data were analysed using descriptive statistics and SPSS. Qualitative data were analysed by using content analysis. This article presented the qualitative data only.
	Sampling/ setting	All stakeholders were invited to participate in the research. Stakeholders were direct entry midwifery students and postgraduate diploma in midwifery students, midwives, midwife managers, 15 teachers, obstetricians and paediatricians. 15 students out of 20 participated in the final questionnaire and group interview. 12 out of 13 preceptors participated in the mid-point of preceptorship. 119 midwives, 7 midwife managers, 15 teachers were included at the end of the programme.
Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Abstract was well developed, provided a well balanced summary of the study. - Content validity of the questionnaire was ensured as it was checked and reviewed by experts. - Face validity was confirmed as it was reviewed by the members of each group. 	

	<ul style="list-style-type: none"> - Findings were presented in detail and supported by participants' quotes which could confirm the findings. - Findings were compared with adequate relevant literature, leading to drawing the conclusion. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Unable to decide on the dependability of the study as there was no clear audit trail which included how the research process was conducted; how sampling was used to recruit the participants and way data was collected and analysed. - No demographic characteristics were reported regarding participants or setting in which the study was conducted which made transferability of the study to another context difficult. - Sample size was small and it is not known how representative it is of the total population, which restricts generalisation of findings to all supernumerary preceptorship programmes.
Findings	The student learning was successfully achieved by being present in the practice and supported by the preceptors. This was because receptors had time to teach the students. Students felt that 18 weeks without annual leave was demanding.
Inclusion/ Exclusion Criteria	Not stated.
Clinical Implication	Development and implementation of supernumerary preceptorship programme in the clinical setting represented a beginning for culture shift where preceptors and midwives start to value their role in educating, supporting and providing constructive feedback to the students.

13	Author/ Year	Charleston R. & Happell B. / 2005
	Title	Attempting to accomplish connectedness within the preceptorship experience: The perceptions of mental health nurses. The title reflected the nature and scope of the study.
	Aims	To explore and describe experiences of preceptorship from the perspective of mental health nurses who fulfilled the role of preceptor during the study.
	Objectives	Not stated.
	Research Questions	Not stated.
	Methodology	Grounded theory approach (Strauss & Corbin 1990). This approach was appropriate as the authors intended to develop theory from the data generated.
	Data Collection Methods	Individual interviews. No further detail was given.
Data Analysis Methods	Analysis of data was carried out in line with grounded theory procedures outlined in Strauss and Corbin (1990). Open, axial and selective coding techniques were used to progress data analysis.	
Sampling/ setting	- Purposive and theoretical sampling technique was used to select participants. Nine mental health preceptors were included in the study. Study was undertaken in one metropolitan area mental health service in the state of Victoria, Australia	
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract not clearly structured, it did not include the study conclusion. - Ethical approval was obtained from clinical and academic ethics committees and all participants. - Credibility of the study could be enhanced by reading and re-reading the study data for clarification of emerging themes and then using participants' words to demonstrate findings. - Findings were compared with adequate relevant literature leading to the drawing of clear conclusion. <p>The weaknesses of this study were that:</p> <ul style="list-style-type: none"> - Study robustness falls under question as data collection and analysis were not adequately described which impacted on the dependability of the study. - Demographic characteristics of the participants were not adequately described and the study was conducted in 	

		only one setting. The latter two points made the possibility to transfer the study findings to another setting difficult.
Findings		<ul style="list-style-type: none"> - Mental health nurses looking for achieving connectedness in the preceptorship relationship. - Preceptors wished to create a positive preceptorship experience for preceptees by feeling well prepared for the role, communicating well with other preceptors to achieve consistent application of the relationship. - Preceptors need training and preparation to fulfil their role effectively and provide a positive experience for the preceptees. - Lack of: time, work's system, communication with other preceptors, support, and inadequate resources as well as level of acknowledgment for the preceptor role was perceived as the major factors inhibiting the preceptor's role. - Stigma regarding mental illness affected preceptees' perceptions and degree of interest in this service. - Inconsistent application of preceptorship relationship due to the varied experiences of preceptors and preceptees.
Inclusion/ Exclusion Criteria		<ul style="list-style-type: none"> - Inclusion criteria included mental health nurses who had preceptor experiences. - No exclusion criteria.
Clinical Implication		<ul style="list-style-type: none"> - This study has a significant implication for nursing practitioners and clinical educators in mental health nursing as it could have a powerful impact on the preceptees' attitude toward mental health. Health service managers and mental health nurse educators begin to feel deficit in the area of preceptor preparation by providing preceptors formal training as a matter of priority. - It also has a substantial implication for recruitment in how well preceptors receive students and how practicum experiences unfold.

14	Author/ Year	Clark T. and Holmes S./ 2007
	Title	Fit for practice? An exploration of the development of newly qualified nurses using focus groups The title reflected the scope and nature of the study.
	Aims	To explore participants' perspectives of the competence of newly qualified nurses and the factors impacting on competence development once they enter 'the real world' of every day practice.
	Objectives	To gather information regarding the competence of newly qualified nurses and provide the basis for further research.
	Research Questions	Questions for focus group were stated. For example, are newly qualified nurses ready for autonomous and independent practice at the time of registration?
	Methodology	Qualitative exploratory method. This approach was appropriate as it helped to achieve the study aims by looking at different perspectives and generated deep understanding of the phenomenon under study.
	Data Collection Methods	Focus groups and individual interviews using a topic guide were used to collect the data. 12 homogeneous focus groups, each consisting of 6-10 participants, either preceptees or preceptors or practice development nurses, were conducted. Individual interviews were conducted for the nurse managers. Data from individual interviews was added to the content obtained from focus groups
	Data Analysis Methods	All interviews were tape-recorded and transcribed verbatim. Content analysis was made to identify relevant themes. Similarities and differences among groups' experiences were identified by comparing the emerging categories using a 2x2 cell design.
	Sampling/ setting	Purposive sample of 105 volunteer participants including 50 newly qualified nurses, 44 preceptors, 11 practice development nurses and 5 ward managers were included in the study. Data was collected from three NHS Trusts in the South of England.
Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Abstract was well developed, clearly stated and distinguished between conclusion and findings. - Validity in data interpretation and credibility of conclusion were achieved by returning the emerged themes and categories identified within the data to the participants. - Use of the triangulation technique, by comparing data generated from individual interview with focus group, enhanced the data credibility. - Reliability of the findings was confirmed by analysing data by both researcher and an experienced practitioner. - Confirmability of study findings was achieved by using narratives from study participants as examples. 	

	<ul style="list-style-type: none"> - Ethical measures were considered. - Clear audit trail was stated which enhanced the study dependability. <p>The study weaknesses were that:</p> <ul style="list-style-type: none"> - Generalisability of the findings may be difficult as descriptions of the study setting and participants were not provided, sample size was small and not representative of the total population like other qualitative studies.
Findings	<ul style="list-style-type: none"> - A total of six themes emerged from the collected data. These were: ready for practice?, a question of confidence, approaches to staff development, core and specialist skills, competence versus competencies and the role of preceptorship. - There was a general consensus among the participants that newly qualified nurses are not ready for independent practice on registration. Preceptees felt they were 'fit for practice' within six months of qualification. Time is required to enhance consolidation of preceptees' skills and level of confidence thereafter. Importance of support was expressed by participants. - There was difficulty in agreeing what is expected from newly qualified nurses in their preceptorship period. Preceptors had different expectations of their preceptees. Some expectations were high. - Findings revealed more concern regarding competencies rather than competence (ability of preceptees to deliver holistic care). - There was an overlap between preceptorship and mentorship concepts and role overload for the preceptor. Preceptor support was perceived as crucial for the development of competent practice. - Eight factors were identified as important for promoting competence in the preceptees. These were: expectations of new nurses, confidence, context and environment, knowledge underpinning actions, effective preceptorship including support, time to allow integration of skills and knowledge, opportunities to learn in practice or reflect on actions, acceptance into the ward team.
Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - Not stated.
Clinical Implication	<ul style="list-style-type: none"> - The study has an implication on clinical practice as it called the attention of practitioners to the fact that newly qualified nurses are in need of continuing development during the early stages of their practice.

15	Author/ Year	Clynes M. /2008
	Title	Providing feedback on clinical performance to student nurses in children’s nursing: challenges facing preceptors. The title reflected the scope but not the nature of the study.
	Aims	To explore preceptors’ perceptions of providing feedback on clinical performance to post-registered student nurses.
	Objectives/ purposes	Not stated.
	Research Questions	Not stated.
	Methodology	Qualitative approach. It was difficult to decide on the appropriateness of the methodology as it was not specified which qualitative approach was adopted.
	Data Collection Methods	Semi-structured interviews began with a broad opening question ‘tell me about your experiences of giving feedback to post-registration student nurses? Interviews were applied for collecting study data. This was appropriate as it allowed the collection of comprehensive data about the phenomenon been studied.
	Data Analysis Methods	Data was transcribed verbatim. Thematic analysis was used to identify the major themes and categories that related to the provision of negative feedback, and the factors that may hinder the provision of feedback.
	Sampling/ setting	Ten preceptors working in a children’s hospital in the Republic of Ireland were selected purposively from all ward areas within the hospital.
Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Abstract provided a reasonable summary of the study, but did not clearly differentiate between the findings and conclusions. - Ethical approval, written and verbal consent was obtained - Confirmability was achieved by reading the transcript line by line to increase the researcher’s familiarity with the data collected and by using examples of participants’ narrative, which indicated that data reflected participants own experiences and views. - Discussion was clearly written and findings were compared with adequate relevant literature, leading to the drawing of clear, concise conclusions. 	

	<p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - The study was undertaken in one hospital during a short period of time and limited to preceptors' views which made generalisability of the findings impossible. - Credibility of data is questioned as more data regarding data collection and analysis is needed and only one sample source and technique for data collection and analysis was applied. - A lack of adequate information on each phase of the research process (audit trial) which might impact on the study's dependability.
Findings	<ul style="list-style-type: none"> - Providing or writing positive feedback is easier than giving or writing negative feedback. - Preceptors disliked giving negative feedback, wishing to avoid hurting the preceptees' feelings; they perceived negative feedback as criticizing the preceptees. - All participants perceived that giving and receiving negative feedback was difficult, particularly in the case of post-registered nurses who, being registered nurses, were expected to have a certain level of knowledge. Providing feedback requires a more expert preceptor. Most preceptors were uncomfortable giving feedback. Participants were aware that they were accountable for providing feedback to the preceptees. - In this study, the 'sandwich technique', whereby negative feedback is provided between two pieces of positive feedback, was described as a useful means of giving feedback. - Insufficient time to work with the preceptees, ward workload and inadequate preparation for the preceptor role were factors which impacted on the preceptors' ability to give feedback.
Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - The study included all preceptors working in a children's hospital from all ward areas who had at least 12 months' experience as a preceptor. - Operating theatre and intensive care unit staff were excluded because the preceptees' placements were of short duration, i.e. two to four weeks.
Clinical Implication	<ul style="list-style-type: none"> - This study has an implication on clinical education as it made preceptors more concerned with balancing the need to provide feedback during preceptorship and being sensitive to the needs of the preceptees.

16	Author/ Year	DeCicco J./2008
	Title	Developing a Preceptorship/ Mentorship Model for Home Health Care Nurses The title reflected the scope but not the nature of the study
	Aims	To conduct an in-depth analysis of the preceptorship programme of Saint Elizabeth Health Care.
	Objectives	To create and develop a transformed, sustainable model of preceptorship/mentorship for the organisation. This article describes the process followed by Saint Elizabeth Health Care to develop a preceptorship programme and highlight its benefit for home health care nurses.
	Research Questions	None stated.
	Methodology	Qualitative summative evaluation was considered appropriate to evaluate the programme's effectiveness in order to decide whether it should be continued, generalised or replicated
	Data Collection Methods	Three methods were used to collect data. These were: 8 focus groups, 8 key informant interviews and workflow analysis. The focus groups conducted by teleconference with 27 employees to ease participation across the province. Four of the focus groups already existed before the creation of the preceptorship/mentorship programme and the other four were formed, with the same participants, after the development of the programme. Workflow analysis included documenting each step of the preceptorship process.
	Data Analysis Methods	Focus group meetings and interviews of key informants were taped and transcribed by an external transcriptionist. Content analysis was used to uncover the major recurring themes.
	Sampling/ setting	Purposeful sampling was applied to recruit homogeneous groups of preceptors, preceptees, managers, clinical resource nurses and health service supervisors. Face-to-face and telephone interviews were conducted.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Using two sets of focus groups allowed for member checking as data would be validated by the participants in the first focus group. - Using triangulation technique for collecting data helped to provide completeness and improve the clarity or precision of the research findings, which enhanced credibility of data. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - No clear summary of the work was given as it was not clearly stated what the findings and conclusion were. 	

		<ul style="list-style-type: none"> - As some interviews were conducted by telephone, there was a potential for selection bias as the interviewee may not have been the person requested by the interviewer. - The study was conducted in one setting with a small number of participants, which reduces the possibility of generalisation of the findings to all programme stakeholders. - Transferability of the findings was not possible as there was no information regarding the demographic characteristics of the participants or the study context. - There was insufficient detail of the audit trail which impacted on the study dependability. - There was a potential of reporting bias as the author presented the findings without any participant quotes. - There was no evidence that the findings were compared with relevant literature; it appeared the author discussed only her own study findings. - Conclusion was not clearly stated.
	Findings	<ul style="list-style-type: none"> - Findings of the study represented various advantages of preceptorship for the organisation, i.e. enhance recruitment and retention within the organisation, provision of career building opportunities for preceptors after having extra responsibilities and accountability; preceptees felt supported and connected to the organisation. - Five areas were identified as in need of improvement: variation in preceptorship processes, accountability for preceptorship programme, continuity of preceptor, reward and recognition for preceptors and ‘protected’ time to precept. - A more standardised preceptorship programme to promote consistent and efficient practices across the organisation was needed. - Preceptees were always paired with more than one preceptor. - There was a lack of trained preceptors. - Preceptors were not adequately recognised or rewarded for their dual role. Rewarding strategies were suggested by the participants to include continuing education opportunities and conference attendance and enhanced remuneration. - Staff shortages and ward workload reduced time available for preceptors to work with preceptees. This made preceptors feel pressured which lead them to push the preceptees along too fast. - All participants perceived preceptorship as a worthwhile programme and preceptors a valuable resource working as ‘ambassadors’ for the organisation.

		- As a result of the above findings, various changes were made to the new preceptorship programme including the assignment of CRNs as coordinators of the programme, training and educating preceptors. A reward and recognition package for preceptors was created and preceptors can now communicate on line with other preceptors around the province.
	Inclusion/ Exclusion Criteria	Not stated.
	Clinical Implication	The clinical implication of this study is that clinical practitioners could use the information stated in the study to develop similar preceptorship programmes that fit the unique needs of their organisation.

17	Author/ Year	Duffy A./ 2009
	Title	Guiding students through reflective practice - the preceptors' experiences. A qualitative descriptive study The title reflected the nature and scope of the study.
	Aims	To explore the preceptors' perceptions and experiences of using guided reflection as a learning tool in the clinical practice area.
	Objectives	<ul style="list-style-type: none"> - To reveal the nature of preceptors' experiences of guiding preceptees via reflective practice. - To determine how preceptors' experiences impacted on their practice and added to the preceptorship process.
	Research Questions	What are nurse preceptors' experiences of guiding students through reflective practice?
	Methodology	A qualitative descriptive research design. This approach was considered appropriate as it helped to provide deep and holistic understanding of the phenomenon under study.
	Data Collection Methods	Data was collected over a period of three weeks using semi-structured qualitative interviews. The interviews lasted about 20 to 40 minutes. This was appropriate as it helped to collect detailed information about the participants' experiences and allowed the researcher to achieve the study aims and objectives.
	Data Analysis Methods	Interviews were transcribed verbatim and data was immediately analysed using Burnard's method: a 14-stage method of thematic analysis for analysing interview transcripts in qualitative research
	Sampling/ setting	A convenient and purposive sampling was used to recruit eight preceptors who volunteered to participate. One withdrew during the study for personal reasons
	Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract was well developed and structured, providing a balanced summary of the work - Ethical measurements were considered and stated clearly. - Credibility of the findings was confirmed by returning them to the participants to double check that the researcher's interpretation matched their meanings. - Audit –trail was documented to assure dependability. - The validity of the data was confirmed independently by two people. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Detailed description of participants' demographic characteristics and study settings was not provided. The

		<p>number of teaching hospitals included in the study was not determined, which made the transferability of findings to another setting difficult.</p> <ul style="list-style-type: none"> - Although authors had mentioned that participants were informed about inclusion and exclusion criteria, the criteria were not stated clearly in the study. - The study findings cannot be generalised to the larger population because of the small sample size
	Findings	<ul style="list-style-type: none"> - Three themes emerged from the data analysis: training and development, critical relationship and guided reflection - the past, the present and the future. - Preceptors had little or no experiences of using reflective guidelines of preceptorship. - Inadequate training and development of preceptors was a factor which contributed to ineffective preceptorship. - Preceptor-preceptee relationship is critical within the preceptorship process. - Preceptors' experience of reflection in the past and present was not up to the expected level and that could not assist the preceptees learning. - Formal support for preceptors and preceptees is crucial for an effective preceptorship process as it enhances preceptors' and preceptees' job satisfaction and reduces preceptors' negative feelings towards the preceptees.
	Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - Not clearly stated. However, within the text, it was stated that participants were required to complete a teaching and assessing course or a preceptorship course.
	Clinical Implication	<p>This study has clinical education and practice implications. First, it emphasised that nurse educators should acknowledge the importance of the reflection process in clinical practice and encouraged preceptors to apply it to teaching the preceptees in clinical practice. Second, it stressed the need for preceptors to consider continuous follow up and updating of their knowledge in order to effectively fulfil the role of preceptor in clinical practice.</p>

18	Author/ Year	Harbottle M./ 2006
	Title	An investigation into the perceived usefulness of preceptorship: an exploratory study between two radiotherapy centres The title reflected the nature and scope of the study.
	Aims	To examine the perceived usefulness of preceptorship by exploring the views of therapeutic radiographers who undertook preceptorship as part of the 'Radiography Skill Mix'.
	Objectives	To explore what participants understood preceptorship to be. To explore participants' perceptions of the problems associated with implementing preceptorship and its potential benefits.
	Research Questions	Not stated
	Methodology	Exploratory, qualitative design using a constructivist methodology was adopted in this study. This approach was considered appropriate as it helped to illustrate different radiographers' views about the benefits of preceptorship
	Data collection methods	Two focus group interviews were conducted to collect the data. This was appropriate as it helped to provide a comprehensive understanding of the phenomenon under study through the group interaction and debate.
	Data Analysis Methods	Data was analysed using thematic analysis method based on Burnard's 14 stages. This method was appropriate as it helped to put the data generated from the focus groups into themes and categories.
	Sampling/ setting	A purposive sampling technique was used to recruit the study participants. 12 newly qualified radiographers were included. Six per group from two different departments were included, one had a preceptorship programme and the other did not.
	Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Ethical approval was obtained and ethical measurement concerning participants' rights, anonymity and confidentiality of the data obtained was assured. - Study findings provided unique understanding of preceptorship of newly qualified radiographers, adding to the existing knowledge. - Recommendations were offered for successful preceptorship in clinical practice. - Findings were clearly presented and supported by samples of participants quotes which confirm the findings generated.

	<p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Lack of transparency: it was not clear what the researcher actually did, how participants were recruited, how the data were collected or the researcher's role during the research process. All of these factors impacted on the dependability of the study. - Credibility of the findings was questionable as it is not clear how the validity of the data was ensured. - Transferability was difficult as there was no information on the participants' demographic characteristics. - generalisation of the findings to all newly qualified radiographers was difficult.
Findings	<p>Four themes were generated related to the perceived usefulness of preceptorship. These were definition, time, professionalism and implementing preceptorship. The findings revealed that preceptorship was valuable. Different meanings of preceptorship were existed. Time was required for the preceptors to meet with the preceptees. Participants' understanding of the programme duration varied. Professionalism was perceived by two of the participants' departments as essential for a successful preceptorship programme. The findings revealed the importance of having a coordinator to help preceptorship run smoothly.</p>
Inclusion/ Exclusion Criteria	<p>Not stated</p>
Clinical Implication	<p>This study had clinical implications on clinical practice as it called the attention of clinical practitioners to the importance of the support and presence of a coordinator for successful a preceptorship programme in the clinical setting.</p>

19	Author/ Year	Henderson A., Fox R. and Malko-Nyhan K./ 2006
	Title	An Evaluation of preceptors' perceptions of educational preparation and organisational support for their role The title reflected the nature and scope of the study.
	Aims / purpose	<ul style="list-style-type: none"> - This study aimed to evaluate preceptors' perceptions of a 2 day educational workshop and the support received to prepare them for the preceptor role. - The purpose was to identify the appropriateness and usefulness of educational and managerial support provided to preceptors in the study setting.
	Objectives/ hypotheses	Not stated.
	Research Questions	Not stated.
	Methodology	A longitudinal, descriptive qualitative study design was adopted in this study. This approach was considered appropriate as it helped to achieve the aims of the study.
	Data Collection Methods	6 focus group interviews were conducted to collect the data. They were conducted at 2 to 3 months and 4 focus groups were conducted at 6-9 months after the workshops. Additionally, individual interviews were conducted. This was considered appropriate as it helped to explore preceptors' perceptions of the benefits of education and support received.
	Data Analysis Methods	The thematic analysis method was used to generate the findings.
	Sampling/ setting	Thirty six preceptors were included in the study. No sampling frame was identified.
Methodological Robustness	The study's strengths were that: <ul style="list-style-type: none"> - Abstract represented a well balanced summary of the study process. - Ethical approval was obtained to conduct the study, ethical measurement for each participant before their participation was considered to ensure validity of the study. - Triangulation of the data collection techniques and time enhanced data credibility. - Findings were presented and supported by participants' quotes, which confirmed the findings. 	

	<ul style="list-style-type: none"> - Findings were compared with adequate relevant literature to ensure validity of the study. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - It was difficult to assess the appropriateness of the sampling technique used to recruit the study participants as it was not identified. - No details on how the interviews were conducted, how many individual interviews were conducted and how themes were generated. - Lack of transparency in the research process impacted on the study's dependability. - Small size of the sample and examination of one programme in one setting restricted generalisation of the findings to all preceptors. - Transferability was difficult as there was no data regarding the study's participants and setting.
Findings	The findings revealed that all preceptors were satisfied with the preparation provided during the course. They were also satisfied with their role as preceptors as this role provided them with the opportunity to learn from others. However, the findings revealed that preceptors lacked practical support due to limited time.
Inclusion/ Exclusion Criteria	Although inclusion criteria were not clearly identified, the study included nurses who had attended the workshop within the past 3 months of the study conduction period.
Clinical Implication	The study identified different issues which needed to be considered by the preceptors and educators in the clinical practice of the research hospital. Several recommendations were made.

20	Author/ Year	Kaviani N. and Stillwell Y./ 2000
	Title	An evaluative study of clinical preceptorship The title reflected the scope but not the nature of the study.
	Aims / purpose	The aims were to evaluate the effectiveness of the preceptorship programme in the study setting and to provide ways for further improvement in the achievement of quality clinical outcomes. The purpose was to examine the perceptions of preceptors, preceptees and nurse managers of the preceptor role and the factors which impacted on the role.
	Objectives	To help registered nurses and clinical nurse educators to effectively integrate, support and assist the development of the preceptees' clinical competence.
	Research Questions	Not stated
	Methodology	A qualitative, evaluative research design was applied in this study. This approach was appropriate as it helped to evaluate the programme and formulate recommendations for further improvements.
	Data collection methods	Two focus group interviews were conducted to collect data from preceptors' and student groups. Individual interviews were conducted for each manager.
	Data Analysis Methods	Data obtained were analysed thematically but no specific technique was clearly stated.
	Sampling/ setting	A convenience sample of six preceptors, 13 3 rd year nursing students and 2 nurse managers from clinical and an education setting was used.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract provided a balanced summary of the study. - To ensure validity of the study, ethical approval was obtained from all participants involved and from the setting's administrative personnel. - The study generated valuable data regarding the preceptor role and factors which could impact on the success of the role. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Generalisation of findings was impossible as the sample was not representative of a specific population. - Methodological rigor was questionable as there was no clear audit trail especially regarding data analysis 	

		technique, which reduces the dependability of the study. Findings were presented and compared with inadequate literature and not supported by participants' quotes which minimised the credibility and confirmability of the findings. Although two data collection techniques were applied, it is not known how each was conducted and what the role of researcher was during the data collection process. Findings could not be transferred to any setting as no demographic characteristics were provided about the study participants or settings in which the research was conducted.
	Findings	The findings were grouped into three categories: organisation, preceptor and preceptee. The findings revealed the value of the preceptorship programme for improving preceptor knowledge as it helped them to identify their own professional development needs. Formal preceptor preparation was important as it improved preceptees' learning and teaching opportunities. The findings also highlighted the importance of providing formal recognition of the preceptor role in practice by offering adequate time and resources. These were considered factors which affected the preceptor role.
	Inclusion/ Exclusion Criteria	Not stated
	Clinical Implication	This study had implications on clinical practice as it highlighted various issues which should be considered by preceptorship stakeholders to enhance the programme's effectiveness in terms of preceptor preparation and clinical education.

21	Author/ Year	Kelly D., Simpson S. and Brown P./ 2002
	Title	An action research project to evaluate the clinical practice facilitator role for junior nurses in an acute hospital setting. The title reflected the scope and nature of the study.
	Aims	To explore whether a new clinical practice facilitator role would meet the needs of additional support. To develop and evaluate a pragmatic framework to guide its implementation across the trust more widely.
	Objectives	To pilot and evaluate the clinical practice facilitator (CPF) role To determine key factors which contributed to the success of such posts. To develop a framework for CPF practice to support its function. To identify the future potential of the role for the trust.
	Research Questions	Not stated
	Methodology	Action research design was applied. This approach was considered appropriate as it was intended to be educative and problem solving, helping to bring about changes in human situations.
	Data Collection Methods	Three sources were used to collect data in the assessment phase: 1- assessment questionnaires which were distributed to all nursing staff employed in the project areas between July and October 1998. 2- Recruitment and retention data of the areas. 3-Educational audits of the clinical areas were accessed. Monthly face-to-face meetings were conducted with the CPF to gather data reflecting their experiences throughout the action phase. A short evaluation questionnaire was distributed to all available nurses in the project areas in evaluation phase. The response rate was 80%.
	Data Analysis Methods	Thematic analysis was applied to analyse data obtained from a randomly selected 30 questionnaires and educational audits
	Sampling/ setting	Clinical areas covered by each CPF were Accident & Emergency, Private Patients Unit, Neuromedicine, Neurosurgery, Acute Medicine and Acute Surgery of one hospital. 15 (43%) ward managers, 98 (39%) registered nurses and 8 (37%) human assistants participated by completing the questionnaire. This demonstrated a low response rate.
Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Ethical approval was obtained to conduct the study. - Action research phases were clearly stated and findings were presented clearly and supported by participants' quotes and tables to ensure the validity of findings. 	

	<ul style="list-style-type: none"> - Content validity of the questionnaires used was achieved to ensure study rigor. - Clear conclusions were drawn. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Abstract did not clearly summarize the research. - The findings cannot be generalised as the study was conducted in one hospital and by a small number of participants.
Findings	95% of all respondents were ‘satisfied’ or ‘highly satisfied’ with the CPF role. Support was available for junior nursing staff. It revealed that the post holders effectively demonstrated the role benefits by enhancing the profile of clinical facilitation.
Inclusion/ Exclusion Criteria	Not stated.
Clinical Implication	This study provided an effective way to meet the Trust’s goal to support the junior staff in coping with the reality of workload and pressure in nursing practice.

22	Author/ Year	Myrick F. and Yonge O./ 2004
	Title	Enhancing critical thinking in the preceptorship experience in nursing education The title reflected the nature and scope of the study.
	Aims / purpose	The aim was to explore how the critical thinking ability of graduate nurses is enhanced in preceptorship. The purpose was to examine the preceptorship experiences in enhancement of critical thinking in graduate nursing education.
	Objectives	Not stated
	Research Questions	What is the perception of preceptors with regard to critical thinking and the process that it entails in graduate nursing education? What is the perception of graduate nursing students with regard to critical thinking and the process that it entails?
	Methodology	A grounded theory approach was adopted. This was an appropriate design as the author intended to create theory within the impeded data. The study was conducted over three years (1999-2002)
	Data collection methods	45 semi-structured, tape-recorded interviews were conducted for collection of data.
	Data Analysis Methods	Constant comparative analysis was applied to analyse the data. This was an appropriate method as it allowed open coding, theoretical coding, selective coding, reduction and comparison in order to generate the findings.
	Sampling/ setting	Sample included 10 preceptees and 8 preceptors who participated in the study The setting included community health nursing, family health nursing and tertiary care from two university graduate nursing programmes located in two large areas in Western Canada.
Methodological Robustness	The strengths of the study were that: <ul style="list-style-type: none"> - Abstract provided a well balanced study and distinguished between conclusion and findings. - Credibility of the data was confirmed by the participants themselves. - Ethical approval from each participant as well as settings was obtained to enhance the study validity. - Findings could be transferred, with caution, to another context based on the suitability of that context to the study context. - Authors tried to provide clear audit trail of the research process which enhanced the dependability of the study. - The study generated a substantive theory that could be valuable in the reality of preceptorship experiences of graduate nurses. 	

		<p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - It was impossible to generalise the findings to all graduate preceptorship programmes because of the small sample size, also because some preceptors were not nurses.
	Findings	The findings revealed that a relational process was vital for enhancing the critical thinking ability of the preceptees. This process was seen as a complex ongoing, dynamic, interpersonal relationship between preceptees and their assigned preceptors. Expertise of the preceptor played a major role in preceptees' experiences. Factors such as respect, flexibility and trust were found to impact on student critical thinking to improve.
	Inclusion/ Exclusion Criteria	Inclusion criteria were that participants were able to speak and comprehend English, had preceptorship experience and were willing to participate and sign a consent form.
	Clinical Implication	The study called the attention of the preceptors and preceptees to the importance of their relationship for a successful preceptorship programme. It provided data regarding the behaviour of preceptors required for running an effective programme, which needed to be taken into account by preceptors in clinical practice.

23	Author/ Year	Ohrling K./ 2000
	Title	Being in the space for teaching-and-learning: the meaning of preceptorship in nurse education The title reflected the nature and scope of the study.
	Aims	To elucidate preceptees' and preceptors' lived experience of preceptorship and develop an understanding of the meaning of being a preceptor, of being precepted and of teaching and learning in a preceptor-preceptee relationship during student nurses clinical education on a hospital ward.
	Objectives	Not stated
	Research Questions	Not stated
	Methodology	A phenomenological research design based on hermeneutic philosophy was adopted. This was considered appropriate as it helped to provide deep understanding of everyday lived experiences of the study phenomenon.
	Data Collection Methods	One-to-one interviews were conducted for each student and preceptors. This was also considered appropriate as it helped to collect comprehensive data about the lived experience of the examined phenomenon from different perspectives.
	Data Analysis Methods	Phenomenological-hermeneutic analysis method was used. This was appropriate as it helped to uncover themes related to the investigated phenomenon. However, data collected from the preceptors were analysed one year after the analysis of the preceptees' texts.
	Sampling/ setting	The staffing frame was not clearly stated. However, it seemed that the author used a convenience sampling frame as all students available on the programme during the study period were selected. 17 (out of 20) student nurses and 16 preceptors agreed to participate in the study.
	Methodological Robustness	The strengths of this study were that: <ul style="list-style-type: none"> - Abstract provided a well balanced study. It clearly stated the findings of the study. - Findings generated from students were validated by discussing them with the co-author and thesis supervisor. - These findings were also confirmed by comparing data generated from the 1st 12 interviews with the latter five interviews. - Reliability of the findings was ensured by inviting 7 of the nurses who participated in the study to attend a presentation of the findings and discuss them. - The findings could be transferred with caution as clear demographic characteristics of the participants and

		<p>context were provided.</p> <p>The weaknesses of this study were that:</p> <ul style="list-style-type: none"> - Generalisation of the study to all nursing students and preceptors involved in the preceptorship programme was impossible because of the small sample size.
	Findings	<ul style="list-style-type: none"> - The findings revealed different themes related to: the meaning of preceptorship when learning in practice by being in a mode of learning, preceptors facilitating the student nurses learning, relationship with the preceptor when learning, the meaning of preceptorship when teaching in practice and the impact on daily life of being a preceptor, teaching strategies of the preceptors, relationship with the student nurse when precepting and learning when precepting in practice. - These themes all moved toward the direction of enhancing competence and responsibilities of the students and preceptors. The findings revealed that the preceptor role was important for the learning student in clinical practice due to their limited clinical experience. Preceptors' ability to teach and practice were enhanced through the role of preceptor.
	Inclusion/ Exclusion Criteria	Not clearly stated
	Clinical Implication	The findings of this thesis could provide nurse educators with some insight into the value of affording nurse students access to teaching and learning when in clinical nursing practice. Additionally, it could call the attention of the organisation to the importance of the preceptor role for development of the programme and highlight valuable strategies for preceptors to apply in a teaching situation.

24	Author/ Year	Ohrling K. and Hallberg I./ 2001
	Title	The meaning of preceptorship: nurses' lived experience of being a preceptor The title reflected the scope and nature of the study.
	Aims	To explore registered nurses' lived experience of the process of preceptoring and develop an understanding of the meaning of preceptorship when precepting student nurses.
	Objectives	Not stated
	Research Questions	Not stated
	Methodology	A Phenomenological research design based on hermeneutic interpretation was adopted in this study. This was considered appropriate as the author aimed to generate deep understanding of the lived experience of preceptorship from single Swedish perspectives.
	Data Collection Methods	One-to-one interviews were conducted to collect data. Interviews were documented by taking notes
	Data Analysis Methods	A phenomenological-hermeneutic analysis method was used to analyse the data. This was an appropriate tool for analysing the lived experience of the participants and allowed the generation of findings in themes.
	Sampling/ setting	<ul style="list-style-type: none"> - 17 preceptors from two hospitals in Northern Sweden participated in the study - No sampling frame was stated to show how participants were recruited.
	Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Ethical approval and measurement were considered and achieved prior the study and conducted to ensure validity of the study. - The findings and discussion of the findings were presented clearly in the same section and supported by participant quotes and compared by adequate relevant literature, which confirmed the validity of the findings. - Conclusion was stated clearly. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Abstract did not distinguish between results and conclusions. - There was a potential for missing data and reporting bias as the interviews were not tape-recorded, which

		<p>reduced the credibility of the data collected.</p> <ul style="list-style-type: none"> - Due to small sample size, generalisation of the findings to all preceptors in a Swedish context was impossible. - Audit trail was not adequately transparent which made the decision on the study dependability is difficult.
	Findings	<ul style="list-style-type: none"> - The findings presented one part of the study which was concerned with illuminating the lived experience of preceptorship from the Swedish perspective. - Two themes and eight sub-themes were generated. The first theme was sheltering the student when learning. Its sub-themes were: negotiating the aim, conferring with others, choosing actions and assessing competence, related to co-operating and value dimensions. The second theme was facilitating the students' learning were the sub-themes: using different methods, providing concrete illustrations, conversing and reflecting, related to the dimensions of task-oriented learning and communicating. - The meaning of preceptorship was understood as reducing the risk of the students learning helplessness and enhancing student clinical learning. - Further support for the preceptors and development of their role was required.
	Inclusion/ Exclusion Criteria	<p>The criteria included:</p> <ul style="list-style-type: none"> - Preceptors who had a previous preceptor experience with an individual student during her/his final year of a 3 year nursing programme. - Preceptors who agreed to precept a student nurse during her/his nursing practice on a hospital ward. - Nothing was stated regarding the exclusion criteria or if any participants were excluded, and the corresponding reasons.
	Clinical Implication	<p>This study suggested different strategies for consideration by the preceptors and organisation personnel for successful development and implementation of preceptorship in a clinical setting. If these strategies are considered by them the preceptees' learning could be improved and clinical practice and education process could be enhanced.</p>

25	Author/ Year	Turner R. / 2007
	Title	Preceptorship in Nursing: preceptors' and preceptees' experiences of working in partnership The title reflected the nature and scope of the study.
	Aims	To explore the preceptors' and preceptees' perspectives of their experiences of working in relationship during the preceptorship period.
	Objectives	To explore how the preceptor and preceptee establish their partnership and progress their working relationship during the clinical orientation period.
	Research Questions	What practical pathways do the two parties generate in order to help sustain the relationship? What is the preceptor thinking prior to the partnership, knowing that they have a clinical load to consider, as well as having someone they are responsible for, whilst ensuring they provide a safe and effective introduction into the clinical area? What are the preceptors' and preceptees' insights into the practicalities of working such a relationship? How do both these parties establish and progress their working relationships bringing it to closure at a suitable moment? What learning takes place for the preceptor and the preceptee while they are in their roles? What does the preceptorship partnership mean to those within the relationship?
	Methodology	An exploratory, descriptive qualitative research approach was adopted for this study. This was considered appropriate as it provided a deep understanding of the meaning of the phenomenon that was little known.
	Data Collection Methods	Tape-recorded, semi-structured interviews using open-ended questions were used to collect the data. This was an appropriate approach for this qualitative study.
	Data Analysis Methods	Content and thematic analysis approach was used to analyse the data obtained. This was appropriate as it revealed different themes related to the examined phenomenon.
	Sampling/ setting	Purposeful sampling was applied to recruit the participants. Participants were recruited from the local District Health Board. Three pairs of registered nurses who together had participated in and completed a preceptorship partnership and were no longer working in the same department agreed to participate.
	Methodological Robustness	The strengths of the study were that: - Ethical approval was obtained from each party involved to ensure validity of the study. - Credibility of the findings was ensured by using triangulation of data sources (preceptors and preceptees),

	<p>interpretation was then confirmed by the participants themselves.</p> <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Clear description of the research process was provided, but was not adequate to decide on the dependability of the study. - No demographic characteristics of the participants or setting was provided, which restricted the transferability of the findings to another similar setting.
Findings	Preceptor-preceptee relationship grew and developed as a result of open communication and respect for each other. The findings revealed preceptees' satisfaction of being precepted, supported by the preceptors. This positive experience facilitated their integration into the role effectively. This relationship enhanced preceptors' understanding of how to support the learning process and apply evidence-based practice.
Inclusion/ Exclusion Criteria	Not stated
Clinical Implication	This study provided a valuable insight to preceptors; preceptees and the organisation about how a successful relationship could be developed and sustained and what factors could enhance or inhibit this relationship. Findings could also be used by the personnel responsible for developing the preceptorship programme.

Mixed methods Studies		
No	Items	Details
26	Author/ Year	Almanda P., Carafoli K., Flattery J., French D. and McNamara M./ 2004
	Title	Improving the retention rate of newly graduated nurses The title did not actually reflect the nature or scope of the study.
	Aims/ purpose	The purpose of this study was to offer an adequate educational and supportive system for new graduate nurses using preceptor programme in order to increase retention rate.
	Objectives	Objectives were not stated.
	Research Questions	Will a newly designed preceptor programme provide new graduate nurses with adequate education, support and acceptance in their new role as staff nurses and thereby increase retention rates?
	Methodology	Quantitative and qualitative, mixed methods were adopted. Survey design was adopted for both methods. This approach was considered appropriate as it helped to achieve the study's purpose and highlighted new ideas related to preceptorship programme and retention rate.
	Data Collection Methods	Data was collected using a coded survey tool. This tool addressed satisfaction, reasons the new graduates may have considered for leaving, and feedback for possible improvements in the programme. It contains yes/no and open-ended questions as well as visual analogue scales (VAS). Validity was maintained by teaching all professional development staff (PDS) the correct use of VAS to be available for helping the preceptees with the survey.
	Data Analysis Methods	Methods used for analysing qualitative or quantitative data were not stated. This may impact on the reliability and dependability of the research and replication as I am not sure if the statistical measurements or the qualitative methods used to analyse the data were appropriate or not.
Sampling/ setting	<ul style="list-style-type: none"> - A convenience sample of 40 (89%) out of 48 (100%) new graduate nurses who entered the practice were included in the study. Two nurses were excluded because they did not complete the programme, survey was not sent to them and they were not counted in the statistics, but they were counted in the hospital retention rate. - The study was conducted in one small, 150 bed, nonteaching, community hospital in Eastern Massachusetts. 	

Methodological Robustness		<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Abstract was well structured. However, it was not provided complete summary of the work. - Data generated from the qualitative stage were confirmed by the participants themselves (five nurses) which ensured the credibility (internal validity) of the findings. - The study illustrated new findings related to the preceptorship and retention rate, contributed to the body of knowledge available. - Having triangulation methods (quantitative and qualitative) helped to enhance the validity and credibility of the findings by cross-checking quantitative with qualitative findings. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - External reliability of the data was questionable as data analysis methods were not stated. - There was not enough detail in the text to justify the conclusion. Despite the tables and quotes which permit some checking for accuracy, these were very few. - Sampling size was small and the study conducted in one hospital which made generalisation of all new graduate nurses impossible. - The study lacked randomisation and control. Population was not clearly stated, sample was not representative as it was small, which also made generalisation difficult. - Conclusion was not clearly stated. There were no adequate comparisons with other relevant literature. There was a potential for personal bias as authors focus on discussing their comments and findings rather than discuss the study findings with available literature findings. - The study was difficult to replicate because it was conducted in a natural, uncontrolled setting.
Findings		<p>Findings of quantitative data indicated that 35 nurses stated that they heard about the preceptor programme and this influenced their decision to come to the hospital. The programme was as these 35 participants expected, while it was not for 5 participants. Length of programme, matching the preceptor with the preceptee and availability of professional development (PD) staff were ranked as the most important aspects. Money, shift availability and location were indicated as factors they may have considered when going elsewhere. The findings indicated an overall high satisfaction rate ((3.7%). The overall retention rate was increased by 29%. 3 nurses left within one year because lack of support or acceptance.</p>

		Findings of qualitative data presented that no theme was generated to improve the programme considering suggestions from the 5 participants who stated that the programme was not as they had expected. Three themes were generated from the question: what else do you think the PD could do to prepare and support new graduate nurses? These themes were: hands-on-learning, instructions on systems/paperwork and education/support from PD staff. The majority of comments regarding support and education were positive.
	Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - Inclusion criteria were not specifically stated, but the sample included all new graduate nurses who completed the programme. - Exclusion criteria were also not clearly and specifically stated, but it was indicated that the participant who did not correctly understand the VAS was excluded.
	Clinical Implication	To obtain an effective programme and high retention rate, the programme should be offered on a continuous basis during the time of staff shortages and times of adequate staff. PD staff should be available 24 hours a day.

27	Author/ Year	Farrell M & Chakrabarti A / 2001
	Title	Evaluating preceptorship arrangements in a paediatric setting. The title clearly stated the scope and nature of the study.
	Aims/ purpose	To evaluate the effectiveness of the study setting's preceptorship programme using an audit.
	Objectives	<ul style="list-style-type: none"> - To establish compliance with the Trusts' standard for preceptorship. - To identify the extent of utilisation of learning contracts within the preceptorship period. - To assess the use and value of competency assessment for admission and discharge as a means of promoting the clinical development of the preceptee. - To establish the implementation of arrangements for ongoing personal and professional development following completion of preceptorship. - To ascertain preceptor and preceptees' level of satisfaction with the arrangements for preceptorship.
	Research Questions	Not stated.
	Methodology	Quantitative and qualitative research methods. This was an appropriate methodology as it helped to achieve the research aims and illustrated preceptors' and preceptees' perceptions of preceptorship and their satisfaction with the current programme.
	Data Collection Methods	Data was collected in two phases. Phase one involved face-to-face questionnaire of newly qualified nurses near to or already completed their preceptorship period and observations for evidence of key documentary resources within the clinical setting. Phase two contains two in-depth focus group interviews to explore key findings originating from the first phase of the audit with both preceptees and preceptors. Each interview was tape-recorded and then transcribed verbatim by an experienced transcriber.
	Data Analysis Methods	Data collected from the questionnaire was entered into a prepared database. This helped to generate specific field reports using the descriptive statistics function available within the database software. Focus group transcripts were analysed independently by both authors using thematic analysis technique. Emergent codes were compared for similarities and differences to generate the themes.
Sampling/ setting	Two sampling populations were selected. First sample was of 17 newly qualified nurses (preceptees) who completed the questionnaire, sub-group (n=5) of 17 newly qualified nurses, invited for the focus group interview to explore their experiences of preceptorship. Second, six preceptors were randomly selected and invited to participate in focus group interviews to elicit their experiences of being preceptors.	

	Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Objectivity and internal validity of the qualitative and quantitative data was achieved by comparing and contrasting findings with other researchers and by using samples of participants' quotes. - Audit-trail was described which assures dependability of the study. - Triangulation by using two samplings and two data collection techniques were used which enhanced data credibility and confirmability. - Results were presented in detail and amalgamated by participants' quotes and tables for checking accuracy. - Discussion was compared with adequate related literature, and then followed by clearly stated conclusions. - Having triangulation methods (quantitative and qualitative) helped to enhanced the validity and credibility of the findings by cross-checking quantitative with qualitative findings. <p>The weaknesses of the study were that</p> <ul style="list-style-type: none"> - Ethical measurements were not stated, so not sure if it was considered. - Validity and reliability of questionnaire used was not stated which may impact on validity and reliability of the quantitative data obtained. - Data cannot be applied to larger population because of the small sample size and study was conducted in only one place. - Transferability of findings is impossible due to lack of information regarding the participants and setting. - No abstract
	Findings	<ul style="list-style-type: none"> - Findings of the questionnaire survey indicated positive results: both preceptees and preceptors were active in achieving and maintaining their responsibilities and preceptees received on-going learning relevant to their needs. In more detail, 13 preceptees completed their preceptorship, four preceptees were coming to the end of the preceptorship, one had obtained an extension of her preceptorship period. - During the preceptorship period, four preceptees indicated that their preceptors had been changed because nurses moved to a new clinical setting. - 82 % of participants had three or more meetings during preceptorship period, 12% just one meeting while 6% indicated that they had no formal meetings. - All preceptees completed at least one learning contract while 65% completed between 4 or more. Learning

		<p>contracts were negotiated and agreed with the preceptors.</p> <ul style="list-style-type: none"> - At the time of audit 94% of preceptees had fulfilled the minimum expected level3 competencies for admission. 76% of preceptees indicated that they had completed a competency level of between levels 4-6. - In relation to the discharge competency, two preceptees failed to identify level of competency achieved. - It was expected that following preceptorship, arrangement for clinical supervision would take place. 29% reported that they had discussed arrangements for clinical supervision. Of the 29% three had already made arrangements for supervision with only one reporting that s/he received clinical supervision following preceptorship. - Findings of the two focus groups' interviews revealed five general themes; the value of preceptorship, resources of preceptorship, shared preceptorship, formal and structured, and the unknown and expected. - Preceptorship was perceived by both preceptors and preceptees as a valuable supportive tool for new nurses. - Available resources are required for effective preceptorship. These resources to include available experienced preceptors, time to fulfil the expected responsibilities, supportive team and organisational culture and informational and teaching resources. However, a critical resource was that of available time. - Preceptors and preceptees indicated positive supportive benefit of shared preceptorship with ward nurses.
	Inclusion/ Exclusion Criteria	<ul style="list-style-type: none"> - Newly qualified nurses who had just completed preceptorship period. - Preceptors who supported some of the included newly qualified nurses during their preceptorship.
	Clinical Implication	<p>Study has clinical and administrative implications as preceptorship should be seen by administrators as an important leadership role. Guidelines and informational resources should be developed to help new nurses recognise the purpose of preceptorship. Preceptorship should be acknowledged by all parties involved. Further research is needed to explore the impact of preceptorship.</p>

28	Author/ Year	Hautala K., Saylor C. and O’Leary-Kelley C./ 2007
	Title	Nurses’ perceptions of stress and support in the preceptor role The title reflected the scope and nature of the study.
	Aims/ purpose	The purpose of the study was: <ul style="list-style-type: none"> - To describe whether preceptors perceive stress and if so, the amount of stress they experience when precepting the preceptees. - To identify the reasons they find precepting stressful. - To explore their perceptions of whether they receive adequate support from other staff.
	Objectives	Not stated
	Research Questions	<ol style="list-style-type: none"> 1. Do experienced staff nurses experience stress when precepting? 2. If so, how much stress do preceptors experience? 3. What are the primary reasons for preceptor stress? 4. Do preceptors perceive that they receive sufficient support from other staff?
	Methodology	A descriptive, exploratory qualitative and quantitative method was adopted. This method was considered appropriate as it helped to elicit quantitative and qualitative data, highlighted new ideas regarding preceptors and their sense of stress during preceptor role that contributed to the body of knowledge.
	Data Collection Methods	A questionnaire was developed containing questions which used Likert-type scales to measure responses and open-ended questions to allow subjects to elaborate on their responses. It consisted of four parts. The first part: illustrated demographic information. The second part included a section for measurement of perceptions of stress in the preceptor role using Likert Scale, this section included open-ended questions to identify the reasons why precepting is stressful. The third part of the questionnaire contained the preceptors’ perceptions of the support scale. The fourth part for the respondents to add any additional comments or remarks regarding their views of stress or support. The questionnaires were distributed to the included preceptors and returned by mail.
	Data Analysis Methods	Descriptive statistics were used to describe the sample and perceptions of support and stress. Coding and grouping the responses into common themes were used to analyse the qualitative data.
	Sampling/ setting	A convenience sample of 65 registered nurses who work in two large acute care hospitals in San Francisco.
Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - The study used mixed method approach which enhanced the credibility and internal validity of the 	

		<p>findings.</p> <ul style="list-style-type: none"> - Complete and clear description of the demographic characteristics of the participants were stated which may help the reader to decide on the possibility of transferability. - Clear and concise descriptions and presentations of the findings integrated with tables and participant quotes were stated, enhancing accuracy of the findings. - Conclusion was consistent with the findings and was plausible. - The study made a difference to the understanding of the support of preceptors during the preceptorship programme. However, it cannot be replicated as it was conducted in an uncontrolled and natural setting which is considered unique. <p>The study weaknesses were that:</p> <ul style="list-style-type: none"> - The study was limited by small sample size, setting and convenience sampling which made generalisation of the findings to all nurse preceptors difficult. The two hospitals may not be representative of all hospitals. - Participation in the study was voluntary which may lead to a potential selection bias as the possibility that preceptors who experienced more stress and perceived less support may be more inclined to complete a questionnaire. - Questionnaire was not tested for validity and reliability which may impact on the validity and reliability of the findings. - Findings were discussed and compared with only one study.
	Findings	<ul style="list-style-type: none"> - The response rate was 100%. - A majority indicated that preceptor responsibility was included in their job description and was part of their annual performance appraisal. - 48 participants illustrated that they did not receive special recognition from their managers. - 83% of participants perceived that the preceptor role was stressful on a mild to moderate level. Only 11% reported no stress. - Four themes were generated from qualitative data regarding the reasons for preceptor stress. These were: preceptor workload, preceptee skill level, organisational support and preceptor confidence. Many

		<p>participants needed more time and energy for successful precepting of new nurses and caring for their assigned patients. Data indicated inadequate preceptee skills and lack of organisational support and recognition from managers was considered important to some. Additionally, preceptors lacked confidence in being effective teachers.</p> <ul style="list-style-type: none"> - The majority reported that they received adequate preparation for the role and their goals were clearly defined.
	Inclusion/ Exclusion Criteria	Inclusion criteria included nurses identified as preceptors by their nurse managers and who precepted new nurses and/or students. Exclusion criteria were not stated
	Clinical Implication	Workload should be considered when staff nurses are designated as preceptors by assigning a smaller workload than usual. Allocation of sufficient time to teach and carry out patient care. Organisations need to consider recognition and rewarding the effective preceptors to increase their commitment to the role.

29	Author/ Year	Ross H. and Clifford K./ 2002
	Title	Research as a catalyst for change: the transition from student to registered nurse The title did not reflect the scope or nature of the study.
	Aims/ purpose	The aims of the study were to examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified nurse. To identify also areas for discussion and development, both in education and service settings.
	Objectives	Objectives were not stated.
	Research Questions	Not stated
	Methodology	Mixed (qualitative and quantitative) methods. These methods were considered appropriate as they generated data exploring the experiences of the nurses undergoing the transition from student to registered nurse and helped to achieve the research aims and generate new ideas, contributing to the body of knowledge regarding the preceptorship of newly qualified nurses.
	Data Collection Methods	<ul style="list-style-type: none"> - Data were collected over an 8 month period, using pre and post qualifying questionnaires and pre-qualifying interviews. The pre-qualifying questionnaire was distributed to 30 students three months prior to qualification while the post-qualifying questionnaire was distributed four months after qualification. The pre-qualifying interviews were conducted with four of the sample. - The questionnaire was piloted through various stages to enhance its validity and elicit the required information. This included: asking other researchers to comment on the design piloted with 20 nurses of the same cohort, and asking newly qualified nurses to fill-in and comment on the validity of the questionnaire. - The final questionnaire included: questions exploring experiences and expectations of final year students of being qualified nurses and section contained 20 statements on the Likert scale for students to rate their expectations of being newly qualified, with space for comments at the end. The latter section was adapted from Nolan's <i>et al</i> (1998) statements and modified for the purpose of the study and additional statements were added to explore issues of preceptorship. - 19 out of 30 students responded to the pre-qualifying questionnaire. The latter questionnaire followed by conducting four semi-structured interviews to help in comparative analysis of the emerging themes from the latter questionnaire. 13 of 19 respondents completed the post-qualifying questionnaire. Post-qualifying

		interviews were difficult to conduct as the sample who participated in the pre-qualifying interview were moved away.
Data Analysis Methods		Quantitative and qualitative data were generated. However, this article focused on the qualitative findings only. The interview transcripts and free text responses collected by using questionnaire were analysed in categories. However, data analysis methods adopted in this study were not clearly stated by the authors.
Sampling/ setting		A convenience sample (n=30) of one cohort of student nurses who qualified in September 1999 and volunteered to take part out of personal interest in the transition period. 19 students voluntarily responded to the pre-qualifying questionnaire, while four of them participated in the interviews and 13 of these 19 responded at the post-qualifying stage.
Methodological Robustness		<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Ethical measurements were achieved. - Internal validity of the questionnaire was tested - The findings were presented clearly based on the study's aims and supported with participants quotes which confirmed the validity of the findings. - Findings were compared with enough related literature which helped to draw clear conclusion and accordingly clear recommendations. - The conclusion was consistent with the findings reported. - Use of interviews and questionnaires enhanced the credibility of the findings. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Abstract was not well structured as it did not distinguish between the results and conclusion; it was stated as a brief summary of the study. - There was a potential for selection bias as the sample included the convenience nurses who volunteered to participate. - Generalisation of the study was difficult as the sample was small, not representative of all newly qualified nurses and conducted in one study setting. Lacked randomisation. - The study setting and demographic characteristics of the participants were lacking which made the idea of transferability difficult.

		<ul style="list-style-type: none"> - There was a potential risk for missing data and the inability to collect additional data as the questionnaire was a self-reporting tool.
	Findings	<ul style="list-style-type: none"> - The findings confirmed that the transition from student to qualified nurses is stressful for some newly qualified nurses. The majority of these nurses felt inadequately prepared for the new role. - Suggestions to improve the final year were offered by the participants. These included better links with clinical areas, modification of the content and focus of the course, clarification of the roles and provision of support for student nurses during placements. - Newly qualified nurses received inconsistent support and some had no formal preceptorship.
	Inclusion/ Exclusion Criteria	Inclusion and exclusion criteria were not specifically stated as the study included all students in their final year and joined the staff as newly qualified and who volunteered to participate in the study.
	Clinical Implication	The study had important implication regarding support and education of newly qualified nurses could be considered in clinical practice

30	Author/ Year	Scells M. & Gill R. / 2007
	Title	An evaluation of a strategy to improve the support of orthopaedic nurses through a team preceptorship programme. The title reflected the nature and scope of the study.
	Aims/ purpose	To evaluate a coordinated team preceptorship model (CTPM) on clinical and professional development outcomes of staff in an orthopaedic unit.
	Objectives	To evaluate the effectiveness of a CTPM in meeting the needs of the new graduate. To evaluate the degree of satisfaction with the CTPM. To evaluate the coordinator role and its value in the CTPM.
	Research Questions	Was the CTPM effective in providing a positive and supportive environment for the clinical and professional development of new starters and existing staff in a clinical unit
	Methodology	Mixed methods (Qualitative and Quantitative). General interpretive methodology was adopted for qualitative design and the survey method was adopted for quantitative design. These methods were considered appropriate as they helped to achieve the study's aims and objectives and assisted in answering the research questions.
	Data Collection Methods	<ul style="list-style-type: none"> - In-depth individual interviews were conducted for a purposeful sample. Data generated were used as a basis for developing the questionnaire. - A questionnaire was developed and piloted across the orthopaedic unit and then redistributed. Adjustment of the tool was made accordingly and then distributed to 55 nurses of orthopaedic unit.
	Data Analysis Methods	<ul style="list-style-type: none"> - Content analysis of a grounded theory was used to analyse the qualitative data. - SPSS, descriptive data included frequency. Mean and standard deviation was applied to analyse the quantitative data.
Sampling/ setting	<ul style="list-style-type: none"> - All staff were invited to participate. - Purposeful sample of 6 clinical staff nurses (new graduate, experienced nurses and resource preceptors) were drawn from the orthopaedic ward. - The study was conducted in one hospital (60 bed Orthopaedic clinical unit). 	

Methodological Robustness	<p>The strengths of the study were that:</p> <ul style="list-style-type: none"> - Ethical measures were considered - Survey tool piloted and validated for content and face validity to ensure the validity of the data collected. - Test-re-test analysis done to increase reliability of the study. - Mixed methods approach enhanced the credibility and validity of the findings by comparing the qualitative with quantitative data. - Findings were reported clearly and in sufficient detail accompanied by tables which helped to draw a clear conclusion and ensure objectivity of the study. - Conclusion was consistent with the reported findings. - There were adequate comparisons with other relevant literature which helped to draw an appropriate conclusion and recommendation for clinical practice. <p>The weaknesses of the study were that:</p> <ul style="list-style-type: none"> - Abstract was stated in the form of a brief summary of the study which did not distinguish between the conclusion and findings. - The sample was small, not sufficient to validate the survey tool. - Study findings have limited generalisability because of the small sample size and study was conducted in one setting. - The study lacked randomisation and control as it was conducted in a natural and uncontrollable context which made replication of the study difficult. - Lack of demographic characteristics of the participants or detail regarding the study setting which also made generalisation or transferability impossible.
Findings	<p>Qualitative findings revealed 45 common themes from the sample population. These data were used for the structure and foundation of the questionnaire</p> <ul style="list-style-type: none"> - 39 questionnaires were returned (71 % response rate) - The sample consisted of 85% female, 15%male. - 84% worked in one of the roles (preceptee 38%, preceptor 30%, and mentor 16%) with CTPM and 16% did not fill a role, 76% had worked in other models.

		<ul style="list-style-type: none"> - the item of ‘the role of the coordinator was an effective element in CTPM’ had high score, while a response to the statement that the TPM can work without a coordinator had a low score, indicating that inclusion of the coordinator in the model was strongly supported. - CTPM was potential for resolution and prevention of conflict. - CTPM provides continuous support for the new graduate/starter and enhances communication. - Moderate – strong agreement that the CTPM was preferred to other models - CTPM strongly promotes confidence and efficiency in the new staff member. - Coordinator attributes are that they should be educated, knowledgeable, experienced, and industrious.
	Inclusion/ Exclusion Criteria	The study included all clinical staff in the orthopaedic unit who agreed to participate.
	Clinical Implication	- CTPM is a recommended programme for staff development and integration which needs to be considered by other services within the study setting and other health systems.

Appendix C
Ethical Approval Letters

Hospital Ethics Committee Approval Letter was removed for confidentiality purpose

Ms Elham Ali Bukhari
Flat 602 Hacienda Apartment
11 Whitworth Street West
Manchester
M15 DD

3 June 2008

Re: Nature of the preceptorship programme and its impact on clinical nursing care
from the perspectives of relevant nursing staff

Proposal Number: 08/1006/NMSW

Dear Ms Bukhari,

Thank you for attending the Research Ethics Committee Meeting of the School of Nursing, Midwifery & Social Work held on the 28th of May 2008. The Committee are of the opinion that no major concerns or objections are evident and are therefore happy to grant full ethical approval.

During the progress of the study please inform the Committee of any changes or amendments that may be necessary.

On completion of the study would you please provide the Committee with a "Completion of Study Report".

In order to arrange University Insurance cover please forward the complete Insurance Form (enclosed) along with your Research Proposal and a copy of this letter to the Purchasing Office at the address printed on the form.

Best wishes for your study.

Yours sincerely



Howard Shilton
Chair: School Research Ethics Committee

c.c. Dr Ann Wakefield

Appendix D

- **Participants information sheets and consent forms**
- **Focus group and Individuals interview guides**

Participant Information Sheet For Nurse Managers

Participants in the Individual Interview

Project Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Invitation Paragraph:

You are being invited to take part in this research project. The sheet that you have will give you clear information about why the research is being conducted and what it will involve. Before you decide to participate, take your time to read and understand the following information carefully and discuss it with others if you wish. In addition, you can ask questions if any thing is unclear or if you would like more information.

When you decide to participate, you will be asked to sign a consent form as confirmation of your agreement. A copy of the signed consent form and information sheet will be given to you to keep for a future reference.

What is the purpose of the study?

This study is being conducted as part of a PhD in nursing education at University of Manchester by Elham Ali Bukhari. The study aims to explore the meaning of preceptorship and its impact on the clinical nursing care of newly hired nurses (preceptees) as perceived by you an experienced nurse (preceptor). In this study I am intending to explore your perceptions of both newly hired and experienced nurses in response to the preceptorship programme to see whether it is effective for the development of nursing competence.

Why have I been chosen?

You have been chosen to take part in this study because you are one of the senior nurses who have experience of teaching and supporting a preceptee through the preceptorship programme.

Do I have to take part?

No, your participation is voluntary. If you volunteer to participate in the study you will be asked to sign a consent form and will be given a copy of this information sheet to keep. Even if you do decide to take part you will still have the right to withdraw from the study at any time without giving a reason and without prejudice to your employment status. A decision not to take part, will not affect your future promotion prospects.

What will happen to me if I take part?

If you take part, I will invite eight of you to participate in an individual interview at the end of your newly hired nurse's preceptorship period in order to elicit your understanding about the meaning of the preceptorship programme and your perceptions of the effect the preceptorship process had on your respective preceptee's clinical performance and competencies. You will be also asked your age, gender, educational qualifications, and length of your clinical experiences. The interview will last no more than 60 minutes. If you agree, the interview will be audio-

taped and fully transcribed into text. Based on your thoughts common themes from the study will be identified and grouped into categories which will then be used as the basis of a research report in the form of a PhD thesis and publication at academic conferences and in journal publications. However, all the information will be used in anonymous format so you will not be identified by name as only numbers will be used to indicate that the responses have been made by different people.

What are the possible disadvantages and risks of participation?

None except for the time it takes for you to participate in the interview. Also you may not feel comfortable answering some of the questions. However, if you do feel uncomfortable or you suddenly want to withdraw from the interview you can simply ask to stop the tape and leave the interview area or if you want to carry on but do not want to answer a particular question that is fine we can omit that question and move on.

What are the possible benefits of taking part?

You are not going to gain any direct benefits from taking part in the study. However, I hope that the study findings will help the nursing education department to adjust the programme's content, policies and procedures should this be found to be necessary. Also the study will help to promote the clinical education and training strategies, of the hospital and potentially improve the quality of the preceptees nursing practice. Furthermore, it may also help the education department to devise solutions to the problem of turnover and staff shortages.

Will my participation in the study be kept confidential?

All information that is collected from you will be kept confidential. To achieve this confidentiality, any transcript generated from the interview will be coded. Nobody will know your name except the research team this will be me and my two University Supervisors and Dr. Taqwa who will help me to code the data. Other than these people your name and any personal details will not be disclosed to anyone. The information directly identifying you will not be used in any public report or document. Moreover, the tape-recording and transcripts will be stored in a locked cupboard and destroyed at the end of the study.

What will happen to the information?

The data collected from the individual interview will be analyzed only by the research team as stated above. The findings from the study will be documented in the results section of my PhD thesis, which will be presented to the University of Manchester doctoral defence committee as part of the final report for obtaining the degree of Doctor of Philosophy. Furthermore, it is intended to publish the results of the study as academic journal papers, conference posters and/or oral conference presentations. A copy of the research summary will be given to you if you wish.

Who has reviewed the study?

The study has been reviewed by both the Hospital Research Ethics Committee and the University of Manchester Research Ethics Committee. Study Number: 08/1006/NMSW

Who can I contact for further information?

If you have any questions or you need any further information about the study do not hesitate to contact any of the names listed below.

- 1- Elham Ali Bukhari PhD Student Tel #: 02 / 6240000 ext. 21047
- 2- Dr. Ann Wakefield Supervisor Tel #: 00441613067657
- 3- Dr. Margaret Rogers Supervisor Tel #: 00441613067683

Thank you for taking the time to read this information sheet and considering participation this study. Please keep a copy of this information sheet and consent form for your records.

Elham Bukhari
PhD Student

**Consent Form
For Nurse Managers**

Participants in the individual interview

Project Title:

Nature of the preceptorship programme and its impacts on clinical nursing care from the perspectives of relevant nursing staff.

No	Items	Please Initial Boxes
1	I confirm that I have had enough time to read the information sheet and ask any questions about the study.	
2	I confirm that I clearly understand what I have to do in the study.	
3	I confirm that all my questions have been answered by the researcher.	
3	I know that I can withdraw from the study any time I want without giving a reason and without it affecting my employment status.	
4	I know that I will be invited to participate in an individual interview that will last no more than 60 minutes and I would be willing to participate.	
5	I agree to the individual interview being audio taped and transcribed into text.	
6	I agree to data from the individual interview being analysed and used as part of the PhD thesis.	
7	I understand that the data collected from the interview will be kept confidential.	
8	I agree to my anonymised data being used in any published results from the study in academic journals and/or conference presentation or poster.	

Signing your name at the bottom of the consent form means that you have carefully read the information sheet and consent form and that you fully understand the contents. It also means that you agree to take part in this study and your questions have been answered in full. You will be given a copy of this form after you have signed it.

Name of participant

Name of Researcher

Signature of participant

Signature of Researcher

Date

Date

**Participant Information Sheet
For Preceptors, CRNs and Nurse Educators
Participants in the Focus Group Interview**

Project Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Invitation Paragraph:

You are being invited to take part in this research project. The sheet that you have will give you clear information about why the research is being conducted and what it will involve. Before you decide to participate, take your time to read and understand the following information carefully and discuss it with others if you wish. In addition, you can ask questions if any thing is unclear or if you would like more information.

When you decide to participate, you will be asked to sign a consent form as confirmation of your agreement. A copy of the signed consent form and information sheet will be given to you to keep for a future reference.

What is the purpose of the study?

This study is being conducted as part of a PhD in nursing education at University of Manchester by Elham Ali Bukhari. The study aims to explore the meaning of preceptorship and its impact on the clinical nursing care of newly hired nurses (preceptees) as perceived by you as an experienced nurse (preceptor). In this study I am intending to explore your perceptions of both newly hired and experienced nurses in response to the preceptorship programme to see whether it is effective for the development of nursing competence.

Why have I been chosen?

You have been chosen to take part in this study because you are one of the senior nurses who has experience of teaching and supporting a preceptee through the preceptorship programme

Do I have to take part?

No, your participation is voluntary. If you volunteer to participate in the study you will be asked to sign a consent form and will be given a copy of this information sheet to keep. Even if you do decide to take part you will still have the right to withdraw from the study at any time without giving a reason and without prejudice to your employment status. A decision not to take part, will not affect your future promotion prospects.

What will happen to me if I take part?

If you take part, I will invite eight of you to participate in a focus group interview. The interview will be conducted at the end of the preceptorship period of your newly hired nurse in order to elicit your understanding about the meaning of the preceptorship programme and your perceptions of the effect of the preceptorship process on your respective preceptee's clinical performance and competencies. You will be also asked your age, gender, educational qualifications, and length of clinical experience. The interview will approximately last about 60-90 minutes. If you agree, the interview will be audio-taped and fully transcribed into text. Based on your

thoughts common themes from the study will be identified and grouped into categories which will then be used as the basis of a research report in the form of a PhD thesis and publication at academic conferences and in journal publications. However, all the information will be used in anonymous format so you will not be identified by name as only numbers will be used to indicate that responses have been made by different people.

What are the possible disadvantages and risks of participation?

None except for the time it takes for you to participate in the interview. Also you may not feel comfortable answering some of the questions. However, if you do feel uncomfortable or you suddenly want to withdraw from the interview you can simply ask to stop the tape and leave the interview area or if you want to carry on but do not want to answer a particular question that is fine we can omit that question and move on.

What are the possible benefits of taking part?

You are not going to gain any direct benefits from taking part in the study. However, I hope that the study findings will help the nursing education department to adjust the programme's content, policies and procedures should this be found to be necessary. Also the study will help to promote the clinical education and training strategies, of the hospital and potentially improve the quality of the preceptees' nursing practice. Furthermore, it may also help the education department to devise solutions to the problem of turnover and staff shortage.

Will my participation in the study be kept confidential?

All information that is collected from you will be kept confidential. To achieve this confidentiality, any transcript generated from the interview will be coded. Nobody will know your name except the research team this will be me and my two University Supervisors and Dr. Taqwa who will help me to code the data. Other than these people your name and any personal details will not be disclosed to anyone. The information directly identifying you will not be used in any public report or document. Moreover, the tape-recording and transcripts will be stored in a locked cupboard and destroyed at the end of the study.

What will happen to the information?

The data collected from the focus group interview will be analyzed only by the research team as stated above. The findings from the study will be documented in the results section of my PhD thesis, which will be presented to the University of Manchester doctoral defence committee as part of the final report for obtaining the degree of Doctor of Philosophy. Furthermore, it is intended to publish the results of the study as academic journal papers, conference posters and/or oral conference presentations. A copy of the research summary will be given to you if you wish.

Who has reviewed the study?

The study has been reviewed by both the Hospital Research Ethics Committee and the University of Manchester Research Ethics Committee.
Study Number: 08/1006/NMSW

Who can I contact for further information?

If you have any questions or you need any further information about the study do not hesitate to contact any of the names listed below.

1 Elham Ali Bukhari PhD Student Tel #: 02 / 6240000 ext. 21047
2- Dr. Ann Wakefield Supervisor Tel #: 00441613067657
3- Dr. Margaret Rogers Supervisor Tel #: 00441613067683

Thank you for taking the time to read this information sheet and considering participation this study. Please keep a copy of this information sheet and consent form for your records.

Elham Bukhari
PhD Student

**Consent Form
For Preceptors, CRNs, Nurse Educators
Participants in the focus group interview**

Project Title:

Nature of the preceptorship and its impacts on the clinical nursing care from the perspectives of relevant nursing staff.

No	Items	Please initial boxes
1	I confirm that I have had enough time to read the information sheet and ask any questions about the study.	
2	I confirm that I clearly understand what I have to do in the study.	
3	I confirm that all my questions have been answered by the research team	
4	I know that I can withdraw from the study any time I want without giving a reason and without any affect on my employment status.	
5	I understand also that I will be invited to participate in a focus group interview lasting approximately 60-90 minutes and I would be willing to take part.	
6	I agree to the focus group interview being audio taped and transcribed into text.	
7	I agree to the data of the focus group interview being analysed and used as part of the PhD study results.	
8	I understand that the data collected from the interview will be kept confidential.	
9	I agree to my anonymised data being used in any published results from the study in academic journals and/or conference presentation or poster.	

Signing your name at the bottom of the consent form means that you have carefully read the information sheet and consent form and that you fully understand the contents. It also means that you agree to take part in this study and your questions have been answered in full. You will be given a copy of this form after you have signed it.

Name of participant

Name of Researcher

Signature of participant

Signature of Researcher

Date

Date

Participant Information Sheet For Preceptees

Participants in the Individual and Focus Group Interview

Project Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Invitation Paragraph:

You are being invited to take part in this research project. The sheet that you have will give you clear information about why the research is being conducted and what it will involve. Before you decide to participate, take your time to read and understand the following information carefully and discuss it with others if you wish. In addition, you can ask questions if any thing is unclear or if you would like more information.

When you decide to participate, you will be asked to sign a consent form as confirmation of your agreement. A copy of the signed consent form and information sheet will be given to you to keep for a future reference.

What is the purpose of the study?

This study is being conducted as part of a PhD in nursing education at University of Manchester by Elham Ali Bukhari. The study aims to explore the meaning of preceptorship and its impact on your clinical nursing care as perceived by you. In this study I am intending to explore the perceptions of both newly hired and experienced nurses in response to the preceptorship programme to see weather it is effective for developing nursing competence.

Why have I been chosen?

You have been chosen to take part in the study because you are a newly hired nurse currently undergoing a preceptorship programme.

Do I have to take part?

No, your participation is voluntary. If you volunteer to participate in the study you will be asked to sign a consent form and will be given a copy of this information sheet to keep. Even if you do decide to take part you will still have the right to withdraw from the study at any time without giving a reason and without prejudice to your employment status. A decision not to take part, will not affect your employment or your future promotion prospects in any way.

What will happen to me if I take part?

If you take part, I will invite eight of you to participate in an individual interview at the end of the orientation week in order to elicit your understanding about the meaning of the preceptorship and your initial expectations of the preceptorship process. You will be also asked your age, gender, educational qualifications, and length of clinical experiences. The interview will last no more than 60 minuets. If you agree, the interview will be audio-taped and fully transcribed into text. Based on your thoughts, common themes from the study will be identified and grouped into categories.

Finally, to see if your expectations have been achieved and if the preceptorship programme helped you to develop your clinical skills and competencies, I would like to invite all eight of you to take part in a focus group interview at the end of your preceptorship programme experience. The interview will last approximately 60-90 minutes. This too will be audio-taped and transcribed *verbatim* with your agreement. Furthermore, the data that I collect during both interviews will be used as the basis of a research report in the form of a PhD thesis and publication at academic conferences and as part of journal publications. However, all the information will be used in anonymous format so you will not be identified by name as only numbers will be used to indicate that responses have been made by different people.

What are the possible disadvantages and risks of participation?

None except for the time it takes for you to participate in the interview. Also you may not feel comfortable answering some of the questions. However, if you do feel uncomfortable or you suddenly want to withdraw from the interview you can simply ask to stop the tape and leave the interview area or if you want to carry on but do not want to answer a particular question that is fine we can omit that question and move on.

What are the possible benefits of taking part?

You are not going to gain any direct benefit from taking part in the study. However, I hope that the study findings will help the nursing education department to adjust the programme's content, policies and procedures should this be found to be necessary. Also the study will help to promote the clinical education and training strategies of the hospital and potentially improve the quality of preceptees nursing practice. Furthermore, it may also help the education department to devise solutions to the problem of turnover and staff shortages.

Will my participation in the study be kept confidential?

All information that is collected from you will be kept confidential. To achieve confidentiality, any transcript generated from the interview will be coded. Nobody will know your name except the research team this will be me, my two University Supervisors and Dr. Taqwa who will help me to code the data. Other than these people your name and any personal details will not be disclosed to anyone. The information directly identifying you will not be used in any public report or document. Moreover, the tape-recording and transcripts will be stored in a locked cupboard and destroyed at the end of the study.

What will happen to the information?

The data collected from your individual interview will be analysed only by the research team as stated above. The findings from the study will be documented in the results section of my PhD thesis, which will be presented to the University of Manchester doctoral defence committee as part of the final report for obtaining the degree of Doctor of Philosophy. Furthermore, it is intended to publish the results of the study as academic journal papers, conference posters and/or oral conference presentations. A copy of the research summary will be given to you if you wish.

Who has reviewed the study?

The study has been reviewed by both the Hospital Research Ethics Committee and the University of Manchester Research Ethics Committee. Study Number: 08/1006/NMSW

Who can I contact for further information?

If you have any questions or you need any further information about the study do not hesitate to contact any of the names listed below.

- 1- Elham Ali Bukhari PhD Student Tel #: 02 / 6240000 ext. 21047
- 2- Dr. Ann Wakefield Supervisor Tel #: 00441613067657
- 3- Dr. Margaret Rogers Supervisor Tel #: 00441613067683

Thank you for taking the time to read this information sheet and considering participation this study. Please keep a copy of this information sheet and consent form for your records.

Elham Bukhari
PhD Student

**Consent Form
For Preceptees
Participants in the individual and focus group interview**

Project Title:

Nature of the preceptorship programme and its impacts on clinical nursing care from the perspectives of relevant nursing staff.

No	Items	Please Initial Boxes
1	I confirm that I have had enough time to read the information sheet and ask any questions about the study.	
2	I confirm that I clearly understand what I have to do in the study.	
3	I confirm that all my questions have been answered by the researcher.	
3	I know that I can withdraw from the study any time without giving a reason and without it having any affect on my employment status.	
4	I know that I will be invited to participate in an individual interview that will last no more than 60 minutes and I would be willing to participate	
5	I agree to the individual interview being audio taped and transcribed into text.	
6	I agree to my anonymised data in the form of quotes from the individual interview being analysed and used as part of a PhD thesis and academic publications.	
7	I understand that I will also be invited to participate in a focus group interview lasting approximately 60-90 minutes and I would be willing to take part.	
8	I agree to the focus group interview being audio taped and transcribed into text.	
9	I agree to my anonymised data in the form of quotes from the focus group interview being analysed and used as part of a PhD thesis and academic publications.	
10	I understand that the data collected from the interview will be kept confidential	
11	I agree to my anonymised data being used in any published results from the study in academic journals and/or conference presentation or poster.	

Signing your name at the bottom of the consent form means that you have carefully read the information sheet and consent form and that you fully understand the contents. It also means that you agree to take part in this study and your questions have been answered in full. You will be given a copy of this form after you have signed it.

Name of participant

Signature of participant

Date

Name of Researcher

Signature of Researcher

Date

Interview Guide For Focus Group Participants

Research Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Note:

This interview schedule is divided into two parts: **part (1)** explores the participants' demographic data and **part (2)** forms the outline for the focus group interview data. To gain broad facts about preceptorship and to make the focus group interview more relevant, the questions in **part (2)** have been stated based on the study themes but these may be changed, removed or added to based on the participants' responses during the interview.

This schedule will be used to frame the interview with the following groups of staff and will take place at the end of the new nurses' preceptorship programme

- 1- group of new nurses
- 2- group of preceptors
- 3- group of clinical resource nurses and nurse educators

The interview will be run as follows:

At the beginning of the interview, participants will be verbally reminded of the following points:

- 1- This interview is conducted as part of the data collection methods for a PhD research study which aims to elicit your perceptions of the current preceptorship programme and its impact on clinical nursing care. Data collected will fill a gap in current knowledge about how nurses in this practice domain perceive preceptorship and how clinical education could be improved.
- 2- If you agree, the interview will be audio-taped and fully transcribed into text. Common study themes will be identified and grouped into categories. Then, it will be documented in the results section of my PhD thesis, published as academic journal papers, conference posters and/or oral conference presentations.
- 3- Your participation is voluntary, and you can withdraw any time without giving a reason and without prejudice to your employment status.
- 4- Confidentiality and anonymity for your data will be assured throughout the study and thereafter. This means that none of your names will be mentioned in the transcripts and nobody will have access to the data except myself, my two supervisors and Dr. Taqwa. All tapes will be stored in a separate locked cupboard and will be destroyed on completion of the research.
- 5- Whatever is discussed during the interview should not be disclosed outside the group so that everyone's ideas remain confidential to them.
- 6- If possible participants should speak one at a time to allow people to finish their statement so that each person is able to contribute on an equal basis and to make it easier to transcribe the data. However, if people do not feel

comfortable answering any of the questions that question will be omitted and the discussion will move on.

- 7- The questions in the interview will be concentrated on the main study themes. However, it may be changed, removed, or added to based on your responses as the interview discussion progresses.

Participants will also be asked to provide their verbal and written approval regarding the above points before the interview commences.

The main study themes are:

- 1- Nurses perceptions of preceptorship
- 2- Nurses expectations of preceptorship
- 3- Impact of the preceptorship programme on the staff nurses' clinical nursing care
- 4- The influence of supporting services on the success and/or failure of the preceptorship programme and nurses clinical performance.
- 5- Factors affecting the preceptorship programme's failure and/or success.

Part (1): Demographic Characteristics.

<u>Name of the interviewees:</u>	<u>Age</u>	<u>Gender</u>
1-	M / F
2-	M / F
3-	M / F
4-	M / F
5-	M / F
6-	M / F
7-	M / F
8-	M / F

<u>Educational qualification</u>	<u>Length of the clinical experience</u>
1-
2-
3-
4-
5-
6-
7-
8-

Part (2): Focus group Interview

What does the term preceptorship mean to you?

What were your expectations of the preceptorship programme at hospital?

Did/does the preceptorship programme meet new nurse's needs? If so how and why?

Did/does the preceptorship programme meet your expectations? If so how and why?

What was the nature of your role during the preceptorship programme?

What influence did/does the preceptor role have on you as a preceptee/preceptor during the preceptorship programme?

What kind of support did you receive from the nurses on your ward in order to achieve the goal of the preceptorship programme?

What sort of support did you receive as a preceptee/preceptor from the nursing educator in order to enhance your clinical knowledge?

What sort of support did you receive as a preceptee/preceptor from your head nurse in order to facilitate your duty as a preceptee or preceptor?

What kind of support did you receive as a preceptee/preceptor from your clinical resource nurse in relation to your clinical performance as a preceptee/preceptor role?

What type of support do you provide to a new nurse in order to fulfil her/his clinical needs?

Did the support you received make a difference to the overall outcome of the preceptorship programme and/or your clinical performance? If so, how?

How do you ensure that your new nurse received the appropriate support and supervision s/he needed during the preceptorship programme?

How did you assess the clinical performance of your new nurse during the preceptorship programme?

Have you noticed any difference in the clinical performance of the new nurse before, during and after taking part in the preceptorship programme? If so, How?

What would you do if the clinical performance of a new nurse was below the expected clinical standard during the preceptorship period?

What influence did/does the preceptorship programme have on your/new nurses' clinical performance?

How do you think (from your experience) the preceptorship programme contributes to the improvement of nurses' clinical performance?

What are the factors that affect the success of the preceptorship programme?

What are the factors that affect the failure of the preceptorship programme?

What suggestions, additions or changes would you like to see take place to improve the preceptorship programme?

At the end of the interview, participants will be invited to ask any question they may have of the researcher or to make any further comments that they feel have not been aired during the discussion.

Individual Interview Guide For Preceptees

Research Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Note:

This interview schedule is divided into two parts: **part (1)** explores the participants' demographic data and **part (2)** forms the outline for the individual interview data. To gain broad facts about preceptorship and to make the individual interview more relevant, the questions in **part (2)** have been based on the study themes but these may be changed, removed or added to, based on the participants' responses during the interview.

The interview will be run as follows:

At the beginning of the interview, participants will be verbally reminded of the following points:

1. This interview is conducted as part of the data collection methods for a PhD research study which aims to elicit your perceptions of the current preceptorship programme and its impact on clinical nursing care. Data collected will fill a gap in current knowledge about how nurses in this practice domain perceive preceptorship and how clinical education could be improved.
2. If you agree, the interview will be audio-taped and fully transcribed into text. Common study themes will be identified and grouped into categories. These will then be documented in the results section of my PhD thesis, published as academic journal papers, conference posters and/or oral conference presentations.
3. Your participation is voluntary, and you can withdraw any time without giving a reason and without prejudice to your employment status.
4. Confidentiality and anonymity for your data will be assured throughout the study and after. This means that none of your names will be mentioned in the transcripts and nobody will have access to the data except myself, my two supervisors and Dr. Taqwa. All tapes will be stored in a separate locked cupboard and will be destroyed on completion of the research.
5. If you do not feel comfortable answering any of the questions that question will be omitted and the discussion will move on.
6. The questions in the interview will be concentrated on the main study themes. However, these may be changed, removed, or added to, based on your responses as the interview discussion progresses.

Participants will also be asked to provide their verbal and written approval regarding the above points before the interview commences.

Participants will also be invited to take part in a focus group interview at the end of the preceptorship programme as outlined in the participant information sheet.

The main study themes are:

1. Nurses perception of preceptorship
2. Nurses expectations of preceptorship
3. Previous experience with the preceptorship

Part (1): Demographic Characteristics.

Name of the interviewee: Age Gender

..... M / F

Educational qualification Length of the clinical experience

.....

What was your occupation prior to coming to the hospital?

.....
.....
.....
.....
.....

Part (2): Individual Interview

What preceptorship mean to you?

Have you been involved in any preceptorship programme(s) before? If yes, when, where?

What was the nature of your involvement?

What are your expectations of the preceptorship programme at the hospital?

How do you think the preceptorship programme will help you in your new role at the Hospital?

Do you think the preceptorship programme will have any effect on the quality of the nursing care you give to patients in your new role? If so how? And why?

At the end of the interview, participants will be invited to ask any question they may have of the researcher or to make any further comments that they feel have not been aired during the discussion.

Individual Interview Guide For Head Nurses

Research Title:

Nature of the preceptorship programme and its impact on clinical nursing care from the perspectives of relevant nursing staff.

Note:

This interview schedule is divided into two parts: **part (1)** explores the participants' demographic data and **part (2)** forms the outline for the individual interview data. To gain broad facts about preceptorship and to make individual interview more relevant, the questions in **part (2)** have been organised around the study themes but these may be changed, removed or added to, based on the participants' responses during the interview.

This interview schedule will be used to interview nurse managers at the end of their new nurses' preceptorship programme

The interview will be run as follows:

At the beginning of the interview, participants will be verbally reminded of the following points:

1. This interview is conducted as part of the data collection methods for a PhD research study which aims to elicit your perceptions of the current preceptorship programme and its impact on clinical nursing care. Data collected will fill a gap in current knowledge about how nurses in this practice domain perceive preceptorship and how clinical education could be improved.
2. If you agree, the interview will be audio-taped and fully transcribed into text. Common study themes will be identified and grouped into categories. These will then be documented in the results section of my PhD thesis, published as academic journal papers, conference posters and/or oral conference presentations.
3. Your participation is voluntary, and you can withdraw any time without giving a reason and without prejudice to your employment status.
4. Confidentiality and anonymity for your data will be assured throughout the study and thereafter. This means that none of your names will be mentioned in the transcripts and nobody will have access to the data except myself, my two supervisors and Dr. Taqwa. All tapes will be stored in a separate locked cupboard and will be destroyed on completion of the research.
5. If you do not feel comfortable answering any of the questions that question will be omitted and the discussion will move on.
6. The questions in the interview will be concentrated on the main study themes. However, it may be changed, removed, or added to, based on your responses as the interview discussion progresses.

Participants will also be asked to provide their verbal and written approval regarding the above points before the interview commences.

The main study themes are:

4. Nurses perception of preceptorship
5. Nurses expectations of preceptorship
6. Impact of the preceptorship programme on the staff nurses' clinical nursing care
7. The influence of supporting services on the success and/or failure of the preceptorship programme and nurses clinical performance.
8. Factors affecting the preceptorship programme's failure and/or success.

Part (1): Demographic Characteristics.

Name of the interviewee:

.....

Age

.....

Gender

M / F

Educational qualification

.....

Length of the clinical experience

.....

Part (2): Individual Interview

What does the term preceptorship mean to you?

What were your expectations of the preceptorship programme at hospital?

Did/does the preceptorship programme meet new nurse's needs? If so how and why?

Did/ does the preceptorship programme meet your expectations? If so how and why?

What was the nature of your role during the preceptorship programme?

What influence did/does the preceptor role have on a preceptee/preceptor during the preceptorship programme?

What was the nature of support you provided to your new nurse to facilitate his/her transition into the new setting?

What sort of support did you provide for the preceptor to facilitate her/his role in order to make sure the goals of the preceptorship programme were achieved?

Did the support you gave make a difference to the preceptorship programme and/or new nurse clinical performance? If so, how?

How do you ensure that your new nurse received the appropriate support and supervision s/he needed during the preceptorship programme?

How did you assess the clinical performance of your new nurse during the preceptorship programme?

Have you noticed any difference in the clinical performance of the new nurse before, during and after taking part in the preceptorship programme? If so, How?

What would you do if the clinical performance of a new nurse was below the expected clinical standard during the preceptorship period?

What influence did/does the preceptorship programme have on new nurses' clinical performance?

How do you think (from your experience) the preceptorship programme contributes to the improvement of nurses' clinical performance?

What are the factors that affect the success of the preceptorship programme?

What are the factors that affect the failure of the preceptorship programme?

What suggestions, additions or changes would you like to see take place to improve the programme and accordingly improve the quality of your new nurses performance?

At the end of the interview, participants will be invited to ask any question they may have of the researcher or to make any further comments that they feel have not been aired during the discussion.

Appendix E
Simplified Transcription Symbols

Simplified Transcription Symbols

Symbols		Symbols explanation
1	┌	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk.
2	=	Equal signs, one at the end of a line and one at the beginning, indicate no gap between the two lines.
3	(0.2)	Numbers in parentheses indicate elapsed time in silence in tenths of a second.
4	(.)	A dot in parentheses indicates a tiny gap, probably no more than one-tenth of a second.
5	_____	Underscoring indicates some form of stress and emphasis, via pitch and / or amplitude.
6	::	Colons indicate prolongation of the immediately prior sound. The length of the row of colons indicates the length of the prolongation.
7	Word	Capitals, except at the beginnings of lines, indicate especially loud sounds relative to the surrounding talk.
8	.hhh	A row of h's prefixed by a dot indicates an in breath; without a dot, an out breath. The length of the row of h's indicates the length of the in breath or out breath.
9	()	Empty parentheses indicate the transcriber's inability to hear what was said.
10	(Word)	Parenthesized words are possible hearings.
11	(())	Double parentheses contain author's descriptions rather than transcriptions.

Sources: adopted from Silverman 2007, p. 389.