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The Lived Experience of the Nurse Practitioner in the Role of the Clinical Preceptor

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THE LIVED EXPERIENCE OF THE NURSE PRACTITIONER

IN THE ROLE OF THE CLINICAL PRECEPTOR

By

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A Dissertation Presented in Partial Fulfillment

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Doctorate in Nursing Education

Western Connecticut State University

July 2015
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Degree: Doctor of Nursing Education

Title of Approved Proposal: The Lived Experience Of The Nurse Practitioner In The Role Of The Clinical Preceptor

Date: July 29, 2015
ABSTRACT

The education of nurse practitioners requires a combination of theoretical concepts learned through didactic presentations and application of these concepts through clinical tasks mastered in the practice environment. The nurse practitioner acting as the clinical preceptor is an integral part of this education, as the clinical expertise imparted is imperative to learning the advanced diagnosis and treatment modalities and professional socialization necessary for the advanced practice role. This role has very little definition regarding the ongoing need for support and integration into the academic environment.

The purpose of this study was to explore the lived experience of the nurse practitioner in the role of clinical preceptor using a phenomenological approach. This approach, primarily attributed to the work of the philosopher Edmund Husserl, was relevant, as it is rooted in the concept that the ‘lived experience’ is a fundamental source of knowledge.

Purposive sampling using an initial recruitment letter, followed by the snowball method resulted in 16 participants, with data generated using three research questions and collected by confidential interviews. Data analysis incorporated the qualitative methods of Colazzi and the constant comparative techniques described by Lincoln and Guba.

Seven themes were identified, and the findings encompassed both stressors and satisfactions found in the clinical preceptor role. The predominant findings included the rationale for engaging in the preceptor role, the need for increased communication between academic faculty and clinical preceptor, and acknowledgements received by the
clinical preceptors from their students and the academic faculty. This study showed significance by illuminating the challenges in the clinical preceptor role and how academic faculty can help support this role, as perceived by the clinical preceptors. Actual methods of support are presented, along with articulated stressors and satisfactions experienced while engaged in the role.

The outcome was to garner and present needed support mechanisms that would be helpful to nurse practitioner educators to secure, maintain and support this vital component of advanced practice education.
DEDICATION

This study is dedicated to my husband,
who through his unwavering support always makes me realize
nothing we attempt together is impossible.
ACKNOWLEDGEMENTS

To Dr. Cynthia O’Sullivan, whose assignment in her Advanced Leadership course became the catalyst for this study; and who then provided the encouragement necessary to remain focused on a process that, at times, seemed endless.

To Dr. Mary Ellen Doherty, qualitative researcher extraordinaire, who generously shared her expertise, time and enthusiasm for research, and consequently has a convert, one who definitely wants to continue in this practice.

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To the nurse practitioners who participated in this study. Thank you for your time and your amazing dedication to the future of our profession. I am so proud to be considered a colleague.

To my son Alex, who provided me with his IT expertise whenever my frantic attempts to ‘fix’ something failed; and who circumvented many meltdowns with his calm demeanor and instructions to “just relax”.

Lastly, to Janessa and Kevin, and Leigh Anne and Mike, my daughters and sons in law, who over the course of my doctoral education provided me with the ultimate distraction, twin grandsons and two granddaughters. These gifts sprinkled through my doctoral journey always put everything in perspective, and always make me realize how wonderful life truly is.
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CHAPTER 1

Introduction to the Topic

Clinical experiences of the nurse practitioner student are vital to the successful mastery of the advanced practice role. Clinical preceptors are seen as the link between the concepts and evidence-based approaches to care and the realities of actual practice (Barker & Pittman, 2010). A preceptor not only models the details and realities of advanced practice, but also provides current knowledge, opportunity for skill mastery, and a sense of professional collegiality within a clinical practice environment. Exposure to these experiences helps guide the student, not only toward mastery of clinical knowledge and skills, but toward a development of a sense of professional self and purpose within this advanced role.

Precepting, a variation on the traditional apprenticeship method of education, has been a component of nurse practitioner (NP) education since its inception. The clinical education of NPs began in 1965, when Loretta Ford and Henry Silver, a nurse and physician respectively, collaborated in developing the first program for nurse practitioners. This collaboration was in answer to the provision of coverage by Medicare and Medicaid that same year to low income women and children, the elderly, and the disabled population (Ford & Silver, 1967). At the time this coverage was granted, specialization in medicine by physicians decreased the number of available primary care providers. The potential of a more lucrative specialty practice left many rural areas, some which were already medically underserved, with large gaps in the provision of primary medical care. Ford gave credence to society’s demand for primary care services and
nursing’s potential to meet this demand as the reason for the development of an NP program. Coupled with the shortage of physicians, the need for the quick expansion of NP programs was supported nationwide (Ford, 1986).

Initially, the NP role was implemented as an advanced clinical nursing role, with the development of the diagnostic and treatment skills in patient management under the framework of medical mentoring. It was then thought that physicians were the professionals best suited to this mentoring role, and were the primary clinical preceptors within NP programs. This medical mentoring was an accepted practice in both the NP programs developing in the United States and elsewhere in the world. Barton (2006) supported this concept by stating “the developing NP education programmes in the UK adopted medical mentorship as an integral part of their curricula” (p. 820). Other rationale presented to support the medical preceptor/NP student relationship was that goodwill and collegiality between physicians and NPs was important, not only to provide education in the necessary diagnostic skills needed for patient management, but to provide sanction by professional medical organizations. Interestingly, this concept is still embraced by present educators involved in NP education, and the recognition that collaboration by both groups can be beneficial to the public remains acceptable (Hamric, Hanson, Tracy, & O’Grady, 2009). However, the current educational priorities for enhanced interdisciplinary collaboration for both NP and medical students suggest that both groups of learners may benefit from supervised practicum experiences from a range of practitioners. Presumably, NP and medical students learning from both physician and NP clinical faculty may serve to enhance mutual understanding of both professional roles (Kelly & Matthews, 2001).
Despite the initial mentoring by physicians, when the NP role was first envisioned there was opposition by both physicians and nurse leaders regarding the NP model. O’Brien (2003) stated that certain nursing leaders believed NPs were not practicing nursing and the title was misleading. The education of these practitioners in primary care medicine was feared to potentially “control and devour nursing education and practice” (p. 2302). Other adversaries in organized medicine were opposed to nurses functioning in an expanded role without physician supervision. There was concern that NPs were “created in an environment of informal training, a lack of credentialing processes, increasing sophistication of medical care and opposition” (p. 2302). In response to this criticism, NPs began to collaborate and give definition and legitimacy to their role. Precepting was becoming more of a responsibility of this role as the availability of primary care services by the NPs increased through the 1970s, affording the student opportunity to engage in clinical precepting with an NP as a role model. In the early 1970s the Committee to Study Extended Roles for Nurses was formed by the secretary of Health, Education, and Welfare (HEW). The findings of this report supported the belief that advancing the scope of nursing practice through advanced education was essential for the provision of health care for all Americans (American Journal of Nursing (AJN), 1971). The report also supported the collaboration of physicians and nurses in attainment of an advanced practice level of nursing by stating the following recommendation:

The transfer of functions and responsibilities between physicians and nurses should be sought through an orderly process recognizing the capacity and desire of both professions to participate in additional training activities intended to augment the potential scope of nursing practice (HEW 1971 as reprinted in AJN 1971, p. 2348).
Interestingly, as educational programs for NPs were being developed through this
decade and cohesion was being sought between physicians and nurses, professional
discord existed between the nurse educators of NPs and other roles in nursing. Nurse
theorist Martha Rogers, one of the most outspoken opponents of the NP concept, argued
that “the development of the NP role was a ploy to lure nurses away from nursing to
medicine and thereby undermine nursing’s unique role in healthcare” (Rogers, 1972, p.
43). Despite this opposition, the NP role was established, with the need for the provision
of health care far greater than the inferences of the dissolution of the nursing role. In
1980 the American Nurses Association issued a Social Policy Statement declaring that
specialization in nursing in the advanced practice role was clearly established (ANA,

Through the 1980s and 1990s growth in the number of NP programs expanded to
a total of 769 specialty track NP programs (AACN, 1999; NONPF, 1997). The need for
clinical preceptors to support these programs was vast, and academic faculty were
realizing that the challenge of securing clinical preceptors was becoming more difficult.
Through the 1980-90s professional NP organizations were established, among them the
American Association of Nurse Practitioners (AANP). The establishment of this
organization did not unify NPs, as many specialty practitioners such as pediatric and
women’s health NPs formed their own associations, but it provided a major
organizational representation of the role. Paralleling the development of the various NP
organizations was the establishment of the accreditation process, with the American
Nurses Credentialing Center (ANCC) becoming the world’s largest credentialing
organization for the nursing profession. In 2010, ANCC successfully achieved a notable
international credential, known as ISO 9001:2008. This certification in the design, development, and delivery of global credentialing services and support products for nurses and healthcare organizations ensures the ANCC has established proficiency, compliance, and ongoing improvement in the credentialing process (ANCC, 2014). Certifications such as this demonstrate the continuous progression of these professional organizations in ensuring the provision of competent care at the advanced practice level.

The most recent development in the ongoing process to regulate the requirements for the education of NPs is the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education. (APRN Consensus Work Group & National Council of State Board of Nursing APRN Advisory Committee, 2008). This model has been endorsed by 48 professional nursing organizations, including the American Academy of Nurse Practitioners (AANP), American Nurses Credentialing Center (ANCC), and the National Organization of Nurse Practitioner Faculties (NONPF). The goals of the consensus process are to:

- Strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice.
- Develop a vision for APRN regulation, including education, accreditation, certification, and licensure.
- Establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care.
- Produce a written statement that reflects consensus on APRN regulatory issues (APRN Consensus Work Group National Council of State Board of Nursing APRN Advisory Committee, 2008, p. 20).
This report contains definitions of the APRN Regulatory Model, the Advanced Practice Registered Nurse, and broad-based APRN education. Also included is a model for regulation that ensures that APRN education and certification is a valid and reliable process based on nationally recognized and accepted standards. Uniform recommendations for licensing bodies across states, a process with characteristics designed to recognize new APRN roles, and a definition of an APRN specialty that allows the profession to meet future patient and nursing needs is also presented (APRN Consensus Work Group National Council of State Board of Nursing APRN Advisory Committee, 2008). This consensus model, which has a target date of 2015 for implementation, is vital to the regulation of NP education and practice, and impacts all stakeholders engaged in this profession. The clinical preceptor is especially influenced, as this role encompasses both the educational and the clinical role to be modeled by the students they precept. Despite the evolution of nurse practitioner education, including the plan to standardize the clinical requirements, there is very little research regarding the lived experience of the clinical preceptor, which is what this study explores.

**Rationale for Selection of the Topic**

The attraction, securement, and professional support of the clinical preceptor have historically been the responsibility of faculty involved in the advanced practice nursing program. Preceptors are considered a vital resource, and in NP programs they are the educators that fulfill the requirement for students to meet clinical practice hours. Academic faculty in NP programs are increasingly competing for qualified individuals to provide NP students the needed clinical experiences, not only with one another, but also with physician assistant programs and medical schools (Campbell & Hawkins, 2007).
This competition potentially compromises the availability of clinical preceptors, and also strains the quality of and time allotment for the NP to engage in the process of effective precepting. Barker and Pittman (2010) state:

> It is a reality that advanced practice programs are experiencing increases in enrollment and the number of precepted experiences has increased as well. Individual tracks within a program as well as multiple programs within a university or college or within a geographic area often place the potential preceptor in the middle of a cacophony of requests for the service. This is frustrating and can lead to a desire for them “to all go away and leave me alone!” (p. 147).

Due to the projected increase in students in NP programs, and the resultant need for clinical preceptors, it is imperative that the preceptors’ perspective of this process be known so that efforts to provide objective support of the preceptor role may be further undertaken by academic faculty. Academic faculty responsible for student placement and participation in the clinical area may then readily use this heightened awareness of the preceptors’ experience to build upon the positive aspects of the preceptor-student-faculty relationship, which may potentially assist the student to integrate classroom content with evidence-based clinical problem-solving skills.

**Significance of the Study**

NP educational programs have a long and rich history of preparing highly-competent graduates that have advanced the health of the people in this nation and abroad. These programs have evolved over the past quarter century from initial certificate programs to more lengthy masters level programs and now a practice doctorate (NONPF,
2013). Study of the lived experience of NP clinical preceptors is relevant to both the science of nursing and nursing education because the growth of these programs represents a vast focus of resources and faculty in the coming years. The expected increase in NP programs is projected to circumvent the anticipated shortage of primary health providers as the present societal population ages. This increases the demand for qualified clinical preceptors, and most importantly requires a greater understanding of the necessary skill sets needed by academic and clinical faculty. The reciprocal relationship between NP clinical preceptors and nursing faculty has been recognized as a vital process to build a sense of commitment toward NP students (Gibson & Hauri, 2000). The ability to accomplish this will be enhanced as more is known about the experiences of those who precept these students.

The current study is informed by the 1999 AANP Preceptor and Faculty survey, which has not significantly decreased in relevance despite its age. According to the survey, Amella, Brown, Resnick, and McArthur (2001) state:

Information is desperately needed to substantiate the benefits and burdens of precepting NP students, to identify the issues faced by schools for competing preceptors, and to quantify the benefits of a high quality clinical education for the graduates of programs (p. 519).

Despite this plea over a decade ago, very little research has been devoted to the study of the experiences of NP preceptors. According to Brooks and Niederhauser (2010), one of the main reasons chosen to become a preceptor was “the desire to help the students increase their knowledge and skills, and to enjoy the satisfaction of teaching” (p.574). Other reasons in the literature cite the ability “to keep current and give back to
their profession and alma mater” (Lyon & Peach, 2001, p. 240), and to promote the role of the NP within both the academic and societal cultures. NPs who support students in the role of clinical preceptor describe it as one that “fosters independence and skill development, and promotes socialization, positive role concept, confidence and competence” (Gibson & Hauri, 2000, p. 360). Thus, professional satisfaction stems from participating in the education of a student motivated to become a collegial member of the advanced practice profession.

Challenges to the preceptor role presented in the literature include the perception of decreased productivity for nurse practitioners during preceptorships, gaps in communication between the faculty and the preceptor, and a need for closer observation of the student by the nursing faculty (Brooks & Niederhauser, 2010). Technological advances within places of practice have also added an increased challenge, as reflected by issues concerning patient confidentiality and the Health Insurance Portability and Accountability Act (HIPPA) regulations. At most clinical sites electronic medical record systems are designed to be utilized only by practice members, and the amount of time needed to educate students on the practice system, if it is even allowed to be utilized by students, detracts from the professional modeling and patient interaction which is the primary focus of the clinical experience. Yet, unless the student can be allowed the complete patient interaction experience, which would include access to the patient record and the opportunity to document assessment findings, the experience is incomplete. Thus, the responsibility of the integration of technology into the role of the nurse practitioner must be one that the preceptor models. How one integrates technology with clinical
practice is a task that impacts precepting, yet it has not been explored in a research context.

In her work, Brykczynski (2012) states, “Becoming an NP is not merely learning facts and clinical guidelines, performing tasks, or following routines; it involves developing a cluster of patterned and interrelated ways of being that depend upon socially embedded experiential knowledge” (p. 555). This statement gives support to the belief that students learning the role of an NP should be afforded the role modeling and expertise presented by a professional engaged in that role. Consistent exposure to the role of the NP, along with other professionals integrated into the health care team, in varied clinical environments fosters both knowledge building and professional collegiality at the advanced practice level.

**Problem Statement**

There is an increased need to understand the lived experience of the clinical preceptor in NP education due to the expansion of NP programs and the vital role the clinical preceptor plays in imparting this education. However, little research has provided sufficient description of the experiences of those who precept NP students, which makes it difficult to ascertain the specific factors which may support this process. Particularly absent in the literature are comprehensive data describing the process of the experience, benefits or detractors, and the meaning and value of the experience from the perspectives of the preceptors themselves. In addition, with the institution of electronic medical records and other emerging clinical factors, little research has been provided which specifically explicates the impact of these phenomena in relation to the effectiveness, satisfaction, and meaning of the precepting experience as perceived by preceptors. With
an increased need for more NP preceptors, these roles become more and more integrated within the healthcare system. As processes for providing services continue to evolve due to technology, societal changes, and policy reforms, understanding the experiences of NP preceptors is essential. With increased understanding of this experience, stakeholders in the education of NP students will be able to initiate a more informed analysis of the precepting process, which may ultimately support the clinical experiences of NP students, now and into the future.

**Purpose Statement**

The purpose of this phenomenological study was to explore the lived experience of NPs engaged in the role of clinical preceptor for NP students. Little is known about the full range of experiences of NP preceptors engaged in this increasingly sought-after activity, primarily due to the lack of exploration of the actual lived experience of the role present in the literature. The knowledge gained from this study may inform academic nurse educators regarding the quality of this experience for the preceptors themselves. The need to recruit competent clinical preceptors to invest time and resources required to provide this service to NP students makes understanding this process a high priority for faculty members engaged in the education of NP students.

An additional outcome of this study identified objective ways that professional effectiveness in this clinical role can be maintained. Thoroughly understanding and acknowledging the preceptors’ experiences may assist academic nurse educators to gain an appreciation of the full set of forces which not only impact the experience of the preceptor, but the students’ learning process as well. By gaining this understanding, the
The ultimate outcome of the study can be to provide the most cohesive educational experience possible for the student engaged in learning the advanced practice level of nursing.

In summary, the results of the study provide the discovery, description, and clarification of the lived experience of the NP in the role of clinical preceptor in light of the numerous forces that may impact these experiences. Through this process, the identification of potential opportunities to improve the process of clinical education, some of which may potentially include facilitating better understanding of the process between preceptors and academic faculty, are expected to ultimately enhance the process of NP students to learn to provide competent care in the advanced practice role.

**Research Questions**

1. What has been your experience as a clinical preceptor for Nurse Practitioner students?

2. What has influenced your experience, both positively and negatively, as a clinical preceptor for nurse practitioner students?

3. What newly emerging clinical factors impact your ability to precept in the clinical environment?

**Definition of Terms**

**Advanced Practice:** the application of an expanded range of practical, theoretical, and research-based competencies for the provision of health care within a specialized area of clinical nursing (Hamric, Hanson, Tracy & O’Grady, 2014).

**Clinical Practice Hours:** the hours in which direct clinical care is provided under the supervision of a clinical preceptor in the NP role. The direct clinical care is provided to individuals, families, and populations in focused areas of NP practice (NONPF, 2008).
**Clinical Preceptor**: the licensed, credentialed, and experienced NP who is providing the graduate nursing student with knowledge, skill development, and supervision in a clinical environment.

**Clinical Preceptorship**: a time-defined educational relationship between a student and a licensed, credentialed, and experienced NP, with the purpose of providing knowledge, skill development, and supervision in a clinical environment.

**Experience**: the knowledge or skill acquired over a period of time, especially when engaged in a particular profession or by observing someone engaged in that profession. An event or occurrence that leaves an impression.

**Mentor**: one who provides role modeling, apprenticeship, and nurturing instruction. In the majority of nursing articles, mentorship is equated with preceptorship (Davidhizar, 1988).

**Nursing Faculty**: educators who hold the license of registered nurse or NP and are employed by an institution of higher education to teach students enrolled in a graduate nursing program of NP education.

**Nurse Practitioner**: a registered nurse who holds an advanced degree, usually a Master of Science in Nursing or Doctorate in Nursing Practice, and is accredited by a recognized professional nursing organization to practice autonomously in areas such as family practice, pediatrics, internal medicine, geriatrics, psychiatry, and women’s health care. NPs are educated, licensed and credentialed to provide initial, ongoing, and comprehensive care, by diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. (NONPF, 2008 & ANCC, 2014).
Practice: the medical organization in which the NP is employed to provide health care within the scope of practice reflective of credentialing and licensure.

Student: a registered nurse enrolled in a master of nursing or doctorate of nursing practice program with the area of study being a specialty NP track.

**Introduction to the Phenomenological Approach and Rationale for Use**

Phenomenology is “a qualitative research tradition, with roots in philosophy and psychology, that focuses on the lived experience of humans” (Polit & Beck, 2012, p. 737). It studies the human experience from an individual perspective with an attempt to understand the structure and meaning of this experience as it is lived in the world. The development of phenomenology is primarily attributed to the work of the German philosopher Edmund Husserl. Husserl presented the concept that experience is the fundamental source of knowledge and that “lived experience” (Dowling, 2007) is a way of describing a phenomenon as it appears to the person who has experienced or is presently experiencing the phenomenon. In his editorial, Koch (1995) stated “Husserl believed the aim of phenomenology was the rigorous and unbiased examination of things as they appear in order to arrive at an understanding of the human consciousness and experience” (p. 825). Husserlian phenomenology requires the researcher “to suspend personal beliefs about the research phenomena, while seeking to describe the participants’ experiences” (Mapp, 2008, p. 308). Accomplishment of lack of bias by the researcher entailed the concept of “bracketing,” which is the process of setting aside all conscious thoughts, beliefs, and influences that would bias the researcher. The full efficacy of this concept has been debated throughout the literature, both historic and current, with questions posed such as, “Can anyone completely put aside all that has
influenced and fashioned their beliefs and understandings?” (Tuohy, Cooney, Dowling, Murphy & Sixsmith, 2013, p.18). Despite this debate, bracketing has become an accepted component of phenomenological inquiry, with it facilitating a more accurate and precise description of the phenomenon (Dowling, 2007).

The use of phenomenological methodology in nursing research has been supported by nurse researchers who recognize this method as a means to attain better understanding of experiences involving both colleagues and patients. Nursing, and the education of nurses, is a humanistic profession which is committed to caring for all human beings. In order to care in a holistic manner, nursing must continually seek to understand the contexts and meanings of the human life experience. Davis (1973) states that this methodology is similar to actual nursing practice, in that the skills of observation and interaction are highly relevant to the phenomenological approach in nursing research. Edward (2006), continues to support the use of phenomenology in nursing research, stating:

The philosophical underpinnings of phenomenological thought are consistent with the values of nursing practice- the uniqueness of the person, the importance of personal discovery and acceptance of life situations, the need for exploration of meaning of experience, interpersonal relating, potential for personal growth, and use of the self as a therapeutic tool (p. 237).

Thus, this methodology can easily be applied to the study of nursing students and those involved in educating them. The lived experience of all participants can foster an
understanding that results in a more comprehensive education through interpretation of shared experiences.

NPs are educated to approach the care of patients in a patient-centered manner that blends nursing and medical knowledge and applies this knowledge to the presented symptoms. This process requires “listening and attending to the patients’ life-world so it can be incorporated into mutually agreed upon plans for management” (Haworth & Dluhy, 2001, p. 307). History taking is a mechanism that is used to discern the patients’ perception of his symptoms and his own lived experience in coping with these symptoms. Education of the NP in the clinical setting is achieved by learning through experiences with preceptors. Case studies are presented as lived experiences of the practice they are engaged in, and the reflection of lived experiences are used to teach and heighten awareness of the perceptions of the patient and his/her response to care.

In this current study, the focus was on the experiences of the clinical preceptor, with the data gathered through individual, confidential interviews. The experiences of members in the preceptors’ “life-world” were reflected in the preceptors’ story. One of the integral pieces of advanced practice nursing consists of enhancing the medical model of practice to include the identification of holistic differential diagnoses and problems that impact health due to stress and coping responses. The skill of learning to listen to the “whole patient” is acquired in the clinical area, with the preceptor mindfully prompting the student toward acquisition of relevant patient information by listening to the patients’ perspective of the symptoms being experienced and their possible causative factors. In addition, those factors within the healthcare environment which shape the everyday experiences of NPs were considered in light of how they also affect the experience of
precepting. Technology, in relation to the task of documentation, continues to permeate the clinical practice setting with an expected substantial influence on healthcare delivery. Yet, the use of this technology, in the form of electronic medical records, has received little attention in the literature regarding its impact on the educational experiences of NPs. This topic was explored as a factor with the clinical preceptor regarding its relationship to the experience of precepting NP students.

In conclusion, the phenomenological approach expands our understanding of human experiences by exploring the lived experiences of people from their own perspective. Flood (2010) concurs that “this methodology has gained respect as a valid approach to the study of nursing as a science of caring, and offers a means by which human phenomena or the lived experience of nurses and patients can be studied and understood” (p. 13). The basic tenants of this method were clearly appropriate to this study, as the relaying of the lived experiences of the clinical preceptor was the primary data source. These lived experiences allowed a unique perspective of the process of educating NP students which had not been widely heard.

**Assumptions/Limitations**

The following assumptions and limitations are presented as a way to understand the study within an intended context and are explained in relation to issues of participant sampling and inclusion, as well as their rights as research subjects. Further discussion of these areas is included in Chapter Three (Methodology).

1. Clinical preceptors will possess the advanced academic degree required for licensure as an NP and will be credentialed in an area of advanced practice recognized by a professional nursing organization.
2. Clinical preceptors will possess current licensure as advanced practice registered nurses or the equivalent licensure (per state title) and be currently employed in a recognized health care practice as an NP.

3. Clinical preceptors will have the ability to recall clinical experiences as preceptors and possess a willingness to share these experiences with the researcher.

4. Clinical preceptors will be informed that the information given during the data collection will not retain any identifying characteristics, and will not be shared with members of their health care practice, the institution of higher education, or past or present students they have precepted.

Summary

This research explored the lived experience of the nurse practitioner in the role of clinical preceptor. The dissertation documenting this research is presented in five chapters. Chapter One contains an introduction which includes the historical evolution of nurse practitioner education, the purpose, the rationale for selection, and the significance of the study. Definitions of key terms and assumptions/limitations are also included in this chapter. Chapter Two presents the review of the literature, with primary content exploring the recognition and development of the preceptor role and the impact it has on the education of the nurse practitioner, as well as an in-depth evaluation of the gaps in the literature that this study addressed. The third chapter identifies the methodology of the study, including the research design, target population, and recruitment, along with the method of data collection and subsequent interpretation. Chapter Four describes the study’s findings emanating from Colaizzi’s (1978) method of data analysis, which includes the identification of themes and examples of quotations from the participant.
interviews which demonstrate the themes. The fifth chapter concludes the dissertation with a discussion of the research findings in light of the relevant literature, along with the identification of limitations, implications for nursing practice, and recommendations for further research.
CHAPTER 2

Overview of Literature Review

In order to understand the phenomenon of interest, namely the lived experience of the nurse practitioner engaged in the clinical preceptor role, a literature review was conducted. The databases explored consisted of Academic Search Premier, CINAHL Complete, PsycArticles, Medline, and the Health and Psychosocial Instruments Database. This search revealed 70 sources and spanned the years 1967 to 2014. From the literature, several themes emerged which served as the basis for organizing this literature review into subsets of the larger literature sample.

Major subsets that emerged from the literature and are the basis for this review consist of the following: the historical perspective of the evolution of the NP role, the historical perspective of the mentor/preceptor, the role of the clinical preceptor in NP education, and identification of challenges with the clinical preceptor role as articulated within the literature. Bandura’s Social Learning Theory is presented in relation to clinical nursing education with the concepts of observational learning and self-efficacy identified and discussed in relation to NP education. The philosophy of Husserl and the use of phenomenological methodology provide support for the exploration of the lived experience of this clinical role.

The delineation of the clinical requirements within the curriculum of an NP program gives support to the critical component of preceptorship and its impact on student success in providing advanced practice health care. As Barker and Pittman (2010) acknowledge, “Preceptors are the vital link between the concepts and evidence based
approaches to care and the realities of actual practice” (p. 145). The role of the clinical preceptor has evolved parallel to the increase in the scope of practice of the NP; as the NP role continues to grow, preceptors have become irreplaceable in providing the modeling and expertise necessary for its development among new practitioners. Through the identification of the preceptor role and its acceptance as a pivotal way to afford students clinical experience, the preceptor acts as the role model for both clinical skills and professional behaviors that can be emulated.

**Historical Perspective of the Evolution of the Nurse Practitioner Role**

The NP role originated in the 1960s as a mechanism to provide healthcare to underserved populations. The shortage of primary care physicians, along with the general medical disinterest in this population, contributed to the need for the role and, as a result, continuing education programs were established for nurses interested in attaining the status of NP. However, acceptance by professional nursing organizations was at first unenthusiastic, as described by Joel (2009), “Even with the recognized need for this expanded nursing role, it was over e10 years before the American Nurses Association (ANA) formally defined this advanced practice role and established guidelines for continuing education programs that prepared adult and family nurse practitioners” (p. 29).

In 1974, the ANA Congress of Nursing Practice established the NP role as “having advanced skills in the assessment of physical and psychosocial health-illness status of individuals, families, or groups in a variety of settings through health and developmental history taking and physical examination” (Joel, 2009, p. 17). Curricular development was formally established in 1980 with funding from the Robert Wood
Johnson Foundation; and the establishment of the National Organization of Nurse Practitioner Faculty (NONPF) also begun the same year. By the 1980s the educational standard for the NP was a Master of Science in Nursing, with 90% of established programs at the masters or post masters level by 1989 (Pulcini & Wagner, 2001).

Certification through comprehensive examinations began in 1977 by the ANA, which provided uniformity in programs through two credentialing organizations, the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners (AANP). Through the 1980s specialty areas of certification were offered that included family, adult, pediatric, psychiatric, and gerontological NP certifications among others. As of 2014, there are 11 recognized certifications for NPs offered by the ANCC, with the maintenance of family, pediatric, school, acute care, emergency, and adult psychiatric-mental health; and the merging of the adult and gerontological certifications into adult-gerontological primary care or acute care as of January 2014. (ANCC, 2014). This merging of two certifications was in response to the projected increase in size and longevity of the older adult population. The AANP offers three certifications, including adult, family, and adult-gerontology primary care, the latter of which replaced the gerontology certification in December 2012 (AANP, 2014).

As certification criteria became more established and uniform, the requirement for clinical hours increased and became more detailed in specificity. Depending upon the specialty, clinical hours range from 500-600, with the AANC specifying “faculty supervised clinical hours” (ANCC, 2014) and the AANP stating “A minimum of 500 clinical clock hours of faculty supervised practice” (AANP, 2014). The AANP, with these requirements in place, acknowledges the need for clinical preceptors to support
advanced education and the clinical hours required, which have become paramount for academic faculty to secure and maintain. This relationship is also coupled with the responsibility of providing adequate support for the clinical preceptors and ensuring the continuity between didactic education and application to the clinical environment. Satisfaction with the preceptor role and the support needed to maintain and potentially increase satisfaction becomes, to some degree, the responsibility of the academic faculty. The integration of classroom and clinical components of NP education has been identified as critically important among nursing leaders in NP education (Campbell & Hawkins, 2007).

**Historical Perspective of the Mentor/Preceptor**

Hayes (2005) presents the historical origin of the word mentor as beginning with Athena, the Goddess of Wisdom. Hayes relates that Athena disguised herself as a man, using the name Mentor while guiding Odysseus’ son (while his father was at war) toward becoming the future king of Ithaca (Hayes, 2005). Mentoring has then been “traditionally viewed as an intense relationship between novice and expert, and promotes a newcomers socialization and role success” (Hayes, 2005, p. 442).

The concept of mentoring in nursing first appeared in the nursing literature in the 1970s. Ardery (1990) advocated “that the time has come to take this concept seriously, define it rigorously, and evaluate its effectiveness in various teaching and learning situations” (p. 58). The concept was applied across business, education, and nursing by Bowen (1985) who stated:

Mentoring occurs when a senior person (the mentor) in terms of age and experience undertakes to provide information, advice, and emotional support for a junior
person (the protégé) in a relationship lasting over an extended period of time and marked by substantial emotional commitment by both parties. If the opportunity presents itself, the mentor also uses both formal and informal forms of influence to further the career of the protégé (p. 31).

Despite widespread use of the concept of mentoring in the nursing literature, there has not been a specific definition of the concept in relation to nursing, especially in relation to advanced practice education. Further exploration of the nursing literature reveals that nursing authors often use the concept of mentor and preceptor interchangeably. Preceptors were identified as “experts in practice” (Campbell & Hawkins, 2007), a “competent, confident (registered) nurse who exhibits enthusiasm in the work environment” (Mundy, 1997, p. 66) and who “can provide learning opportunities and stimulate critical thinking in developing clinical competence” (Kertis, 2007, p. 238). Advanced practice precepting may be seen as a relationship between an experienced NP and a student with the mutual goal of transferring theoretical knowledge to clinical practice. As the literature focused more on the clinical aspects of guiding novices into practice, the concept of preceptor became more interchangeable with expert; whereas the concept of mentor was presented in more of a guidance role. In a study of relationships between NP students and their preceptors, mentoring was defined as “a voluntary, intense, committed, extended, dynamic, interactive, supportive, trusting relationship between two people, one experienced and the other a newcomer, characterized by mutuality” (Hayes, 2005, p. 443). The same authors presented precepting as “a short term experience; however, given continuity in the relationship, mentoring could occur” (Hayes, 2005, p. 443). One of the most differentiated statements
regarding attributes of the role of preceptor is that “it lacks the emotional and time commitment associated with a mentor” (Stewart & Krueger, 1996, p. 316). The preceptor-preceptee relationship is also viewed as contrary to the mentor-protégé relationship due to the perception of mentoring being more of a “teaching-learning process for the socialization of doctoral students as scholars and scientists” (Stewart & Krueger, 1996, p. 316). Although preceptor and mentor have been presented as interchangeable concepts in the predominance of literature pertaining to clinical teaching, there is additional literature that views these two concepts as unique entities with different outcomes and function, but little specifically applied to the education of the nurse practitioner.

The Role of the Clinical Preceptor

The word preceptor has been defined as, “someone who teaches or gives help and advice to a less experienced and often younger person; a trusted counselor or guide, and a teacher or tutor” (Merriam-Webster, 2015). The clinical preceptor in an NP program utilizes a generalized body of academic knowledge and applies it to specific clinical skill sets needed for the student to successfully interpret the role and attain a level of mastery required to complete an advanced practice program. Clinical preceptors need to hold the certification and licensure of an advanced practice nurse, often having the credential of the same specialty of certification within the NP role as the program in which they are involved. Necessary attributes of preceptors for clinical education have been identified in the literature as consisting of the ability to provide individualized education for the student, connect theoretical knowledge and its clinical application and serve as a role model to students as they assimilate into the new role, as described by Burns,
Beauchesne, Ryan-Krause, and Sawin (2006). The aforementioned authors further state that “The preceptor is expected to have current clinical skills and knowledge, help students recognize their assumptions and think through their management decisions, and model effective communication with clients that emphasize psychosocial aspects of care” (Burns et al., 2006, p. 174). The literature also supports the understanding that “effective precepting is a partnership of the skilled practitioner, the NP faculty, and the focused student” (Barker & Pittman, 2010, p. 148).

Qualities and characteristics of good preceptors are presented in the literature from the perspectives of students and the preceptor themselves. Through various presentations in literature, Hayes (1998, 1999, & 2001) identified both preceptor and relationship characteristics that were perceived as necessary to NP students for a successful learning experience. They consisted of the preceptors’ willingness to invest both personal and professional time and resources both in and beyond the workplace, enjoyment in teaching, and the willingness to share not only knowledge, but values and beliefs along with professional interests. Other characteristics identified by students as necessary to effective precepting as described in the literature included the ability to offer feedback in a nonjudgmental manner and the possession of patience, kindness, confidence, and competence in the role within the clinical environment (Burns et al., 2006).

The purpose of mentoring as defined by Hayes (1998) is “to promote the newcomer’s career advancement, educational and personal development, with the desired outcomes of the process being the meeting of goals, role fulfillment, and self-efficacy for the novice” (Hayes, 1998, p. 525). Freeman (2004) conducted an exploratory study of
the expectations NPs had of a mentoring relationship. Five major qualifications were identified, including being an authority in the field, an educator, a counselor, and having personal commitment. Literature discussing the mentor role in NP education listed several other attributes students noted that were valuable to the role. These included being an authority in the field, having years of experience, possessing organizational ability, and having the ability to nurture and collaborate in the clinical environment (Hayes, 2001; Talley, 2008). Slagle (1986) presented the mentoring role as being a gradual shift, with dependence on the mentor at the beginning of the relationship to becoming increasingly autonomous as the role developed. As the role evolved, a balanced process of “give and take” emerged between the mentor and protégé (Stewart & Krueger, 1996). The concept of this described reciprocity was further identified by Young (1985) who perceived reciprocity in the student-mentor relationship as a development of joint values and goals and a redefinition of themselves through the mentoring relationship.

Burns et al. (2006) posit that NP preceptors may teach in a way they themselves preferred to learn, but need to realize that the students they precept may not share the same perspectives. Students in NP programs are considered adult learners, as they have already obtained a level of education enabling them to practice as Registered Nurses. Their specific level of experience in nursing may vary greatly from only a few months to decades since completion of their basic education in nursing prior to enrollment in an NP program. The complexities of learning the NP role has been described by Brykczynski (2012), who wrote, “becoming an NP is not merely learning facts and clinical guidelines, performing tasks or following routines; it involves developing a cluster of patterned and interrelated ways of being that depend upon socially embedded experiential knowledge”
Students may potentially learn these “ways of being” by observing and modeling the behaviors of the preceptor. Benner (1984) recognized these levels in the Dryfus theory of skill acquisition, which identifies five levels of proficiency during the acquisition and development of skills, and based her Novice to Expert nursing model on these levels of proficiency. These five levels of proficiency are: novice, advanced beginner, competent, proficient, and expert. Benner’s model further informs understanding of the task of the clinical preceptor, with this delineation of levels that must be achieved for success in the role. Dyer and Pardue (1999) acknowledge this model as it supports “principles of adult learning, active participation by the learner, and role modeling by the mentor as important educational components” (p. 12).

The rationale behind engaging in the practice of clinical preceptorship may be viewed from the perspective of the preceptor as a mentor. Hayes (2001) presents the role of mentor as:

A voluntary, committed, dynamic, extended, intense, and supportive relationship characterized by trust, friendship and mutuality between an experienced, respected person (NP preceptor) and a student (NP preceptee) for the purpose of socializing the student and promoting student self-efficacy in taking on the advanced practice role (p. 111).

Although some of this definition might be subjective in interpretation, such as how long ‘extended’ is in relation to a clinical rotation and also if ‘friendship’ should be an attribute of the relationship, preceptors recognize that their clinical presentation is imperative to the professional development of the student (Felstead, 2013). Factors that also come into consideration when engaging in the role consist of the potential for it to
develop into a formal academic position with a university, gaining needed credit for recertification, and expectations of the current position, especially if the practice environment is a part of a university health system or teaching hospital. (Campbell & Hawkins, 2007). Preceptors gain a reaffirmation of their knowledge and clinical autonomy, as having a student gives them opportunity to reflect on the clinical skill and responsibility that is a part of their professional expertise. (Kitchin, 1993; Usher, Nolan, Reser, Owens & Tollefsen, 1999). Historically, NPs engaging in precepting have rarely received monetary gain, although this practice is the subject of ongoing consideration. Precepting has been viewed by NPs as a way to acknowledge or “give back” to the nursing profession, in recognition for those who mentored them during their educational programs (Barker & Pittman, 2010, p. 145).

In summary, the definition of the NP preceptor role, and its subsequent enactment evolve from the viewpoints of the student, academic faculty, and the preceptor (Campbell & Hawkins, 2007). The relationship between the preceptor and academic faculty is the one relationship that is significantly limited in the literature. It is expected that when this lived experience of the preceptor is explored, this relationship will surface in a more definitive way. The recognition of the importance of this role and its needed support has to be paramount, so that the clinical preceptor is able to fulfill the professional requirements of the role, gain personal satisfaction with the task, and afford the student and the academic faculty the product that is necessary for success in the NP role.

**Bandura’s Social Learning Theory**

Reviewing the theoretical literature undergirding the clinical preceptor role in NP education, Bandura’s *Social Learning Theory* emerged as a primary explanation of the
skills preceptors use to educate NP students in the clinical setting as well as those NP students use in the learning process. The Social Learning Theory informs the current study as it explains human behaviors within the context of the process of continuous reciprocal interaction between cognitive, behavioral, and environmental influences (Bandura, 1977). Bandura (1977) stated:

Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them of what to do. Fortunately, most human behavior is learned observationally through modelling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action (p. 22).

This passage emphasizes the concepts of *observational learning*, a term created to define the learning method that utilizes modeling as a way to learn a specific task or behavior, and *self-reflection*, which influences how one perceives their ability to learn or perform a task. These two concepts can be applied to the way both students and preceptors perceive their roles in relation to each other and how, through observation and self-reflection, they can collaborate with each other in the process of learning. Although this model provides a foundation for identified behaviors of learning, it again does not explore the actual impact of the responsibility of imparting these behaviors in a clinical setting among teachers, mentors, or preceptors. Therefore, an intensive study of the experience of the NP engaged in the process of precepting may identify nuances of behaviors impacting the role when describing their lived experience, a phenomenon that is currently not identified in the literature.
The exploration of the experiences of those NPs engaged in the clinical preceptor role is the major aim of this research. Preceptors are presumed to act as role models who help students learn the realities of clinical work. They may also be presumed to foster independence and skill development, and promote socialization, positive role self-concept, confidence, and competence in students developing into the advanced practice role. In addition, NPs may also recognize the importance of precepting students on their own role development. Finally, they may believe that without qualified clinical preceptors, NP students will not gain the skills necessary for them to flourish in their roles. Although these propositions are supported to some degree in the scientific research, a more in-depth understanding of the actual experience of precepting is in order for improvements to be made in the process, so that the advanced practice role may grow, both in numbers of practitioners and in their overall societal influence in promoting quality patient care.

Experiences of Nurse Practitioners as Preceptors

Regardless of motivational factors involved in NP preceptors’ enactment of the role of educator, the literature describes certain challenges that are unique to teaching in a clinical environment. Burns et al. (2006) relate, “Teaching in the clinical setting often occurs at a rapid pace with multiple demands on the preceptor, is variable in teaching and learning opportunities as cases vary unpredictably in number, type and complexity, and has a relative lack of continuity” (p. 172). The clinical setting may impose restrictions on patient population and access, along with the time constraints framed by the appointment schedule and, in some practice environments, limited exam room space designated for the student to practice. A common barrier identified to productive precepting is the lack of
communication between the academic faculty and the preceptor (Barker & Pittman, 2010). Preceptors have also cited lack of support by faculty when students demonstrate difficulties in the clinical area. One source cited professors not being clinically current as an explanation for why students’ difficulties were not well understood by non-clinical academic faculty (Hart & Macnee, 2007; Barker & Pittman, 2010). Detrimental effects on productivity have been cited as well, while in some literature this is refuted, with the realization that experienced students may sometimes increase a preceptor’s productivity (Lyon & Peach, 2001). The clinical preceptor has the two-fold responsibility of presenting professional and clinical behaviors to be first modeled and then developed by the student while concurrently caring for their clients in the clinical setting. Balancing these responsibilities has not been well-studied within the professional literature. The process of modeling has received theoretical attention through the work of Bandura (1977) and others, who describe this process as occurring in many forms. The most common type, behavioral modeling, is when the student demonstrates an understanding of a concept or task by performing it. Another form that is applicable to learning in the clinical environment is verbal modelling, when instruction is given verbally and then executed by the student. These types support the rationale behind Social Learning Theory which suggests that most behaviors are learned through observation and modeling and then formed as the student models and then develops their own behaviors from the experience (Bandura, 1977). Miller (2002) presents the identification of the clinical environment as the first place a student’s inability surfaces. Her statement, “Not every nurse will be a successful nurse practitioner, and it is up to the preceptor to identify problems” (p. 2) poses one of the greatest challenges of the role. The degree of
professional and personal satisfaction they receive while serving as a model for student behavior may also be challenged with instances when the process identifies student deficiencies. However, the experiences themselves may also influence the sense of responsibility they feel toward the profession, as they recognize that another NP had taken the time to teach and welcome them into the profession. In the literature, Barker and Pittman (2010) support this by stating, “Students and recent graduates have also indicated that the decision to be a preceptor in their careers is also based on the experience that they had while being precepted” (p. 145). Preceptors have also gained satisfaction in their task, by first remembering how meaningful their student experience was with a great preceptor and now want to return the favor through the next generation of students (Barker & Pittman, 2010). Bandura (1977) considers this modeling a powerful means of transmitting values, attitudes, and patterns of thought and consequential behavior, and it is the primary learning mechanism preceptors use to educate their students.

Through the review of the literature, the summary of challenges and expressions of satisfaction that impacts the preceptor role are presented. The preceptors themselves, through motivation and a sense of responsibility, focus on overcoming clinical barriers to this task, with the understanding that mentoring is critical in assuring a successful transition to the NP role (Hayes, 2001). The literature supports the need for this current study to explore the lived experience of NPs who precept NP students because it is a phenomenon that has received little attention. Primarily this phenomenon is presented indirectly through the identification of the role in relation to the education of the NP, the perception of the tasks that are the responsibility of the role, and the outcome of the
educational experience as perceived by students as recipients of the expertise of the role. The actual experience of the NP when engaged in this role is a major gap in the nursing literature. The proposed methodology reflects understanding of the teachings of Husserl, the German philosopher, considered the father of phenomenology. His philosophy reflects the belief that doing phenomenological research is seeking wisdom from the practice of living and through this, the understanding of the nature of the lived experience is captured (Koch, 1995). Application of this method of research to this study of the lived experience of the clinical preceptor will enable an active exploration of all aspects of this role through interviews with the experts, the clinical preceptors themselves.

**Instruments Used to Measure the Preceptor Experience**

There is minimal literature that outlines a variety of supportive measures for preceptors through exploring the lived experience of the clinical preceptor. Campbell and Hawkins (2007) have outlined professional rewards such as textbooks, academic faculty offers to speak at the preceptor’s place of practice, faculty offers to edit manuscripts or participate in practice research, certificates of recognition, and letters of reference. Although they list, in detail, various methods of support for NP preceptors, there are very few citations that discuss this concept in great detail through either qualitative or quantitative methodologies. Several studies using objective measures of preceptors’ perceptions and experiences with the role have been published. These are presented in relation to their applicability to the NP preceptor experience.

The Misener NP Job Satisfaction Scale (MNPJSS), a tool developed by Misener and Cox in 2001, is the only published instrument specifically designed to measure NP job satisfaction (DeMilt, Fitzpatrick & McNulty, 2011). The tool is comprised of a 44
question Likert scale with six sub scales: intrapractice partnership, professional interaction, challenge/autonomy, professional growth, time, and benefits. This scale measures the concept of satisfaction in the advanced practice profession. MNPJSS provides perceptions of satisfaction in the advanced practice role, not the NP preceptor role. These three scales, the Preceptors’ Perception of Benefits and Rewards Scale (PPBR), the Preceptors’ Perception of Support Scale (PPS) and the Commitment to the Preceptor Role Scale (CPR), along with the MNPJSS, provided a basis for measurement of the concept of preceptor satisfaction, with identification of the job components of the NP and the separate identification of perceptions of support, benefits, and commitment to the nurse preceptor role.

Dibert and Goldenberg (1995) conducted a descriptive correlational study using this combined tool to examine the relationship among preceptors’ perceptions of the benefits of the preceptor role (p. 1144). Although at first this study appeared relevant to the preceptor role in NP education, further exploration found limitations that decreased the efficacy in exploring this population. It was found that the questions from the scales were developed using guidelines from the preceptor program already in place in the teaching hospital that was the participant’s place of employment (Dibert & Goldenberg, 1995). The sample used consisted of nurse preceptors involved in teaching hospital staff nurses and nursing students (Dibert & Goldenberg, 1995).

A replication study of the aforementioned study (Usher et. al, 1999) used a convenience sample of 134 Australian nurse preceptors with results indicating a clear commitment to the preceptor role and a perception that both material and non-material rewards are derived from acting in this role (Usher et al. 1999). Although this study
supported the already reported satisfactions in the preceptor role, it did not give credence to the preceptor in NP education.

A third study (DeMilt et al., 2011) was a cross-sectional descriptive study examining job satisfaction of NPs. The sample used was 254 NPs attending a national Nurse Practitioner conference. The implications were to gain insight into how NPs could make their work environments more fulfilling and aid in role adaption which is necessary in the NP practice. The MNPJSS was used to measure job satisfaction and the Anticipated Turnover Scale (ATS) was used as a supplemental tool, making a combined total of 56 Likert-type questions (44 for the MNPJSS and 12 in the ATS) (DeMilt et al., 2011). The general results of the study were that NPs range from being minimally satisfied to satisfied with their positions including the benefits, challenge, and autonomy (DeMilt et al., 2011). The limitations present were that the sample did not represent a national NP population, but literature supports the fact that NPs attending these conferences are usually highly motivated within the profession. Also gender perspectives were difficult as there was a very small number of men ($n=6$). This survey suggested that there are multiple job and personal life factors that impact satisfaction, but a larger sample size in a more diverse population of NPs might be considered for a more accurate representation of satisfaction in the role. Again this study, although it did focus on the nurse practitioner population, did not specifically explore the role of preceptor in NP education.

The Preceptor’s Perception of Benefits and Rewards Scale (PPBR) is a tool developed by Mowday, Steers, and Porter (1979) to measure preceptors’ perceptions of opportunities associated with the preceptor role (Dibert & Goldenberg, 1995). The
instrument consists of a 14 item Likert scale and was developed from benefits and rewards suggested in the literature.

The Preceptor’s Perception of Support Scale (PPS) is a tool used to compliment the PPBR, and developed by the same researchers. The PPS consists of a 17 item Likert scale measuring preceptors’ perceptions of support for the preceptor role. It is based on factors contributing to support identified in the literature by Dilbert & Goldenberg (1995) and Usher et al. (1998) and was also used in the two studies presented by these two teams of researchers.

Commitment to the Preceptor Role Scale (CPR) is an 10 item scale adapted from the Organizational Commitment Questionnaire (OCQ) also developed by Mowday et al., initially measured commitment to the organization. It was adapted by replacing the concept of organization with preceptor (Dibert & Goldenberg, 1995, p. 1147). The OCQ was 15 items in its original form, but five items were deleted as they could not be rewritten to represent the concept of preceptor.

Although the value of including the important concepts of NPs’ perceptions of benefits and rewards, support, and their commitment to their role, the three tools used to measure these concepts were developed and utilized with only staff nurse preceptors as subjects, and are therefore not specific to the NP preceptor role. Due to the greater level of independence of NPs in relation to staff nurse preceptors, many of whom precept new staff who will eventually work alongside them, the commonalities and differences among the two types of preceptors are not well understood. Therefore, the experience of the NP preceptor requires further investigation so that important perceptions of the role,
including benefits, rewards, support, and commitment to the role may be explicated through direct conversations with the NP preceptors themselves.

The exploration of these tools and the studies that utilized them support the premise that more comprehensive representation of the experience of the NP preceptor needs to be explored. This gap in the literature provides support for further exploration regarding the lived experience of these preceptors through phenomenological methodology, as it is one of the ways increased understanding can provide mechanisms to understand the experience and address relevant issues as necessary. With the expansion of the advanced practice role in nursing and the growing need for clinical support to accomplish the task, exploring the lived experience of the preceptor is essential for academic nurse educators to be better equipped to work most effectively among this critically important group of clinical educators to maximize their ability to provide critical experiences to NP students.

**Summary**

The exploration of the lived experience of the clinical preceptor utilized in NP programs has not been subject to a great deal of research or representation in the literature. The literature primarily presents how levels of satisfaction with the role of the preceptor impacts the student experience in clinical areas, but these studies are limited in number and scope. Additional research is needed to expand the literature regarding the dynamics of precepting at the advanced level and understanding the specific factors that are perceived to affect the enactment of this role.

Bandura’s Theory of Social Learning (1977), provides the underpinning for increased understanding of the process of learning in a clinical environment and can be
applied to the NP preceptor. The theory particularly informs our understanding of modeling by exploring the NP’s responsibility as role model, not only as it is seen by the student and outside academicians, but by qualifying how NPs see themselves in this role. Both qualitative and quantitative modes of research have been presented as mechanisms to define the concepts of the preceptor role and its attributes, although the literature on this topic is extremely limited. The most common method to understand the NP preceptor role presented in the literature has been through quantitative research which explored students’ perceptions of clinical education involving a preceptor and the role in relation to the expected outcome of clinical skill mastery using Likert based surveys. These studies are limited because of the small number of specific concepts or attributes of the role that are defined by the finite method of data collection methods using standardized questionnaires. Qualitative research, which utilizes individual interviews of clinical preceptors, provides an increased awareness of the participants’ “voice,” and has the potential to present unexplored concepts and attributes.

Qualitative research is conducted with the goals of empowering individuals to share their stories, and of minimizing the power relationships that sometimes exist between a researcher and a participant (Creswell, 2013). It can “uncover taken for granted and unrecognized aspects of care that are embedded in teaching and clinical practice so they can be recognized and valued” (Bryczynski, 2012, p. 562). The phenomenological approach is one that prompts the researcher to be a “clean slate,” without any foregone conclusions or biases toward the role. The study, as it is an exploration of a lived experience, is identified as a simple descriptive qualitative study using phenomenological methodology. The sample population studied provided great
depth to the study because of the profession they are in and their willingness to engage in the clinical preceptor role. Also, the researcher (herself) has held the role being studied, along with being a currently practicing NP. This provided a greater ability to identify similarities in the presenting data within the interviews. It also was recognized as cautionary, as there could have been bias presented by the researcher, as participation in the role being explored and the roles impacted by the clinical preceptor have been part of her professional development.

In summary, the literature provided limited indication that NP preceptors do perceive a level of satisfaction in the role, as well as an understood responsibility toward the profession. There are acknowledged challenges to performing the role to its maximum potential, including limited support and clinical knowledge of academic faculty. However, due to the very limited nature and depth of the studies from which these findings were drawn, a more thorough exploration of the lived experience of the NP preceptor was seen as necessary.
CHAPTER 3

Introduction

The purpose of this research study was to explore the lived experience of the nurse practitioner in the role of clinical preceptor in a nurse practitioner program. With the exploration of the role, the secondary purpose was to identify the challenges of the role and perceived methods of support that academic nursing faculty can provide to promote and maintain satisfaction in the clinical preceptor role.

Preceptors are essential to the provision of nursing education by providing students with reality-based and skills-oriented experience (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Within a nurse practitioner program various challenges permeate the role, and the understanding of these challenges by academic faculty and others involved in the education of the nurse practitioner student can provide the professional support needed to promote a beneficial experience for the clinical preceptor and, as a result, the student or preceptee.

Organization of the Chapter

This chapter will present an overview of the research design, including historical components, the target population, sample size, and the sampling method. The methods of recruitment and data collection will follow along with a summary of the procedure used for the data analysis. Ethical considerations and safeguards implemented for the protection of the research subjects are presented, with limitations of this research design as the conclusion of the chapter.
Research Design

This study used a qualitative design with phenomenological methodology. The purpose of the phenomenological method is to “discover and describe the meaning or essence of participants’ lived experiences, or knowledge as it appears to consciousness” (Hayes & Singh, 2012, p. 50). This method presents exploration into the integrated whole (lived) experience, which aligns well with the holistic belief that comprehensive nursing care encompasses the body, mind, and spirit. The central belief, or core of phenomenology is the intentionality of consciousness, which is explained as “all actions, gestures, habits and human actions have a meaning” (Sadala & Adorno, 2002, p. 283). Parallels between nursing and phenomenology are presented by Taylor (1993), who states “the phenomena that interest nurses are intimately connected to the subjective experiences of patients and nurses as people” (p. 175). Appropriate topics using this method encompass experiences in the nursing profession related to patient care, including the patients’ lived experiences, the educational experiences of the profession, and the lived experiences related to administrative aspects of nursing and the environments where it is practiced. The study of the lived experience of nurse practitioner preceptors encompasses all these realms, as both the student and preceptor provide patient care framed in educational development within the administrative aspects of a practice.

Historically, the development of phenomenology as a method of thought is attributed to Edmund Husserl, a German philosopher who regarded experience as the fundamental source of knowledge. He saw this method as the unbiased observations of experiences as they appear, not as they have been told or interpreted by an observer. Husserl believed the lifeworld (“Lebenswelt”), or lived experience “involves the
immediate, pre-reflective consciousness of life and is understood as what individuals experience pre-reflectively, without resorting to interpretations” (Dowling, 2007, p. 132). The lifeworld has also been described by Husserl as “the world that was already there” and the “world of immediate experience”, two phrases that support the concept of researching the lived experience as a way to utilize unbiased observation as a data source. Lifeworld theory postulates that to understand a social experience the researcher must analyze knowledge that the participants express regarding that experience (Husserl, 1970). In order to accurately describe the lived experience, the researcher must acknowledge any personal or professional biases and receive the imparted lived experiences without any preconceptions. Husserl termed this process “bracketing” which is defined as “the process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomena under study” (Polit & Beck, 2012, p. 721). Giorgi (2000) presents this concept as holding a “phenomenological stance” which enables the researcher to maintain an openness and acceptance, and prevents any judgment regarding the phenomena. Both these concepts were important to identify before conducting this study, with the expectation of utilization, as the researcher has experienced three major components within the study, those being the roles of the nurse practitioner student, the clinical preceptor, and an academic nursing faculty member.

According to Dowling (2007), “Nursing theory developed through the phenomenological approach reflects the reality of nursing practice which is complex and situational” (p. 135). This aligns well with many areas of nursing research, as this humanistic inquiry does not necessarily “problem solve,” but seeks to provide solutions through effective means of formulating procedures and techniques that provide positive
outcomes. Knowledge generated from practice becomes more relevant for nurses. When this concept is related to the lived experience of the clinical preceptor the expected outcome, solutions to potential challenges that might be relayed through the telling of the lived experiences, the science of this research becomes apparent.

Naturalistic inquiry compliments phenomenology as the legitimacy and trustworthiness of a naturalistic inquiry serves to reassure readers of the research study that the findings are valuable to the phenomenon being explored. Lincoln and Guba (1985) presented four criteria for developing trustworthiness of naturalistic inquiry: credibility, dependability, confirmability, and transferability. In 1994, a fifth criterion was added, authenticity, which is primarily within the constructivist paradigm and was formulated as a response to criticisms involving their conceptualizations (Polit & Beck, 2012).

Both professions, nursing and education, which utilize preceptorships, are considered humanistic professions that nurture and provide care for those entrusted to them. In order to educate future nurse practitioners who will be providing competent care in a holistic manner, the meaning of the lived experience of clinical preceptors must be understood. Using a phenomenological approach with this study broadens this perspective by the exploration of the lived experience of these clinical professionals from their own unique perspective

**Target Population**

The target population was nurse practitioners who:

- Possessed the advanced academic degree required for licensure as a nurse practitioner and were credentialed in an area of advanced practice recognized by a
professional nursing organization. These nurse practitioners possessed a current license as an advanced practice registered nurse, or other title indicative of advanced practice in the state in which they are licensed.

- Are presently employed in a recognized healthcare practice as a nurse practitioner and are presently or previously engaged in the role of clinical preceptor for at least two academic semesters for nurse practitioner students enrolled in a nationally accredited nurse practitioner program.

**Sampling Method/ Recruitment**

The sampling method was a purposive sample using the snowball (or network) technique. Purposive (purposeful) sampling, defined as “a nonprobability sampling method in which the researcher selects participants based on personal judgment about which ones will be most informative” (Polit & Beck, 2012, p. 739), impacted the final selection of the nurse practitioners used for the interview. The snowball method of recruitment relies on referrals from research participants to other potential participants with the same characteristics. It takes advantage of social and professional networking, and is utilized when the target population being sought “consists of people with specific characteristics who might be difficult to identify by ordinary means” (Polit & Beck, 2012, p. 262). Through the researcher’s own professional network of practicing NP preceptors and then recruitment from these preceptors’ networks, either through membership in professional organizations or involvement in group or institutional practices, this method produced an adequate sample in both quantity and quality for the study.
The initial sample of practitioners was contacted via a recruitment letter (see Appendix D), and then encouraged to network on behalf of the researcher to identify other interested colleagues. Recruitment of the participants began immediately after IRB approval, with an initial sampling of 12 nurse practitioners receiving the recruitment letter.

**Sample Size**

The sample size was 16 participants. The number of participants was determined when data saturation was reached. Data saturation occurred when no new themes were identified in the interviews.

**Setting**

This data collection was conducted in the field, and defined as “research with the aim of understanding the practices, behaviors, and beliefs of individuals as they normally function in real life” (Polit & Beck, 2012, p.728). The location of all 16 interviews was mutually agreed upon by each participant and the researcher, with the parameters of the ability to freely speak undisturbed and without fear of professional retribution. With the knowledge that the interview might require a lengthy period of time, the comfort and privacy of the participant was a major factor in the decision of the chosen setting.

**Data Collection**

The method of data collection consisted of individual interviews with nurse practitioner clinical preceptors and used open ended questions designed to explore the lived experience of their role. The data collection consisted of face-to-face interviews and continued until no new themes emerged from the data. This saturation was identified after the completion and review of 16 individual interviews.
The protocols included in the study were:

- The interviews were conducted by the researcher and consisted of three research questions (identified on page 12), and relevant follow up questions as prompted by each individual interview.
- The interviews were conducted with only the researcher and the clinical preceptor present, in an environment of the preceptor’s choice that ensured comfort and confidentiality.
- The interviews were audiotaped to ensure accuracy and to give the researcher the ability to review the interviews numerous times during the analysis. The researcher was prepared to take field notes during the interview to ensure clarity for transcription.
- The interviews were transcribed verbatim, with the preceptor being interviewed understanding that there was potential to be recontacted for any clarification needed and for member checking of the interview content once the transcription was obtained.
- The preceptor being interviewed was made aware of the option of stopping the interview at any time, without any given rationale or fear of retribution. Audiotaping of the aborted interview would be erased and the Demographic Profile Sheet would be destroyed.

Data collection did not take place before IRB acceptance of the research proposal, which occurred on February 27, 2015 (see Appendix B). A copy of the IRB application
(Appendix A) and attainment of the required National Institute of Health (NIH) certificate (Appendix C) is included with this proposal. The collection of data commenced after IRB approval was granted. This data collection included:

1. Nurse Practitioner Preceptor Demographic Profile: (Appendix E)
   - Gender and age
   - Highest academic degree attained
   - Specialty accreditation and accrediting organization
   - Number of years as a nurse practitioner
   - Type of practice (private, clinic, community setting, etc.)
   - Number of years in the current practice
   - Number of years as a preceptor
   - Type of nurse practitioner programs experienced as a preceptor (MSN, DNP, etc.)

2. The Qualitative Interviews: were conducted face-to-face by the researcher. The interviews were conducted in a place and at a time mutually agreed upon by the researcher and participant, assuring confidentiality and adequate interaction time, and used the same open ended research questions.

3. Interview Protocol: The interviews began with a brief description of the study and a review of the procedure and consent. After the consent forms were signed, the audiotaped interviews began with the first research question, and followed with the other two during the interviews. The interviews ended when the preceptor being interviewed indicated all information had been given that satisfied the questions posed and any other lived experiences were relayed.
Inclusion Criteria

- Professional licensure and accreditation as a nurse practitioner in a recognized concentration (i.e.: family, pediatric, adult, etc.).

- Experienced in the role of preceptor to a nurse practitioner student enrolled in an accredited nurse practitioner program.

- Employed in a traditional health care practice at the time they were engaged in clinical preceptorship.

- Had the ability to read, speak, and understand the English language, and were willing to engage in the telling of experiences while in the role of clinical preceptor.

Standards of Protection

The research study proposal had been approved by the Internal Review Board (IRB) of Western Connecticut State University. The protocol number assigned to this research study is 1415-111. The participants in the research study have not been identified in the reporting of data in any way. All collected data, both recorded and transcribed, had been coded and kept in secure storage by the researcher in her professional home office to ensure confidentiality. The informed consent (Appendix F) which outlines the purpose of the study and the method of data collection was signed by both the participant and the researcher and maintained with the transcriptions of the interviews. Any participant was allowed to freely withdraw from the study or stop the interview at any time without any given reason or fear of retribution. None of the 16 participants chose this option, and all interviews were utilized in the study.
Data Analysis

The interviews conducted consisted of open ended research questions developed by the researcher and reviewed by faculty involved in advanced practice education. The interviews were audiotaped, with the method described in the consent form that outlined the protective measures utilized to protect confidentiality and anonymity of the data. The audio tapes were transcribed verbatim by an independent professional transcription company, and the corresponding transcriptions were returned to the researcher. Colaizzi’s (1978), method of analysis for qualitative phenomenological data was used. The steps in this method (Polit & Beck, 2012) consist of:

1. Read all protocols to acquire a feeling for them.
2. Review all protocols to extract significant statements.
3. Spell out the meaning of each significant statement.
4. Organize the formulated meanings into clusters and themes
5. Refer these clusters back to the original protocols for validation.
6. Note the discrepancies between the various clusters.
7. Integrate results into a description of the phenomenon under study.
9. Review findings with participants for final validation (p. 566).

This type analysis was chosen for this study as it is recognized as useful when immersion in the data is done to develop new insights, and interviews using open ended questions are the primary method of data collection.
Trustworthiness Criteria

To establish and maintain trustworthiness through the research study, the criteria of Lincoln and Guba (1985), consisting of credibility, dependability, confirmability, transferability, and authenticity, was used. For this study, credibility, which refers to “confidence in the truth of the data and interpretations of them” (Polit & Beck, 2012, p. 584), was assured by using only nurse practitioners who have experienced the role of the preceptor and by providing them with written documentation of the methods being used to affirm the interview and the transcription of its contents as verbatim, with only the researcher conducting the interviews.

Dependability, defined as “the stability (reliability) of data over time and conditions” (Polit & Beck, 2012, p. 585), was established by utilization of a specific set of criteria for the participants (nurse practitioners), an interview protocol, and recognition of the role of the preceptor as the phenomenon that is being explored. Authenticity, “the extent to which researchers fairly and faithfully show a range of realities” (Polit & Beck, 2012, p.585), was assured by verbatim transcription and data saturation, reached with 16 interviews. Transferability, where “the extent of findings that can be transferred to or have applicability in other settings or groups” (Polit & Beck, 2012, p. 585), was assured by the provision of sufficient descriptive data by an adequate sample size and rich data collection through the interviews. Confirmability, defined as “objectivity, the potential for congruence between two or more independent people about the data’s accuracy, relevance or meaning” (Polit & Beck, 2012, p. 585), was assured by the monitoring of the data and the analysis by two expert faculty members. This insured mutual agreement with
the presented themes and provided sufficient data, in the form of collection until saturation was attained.

The methods used to support the criteria consisted of:

1. *Simultaneous Data Collection and Analysis:* the analysis was ongoing as the data was collected. This strategy ensured that questions that gave validity to the data collection were added as the interviews progressed and clarification of key points within the collected interviews occurred as soon as detected.

2. *Expert Debriefing:* one or two faculty of the same or higher educational and professional level as the participant and researcher reviewed the findings as they were analyzed and acted as catalysts for any further review that was undetected as the data collection progressed.

3. *Ethical Considerations:* the information from the interviews was not shared with any professional colleagues except those who guided the researcher through the research process. Content from other interviews was not referenced in subsequent interviews and there was no reference made to other participants during the interviews. The participants in this study were voluntary, of legal age to give consent, and were not given any monetary compensation for their participation. A current textbook pertinent to their professional role was given as a token of appreciation for participation. The participants were offered a chance to read and review the dissertation upon its completion. Confidentiality and anonymity were maintained in the reporting of the results of this study. All data was destroyed upon the completion of the study.
Limitations

The perceived limitations on the study were:

- The availability of NP preceptors in the states of Connecticut or New York as participants; the maximum extent of qualitative collection for this study occurred in these states due to time constraints for completion of the study.

- The inability to reach saturation with 10-20 interviews, which would have entailed increasing the number of interviews.

Summary

This chapter presented the methodology of the research study by identifying the target population, sampling method, data collection, and analysis, along with the inclusion criteria and standards of protection. Clarification of the perceived limitations and awareness of the needed ethical criteria to conduct the study is also documented, completing the purpose of this chapter, which is the provision of the defined procedure implemented and its supporting rationale.
CHAPTER 4

Introduction

This chapter presents the findings from this research study including a demographic description of the sample. Seven themes emanated from the data obtained from sixteen interviews with nurse practitioners who function in the role of clinical preceptor for graduate nurse practitioner programs. Each theme was present in the majority of the interviews which illustrated its significance. Certain themes were further defined with subthemes that were supported with examples of significant statements.

Description of Sample

The sample consisted of 16 nurse practitioners who are presently or previously engaged in the role of clinical preceptor for accredited graduate programs in nurse practitioner education. All 16 preceptors are female and ranged in age from 36 to 72 years, with the mean age being 53.3 years.

Educationally, the highest degree attained by the preceptors was a Doctorate in Nursing Practice (DNP), held by two of the participants, with another preceptor holding an advanced certification, and the remaining thirteen having a Master of Science in Nursing (MSN) as their terminal degree, although three of these preceptors are currently enrolled in a doctoral program in nursing education (EdD). The specialty credentialing held by the preceptors consisted of six preceptors being Family Nurse Practitioners (FNP), four being Adult Nurse Practitioners (ANP), three being Pediatric Nurse Practitioners (PNP), two being Geriatric Nurse Practitioners (GNP), and one credentialed in Acute Care (ACNP). One of the preceptors credentialed as an FNP also held an
Advanced Certification in Hospice and Palliative Care Nursing (ACHPN). The years of practice within their respective specialties as NPs ranged from 3 to 33 years, with the mean being 20.1 years in practice. The years engaged in the role of clinical preceptor in nurse practitioner programs ranged from 1 year to 26 years, with the mean being 9.8 years, and the academic programs precepted consisting of DNP, post master certification and MSN programs, along with a program designed to enable non nursing degreed students to obtain an MSN degree with a nurse practitioner concentration.

All preceptors interviewed were given the opportunity to be interviewed in a place of their choosing, where they could speak without interruption and in a confidential manner. The majority of the participants (12) chose offsite locations, away from their professional practices; and although encouraged to do so, four participants freely chose to conduct the interviews either in a private setting within their facilities (2), or early in the morning in their professional offices (2) prior to seeing patients. All preceptors signed a consent form, and agreed to participate in the study via an audiotaped interview which, after being transcribed verbatim and then read by the researcher, was sent to them for confirmation of accuracy. All were made aware through the consent form that they could withdraw from the study at any point, either during or after the interview, without any negative ramifications. The interview would then be erased and the data not included in the study. All participants expressed understanding of this process, and confirmed that they understood and could communicate in the English language and had the capacity to recall their experiences as a clinical preceptor.
Participants in the Study

The following is a brief professional synopsis of each clinical preceptor participant in the study with all names changed to assure confidentiality.

1. *Amelia* is a 49 year old Adult Nurse Practitioner who attained her Doctorate in Nursing Practice (DNP) one year ago. She has been a Nurse Practitioner for 12 years, with the first 11 years of practice with an MSN as her terminal degree, and has been a member of her current practice for 11 years, which affords her the opportunity to practice and precept in private, clinic, assisted living and extended care settings. She has been a clinical preceptor for 6 years and has precepted in MSN programs with Adult and Family concentrations.

2. *Bess* is a 49 year old Pediatric Nurse Practitioner who has held an MSN degree for the 23 years she has practiced as an NP. She is currently enrolled in a doctoral program (EdD) with a concentration in Nursing Education. She has been in her current practice, a residential program for adolescents, for 8 years. She has been a clinical preceptor for 15 years and has precepted in traditional MSN programs with Pediatric and Family specialty concentrations and in a non-nursing degree bridge program with a Family concentration.

3. *Charlotte* is a 44 year old Pediatric Nurse Practitioner who has held an MSN degree for the 18 years she has practiced as an NP. She has been a member of her current practice for almost 5 years, which is a private, suburban pediatric practice. She has been a clinical preceptor for 18 years, with her students enrolled in traditional MSN programs with a Pediatric concentration and in a non-nursing degree bridge program with a Family concentration.
4. **Darcey** is a 58 year old Geriatric Nurse Practitioner who holds a Master of Science as her terminal degree. She has practiced gerontology for over 30 years and has been in her current practice for 5 years which enables her to precept in the extended care, outpatient and hospital settings. She has been a clinical preceptor for 4 years and has precepted in traditional MSN programs with the concentration in Adult and Adult-Gerontology, and in a non-nursing degree bridge program.

5. **Ella** is a 66 year old Pediatric Nurse Practitioner who has been in practice for 30 years. She holds an MSN as a terminal degree, which is also the educational level of the programs that she precepts. She has been in a School Based Health practice for 27 years and has acted as a clinical preceptor for 26 years for students in both Pediatric and Family concentrations in traditional MSN and non-nursing degree bridge programs.

6. **Francine** is a 58 year old Adult Nurse Practitioner who has practiced for 3 years. She holds an MSN degree and has precepted for 1 year at this level of education. Her practice is in an extended care facility and she has precepted students in the Adult and Adult-Gerontology concentration.

7. **Gianna** is a 60 year old Geriatric Nurse Practitioner who has been in practice for 33 years. She holds both an MS and an MSN degree and precepts at the MSN level with Adult, Adult-Gerontology and Family concentrations. She has been in her current practice for 30 years and has been in the clinical preceptor role for the last 5 years.

8. **Hope** is a 55 year old Family Nurse Practitioner, who has practiced for 29 years. She holds an MSN and is employed in a hospital based specialty practice
consisting of outpatient and inpatient care of patients diagnosed with HIV. She has been in this practice for 20 years and has precepted students in MSN programs for 5 years.

9. *Ilene* is a 52 year old Acute Care Nurse Practitioner who has practiced for 10 years in a hospital setting. She holds an MSN and is presently enrolled in a Doctoral program (EdD) with a concentration in Nursing Education. She has been a clinical preceptor for 8 years and precepts students from traditional MSN programs and the non-nursing degree bridge program with Family and Adult Acute Care and concentrations.

10. *Jacquelyn* is a 40 year old Family Nurse Practitioner who holds a DNP and an advanced certification in Hospice and Palliative Nursing. She has been a nurse practitioner for 13 years and a clinical preceptor for 8 years in the hospital setting where she has precepted MSN students with the Adult concentration and post master certificate students in Palliative Care.

11. *Kate* is a 50 year old Family Nurse Practitioner who holds a MSN. She has been a nurse practitioner for 18 years in a private practice specializing in urology. She has precepted for 10 years in MSN programs with Adult or Family concentrations.

12. *Laurie* is a 52 year old Adult Nurse Practitioner who has been in practice for 17 years. She holds an MSN degree and has precepted at this level of education with the Adult concentration for 15 years. Her practice is primary care and hospital based and her specialty is pulmonary medicine.
13. *Maura* is a 59 year old Clinical Nurse Specialist with an MSN degree and holds a post master certificate as a Family Nurse Practitioner. She has been an NP for 26 years and has precepted nurse practitioner students in MSN programs for 20 years. She has been in her current practice, which is a general surgical outpatient clinic for 9 years.

14. *Naomi* is 36 years old, holds an MSN degree and is credentialed as an Adult Nurse Practitioner. She is presently in a doctoral program (EdD) with the concentration in Nursing Education. She has been a nurse practitioner for 11 years and has precepted for 6 years in MSN programs. Her specialty is Community Health and has been in her current practice for 8 years.

15. *Olga* is 72 years old, holds an MSN degree and is credentialed as a Family Nurse Practitioner. She has practiced for 23 years in the area of geriatric psychiatry and is in her current extended care practice for 15 years. She has acted as a clinical preceptor for 4 years in traditional MSN and the non-nursing degree bridge program.

16. *Paige* is a 54 year old Family Nurse Practitioner who holds an MSN, and is presently enrolled in a doctoral program (EdD) with the concentration of Nursing Education. She has been a nurse practitioner for 17 years and has been in the role of clinical preceptor for 24 years. Initially she was a preceptor as a registered nurse for staff nurses, and then as a nurse practitioner for MSN and DNP programs with the concentration in Family. She has also precepted for the non-nursing (bridge) program. She is presently employed in a hospital owned outpatient practice.
At the time of the study, all clinical preceptors had been presently engaged in precepting N.P. students or had done so within a year of the interview. All met the inclusion criteria of the study and were actively practicing in their nurse practitioner role.

Summary and Detailed Analysis of Findings Related to the Research Questions

The findings of the study are organized into themes with certain themes being further defined with subthemes. A concise description of each theme is presented, followed by examples of significant statements depicting that theme. A summary at the end of the descriptive quotes, identifies the key components extracted from the interviews. The themes presented as follows:

I. The Decision to Become a Clinical Preceptor

II. Communication Between the Clinical Preceptor and Academic Nursing Faculty

III. Extraneous Factors Impacting the Role of Clinical Preceptor
   a. Electronic medical records
   b. Time allotment
   c. Billing and coding

IV. Precepting the Non-traditional N.P. Student

V. Stressors Impacting the Clinical Preceptor Role
   a. Negative student behaviors and attitudes
   b. Failing a student
   c. Loss of productivity and increased workload

VI. Personal and Professional Gain from Clinical Precepting
VII. Acknowledgement for Clinical Precepting

a. From student to preceptor

b. Academic faculty and university acknowledgement

c. Suggested acknowledgement by the clinical preceptors

**Theme I: Decision to Become a Clinical Preceptor**

All 16 clinical preceptors presented the reasoning behind their initial and continuing decision to precept nurse practitioner students. Some spoke about their entrance into the precepting role and the clinical experiences they could offer students. Other preceptors mentioned their feelings of responsibility to the nursing profession and specifically the nurse practitioner role. The following excerpts from the interviews illustrate this theme.

*Amelia* spoke of how a physician in her practice was contacted by a university to precept nurse practitioner students. She stated, “The physician had not precepted nurse practitioner students before so (he) deferred to me, and I agreed, so together we began precepting. We’ve been doing it ever since.” She added that “there is a lack of clinical preceptors for students and her practice offers a wide variety of clinical opportunities because it consists of a private practice, a public clinic and extended care facility services”. Amelia concluded that through her practice she “wants to instill the need for students to take that step to help out in their community…..and with vulnerable populations.”

*Francine* reflected back on her NP student days with the knowledge she has today. She stated, “I guess I didn’t realize when I was a student, it was very, very difficult to get preceptors, and especially in the field I was interested in. They kept saying to me,
‘It’s just that I’m too busy. I don’t have time for you.’” Francine mentioned the things she wants to instill in her students, stating, “It’s teaching them safety, respect and dignity for this (geriatric) population….giving somebody this quality of life, in the life they have left is huge. They are dignified human beings who happen to be at a different phase in their life.” As far as why she began and continues to precept she states” I think it’s kind of like paying it forward. Somebody did this for me and I am happy to do it for somebody else. If I can teach somebody else to respect the elderly in the same way, I am happy.”

*Naomi* recalled “I started precepting probably like 2 years in. I think my strongest motivation to take students in the beginning and has continued, is my need to give back to the profession for what people did for me; you know, I think that’s why I got involved in it. I think its intrinsic satisfaction, to try to think I’m helping the profession that way. I feel like when I was a student I had great clinical experiences. You have some that are less than others, but those ones that were great I take with me to this day, and I think it has just always been my thought that I would always contribute back to the profession that someone did for me. So it was without a doubt, that I would take a student when I was ready.”

*Charlotte* recalled precepting students since her own graduation. She stated “I have precepted NP students in pediatrics for 18 years. Since my graduation date I was asked to precept. I’ve only been with one school of nursing, the program I graduated from, so I don’t have experience with lots of different places.” She added, “I want to precept because I think it is important. I had preceptors and I feel I need to turn it around and give back.”
Laurie commented on her personal reasons for precepting and also reflected that “I really do it because I am a graduate of the program and I want to give back.” She often agrees to take the students who either can’t find a clinical placement or have lost their clinical placement for one reason or another. “I usually get the ‘fly-by-nights’, like the students they have no place to put. They (academic faculty) know I will probably take them. All of a sudden people lose their clinical (site) and they call me.” She added some details about the clinical experience offered at her practice stating, “Basically, I have said to myself these students probably never had a specialty focus on pulmonary medicine. So what I am going to do is focus on the lung assessment, lung sounds and lung meds and I’m going to focus on dealing with chronically ill patients and smoking cessation, and that’s what I have basically done…and because I have to see the patients in a certain period of time, I also think the students get the ‘time management thing’.”

Jacquelyn discussed her journey from novice NP to expert NP and the fact that she didn’t want to precept students until she herself had some experience. She realized “I think I got comfortable in my own practice finally. It takes a few years, you go through the whole novice to expert. I’m like ‘OK, now I can take on some students’”. She went further to elaborate on her hospital based palliative care practice, “Our program and my role here is very unique. I think trying to encourage NP students to have that sense of autonomy, and really trying to help them understand what our scope of practice is…I think that is important.” She added, “Again, hospital wise, I think I am very fortunate here that I get to come in and really prove how autonomous we can be.”

Ella commented on her school based setting, and stated “I think it is such a unique clinical setting, school based is. It teaches them (students) a different way of interacting
with your patient who is a child. You teach the students how they are a guest in the
school, and how they can interact by teaching health and (disease) prevention. (You)
teach holistic care of not only the child but the family.”

*Hope* shared information from her HIV patient practice. She shared her reasons to
precept by commenting “I do an HIV practice and some people have never come across a
person with HIV. If I can give them (students) the idea that these patients are as special as
I feel that they are as individuals, then if you can pass that idea on, they’ll maybe carry
that with them…maybe shed a few myths that have been passed on, or to look at people
in a different way would allow them to be compassionate and respectful of other people,
as they all deserve.” Hope went further to say, “If you don’t train the next generation,
there won’t be any more nurse practitioners. Part of nurturing the patient is teaching other
people to nurture those the way you have, in order to keep your practice great.”

*Kate* discussed the focus of her (urology) practice as a reason she precepts. She
stated, “Our focus is a little bit different than in primary care. They (students) look at
those disease entities that have now become complicated and are beyond a general
practitioner following them and now have to be referred out. They (students) get to see
how we focus that evaluation in more of a specialty area. In addition, we do a lot of
procedures in our practice, so that’s a different look at the NP role.”

*Gianna* mentioned that in addition to her clinical role as a nurse practitioner, she
is an administrator of the extended care facility, which gives her the opportunity to model
other components of the NP role besides clinical ones. She ascertains that students benefit
from modelling NPs in administrative leadership, education and research as well as
clinical care. She reflects on her decision to precept saying “I really looked to become a
preceptor. I was very open to becoming a preceptor because I felt that I was in a position that allowed me the flexibility to do that, to devote the time to it, the energy to it. I felt that I was at a point in my career that I felt it was time to give back to my career. Giving back to my profession is what feeds me. I am very happy to do it, because it’s something that makes me feel good that I am able to contribute”.

Ilene described how she models the hospitalist role with students. She stated, “I deal with a lot of emergency situations where I just take off and I’m like ‘Follow me’. Yet it teaches organizational ability. I probably can’t teach any other way (on the unit) than to show that I stay on my feet and I have one patient in my head…but then I enter a room and I focus again.” Ilene credited prior preceptors that she had with providing the desire and motivation to become a preceptor. She stated, “Prior preceptors that I’ve had in my nursing career are pretty much why I’m a preceptor. I believe that we need to give back what we learned from other NPs”.

Darcey had a very pragmatic perspective when it came to discussing her reasons for precepting. She stated, “It’s something I do because it needs to be done. I’m pretty committed to helping the young people. I find most of the patients feel the same way. When I say, ‘We have to educate the young folks and bring them on board, the patients usually appreciate that. I just feel it’s my duty.” She continued “Because precepting is the only way I feel we can teach our colleagues and who will be our colleagues, and I come from the old school and feel it’s my way to give back”. Her reasons were summarized by “All in all, I had very good people who said ‘yes’. It’s my way of trying to make up for the phrase ‘nurses eat their young’.”
Paige expressed the sentiments of many NPs in the study. She stated, “I can’t imagine not sharing my love for the profession with my students. I love having them learn and I love seeing the transition. I had great preceptors and that’s what made me want to become a preceptor because I realized the value of it early on.”

Maura agreed with the aforementioned comments and added, “I appreciate the role I am in. I want to make sure people behind me learn the role well. I want nurse practitioners to be of good quality and do a good job. I believe in the role and I have to be a part of their educational process.”

In conclusion, the predominant reason given for acting as a clinical preceptor stems from the strong responsibility of giving back to the profession, and specifically the nurse practitioner role. This was expressed in various ways by the majority of the participants, with reflections on their own fortune of having good preceptors and the expectation of continuing this role as the primary support for a clinically strong profession. Other reasons, such as appreciation of the NP role and wanting to share this, the desire to model the specific nature of a specialty practice and again, their own experiences of having very good role models when they were students, all contributed to the positive belief summarized by a preceptor’s statement that “If you don’t train the next generation, there won’t be any more nurse practitioners. Part of nurturing the patient is teaching other people to nurture those the way you have, in order to keep your practice great.”
Theme II: Communication between the Clinical Preceptor and Academic Nursing Faculty

Communication was one of the more immediate themes that emerged from the research question ‘What has influenced your experience, both positively and negatively, as a clinical preceptor for nurse practitioner students?’ The relationship between academic faculty and the clinical preceptor is imperative for the student to receive a cohesive advanced practice education. The two components, didactic learning and clinical experience merge, and provide the comprehension needed for successful mastery of the role. The clinical preceptors reflected on the regularity, methods and other factors that comprised the communication experienced with academic faculty and expressed their needs for expansion and continuation of this relationship.

Amelia stated “The communication from the universities are not very clear. You have evaluations and you’re given the expectations, but that’s the only communication you have with the university. I have only been seen by one faculty member. It’s very choppy between the university and my end, the preceptor. I have only had one faculty member stop by once. I would think that they would want to have at least more of a conversation, especially as the student progresses, and what the student may or may not need. There should be some contact with the person that is teaching the actual course.”

She added, “I can’t gear my teaching (precepting) towards whatever the program outcomes are if I don’t have the program outcomes and if I don’t have the discussion with the faculty. Communication with the faculty and the university would be key. A face-to-face meeting even once a semester is fine, but an e-mail from the faculty members of the
course would be very, very helpful. At least if I have questions, I could have a contact point to reach them.”

*Darcey* had a similar experience and admitted, “I don’t have a lot of contact with faculty. When I have students I precept in my office, I see the faculty. They maybe come in once a semester to visit. One particular university never comes to visit me. Never. I’ve never seen them. I’ve only ever met them once in the four years I have been doing this for them. I’ve never met them in person. They e-mail me, but I’ve never met anybody. Whereas with the other university, at least they will come and sit down once during the semester and say, “How are things going? How’s this student doing? That sort of thing. A lot of them have no contact with them (students). Now that I think about it, it might not be the greatest thing. Maybe we should have more.”

She continued with the reflection, “I think I'm doing a good job of it, but I don't really know. It would be nice if someone said, "Okay, how did it go with that student this semester? What problems did you have? Is there anything I could have done to support you? Any concerns?" Maybe we could do it better if we had some support from faculty. I'm not a teacher. I’m not teaching. I do the precept thing, I'm not trained. It would be nice if they gave us an idea. I guess the students are turning out okay because no one's coming back and saying, "These did a lousy job this year."

*Bess* continued this sentiment expressing “Frankly, I precepted for public and private universities and the faculties don’t do much for you. I didn’t have any site visits to speak of, and I think that is very important. I don’t think that you can blindly trust that the students are getting a good experience without visiting (the site) and knowing the preceptors. In a couple of articles I’ve read lately, it really shows that when the clinical
faculty or preceptors are involved more with the full time faculty, the students get a better experience all around.” She continued this thought with, “I didn’t know the faculty (where) the students were coming from. They didn’t visit, they didn’t communicate, and they didn’t come to the site. I think that had to do with the fact that a lot of them were not nurse practitioners, I’m not sure, but they were just not comfortable in what I was doing.”

*Olga* was fortunate in her last experience, and she relayed that “The last faculty that I was exposed to had been extremely supportive and have had a lot of personal contact. They started with one-to-one contact and actually finished it with a one-to-one where they came to see me. They met me for coffee and talked about the experience. It was very clear what was expected and what was accomplished. That was a very positive thing. They kept track of things during the semester and would email me and say “Well, I think that this student should be doing such and such, for example, independent assessment at this time.” My answer would be ”She's right on track.” That was a positive thing”.

*Laurie* admitted to experiencing site visits from the faculty. She described them as, “The faculty member does come in, usually once a semester while they’re (students) there. I guess they spend about 5 minutes there, just to make sure, I guess, that the student isn’t killing people.” “I don’t even have a can or can’t as to what they are eligible doing. Maybe years ago somebody said that to me, but I’ve just done my own thing.”

*Maura* relies on her experience as a preceptor to navigate the role. She relates that “Students come to me and I get a name. That's all I get. I don't get a background. Faculty of the nurse practitioner student, very rarely do I hear from them, which is fine because I take that as, whoever that person is, knows me well enough. If it's a person I don't know,
they usually try to find me, but I don't really hear from them. I would at least like a phone

call to see, ‘Hey, how's my student doing?’ Or an e-mail, ‘How's the student doing?’ If

you don't want to place a phone call, ‘e-mail me back.’ Then I know there's a connection

somewhere.”

In conclusion, the theme of communication was considered imperative to the role

by all preceptors. The issues between communication between academic faculty and the

clinical preceptor were expressed by many, with the consideration of a site visit being

one of the tasks not implemented by academic faculty, yet viewed as important by the

preceptors. Methods of communication other than actual site visits were reviewed, with

the importance of monitoring the progression of the student a primary reason given as

rationale for ongoing communication between the two educators.

**Theme III: Extraneous Factors Impacting the Role of the Clinical Preceptor**

This theme evolved from the research question, “What newly emerging clinical

factors impact your ability to precept in the clinical environment?” This question was

posed without any reference to prior portions of the interviews, and remained an

independent directive for the interview to continue. The predominant influence was the

introduction of the electronic medical record into the various practices.

**a. Electronic medical records (EMRs).**

*Amelia* expressed support of this integration into the learning experience for NP

students by acknowledging “Students have to be able to access EMRs. No better way to

learn than to have your own documentation system to tell you. We have a web based

program, so we are able to do our medical records anywhere, …making sure that students

are able to access their electronic medical record for whatever site they may be going to
is extremely important, especially now that all the data is kept in there.” She continued, “Not only do the data, but a lot of the programs have the evidence based practice, clinical reminders right into them as well as pharmaceutical interactions and complications. It’s all for patient safety.”

Darcey supported this statement with her own practice, stating, “I give them the experience of the EMR, I think they need that….They have to know what it’s all about. That’s a big part of it. It also helps them, I find, to organize their thoughts and their notes. When they’re trying to write a note, a lot of the time I find they had trouble organizing the notes, so the EMR gives them a template basically, and guides them, prompts them. Then they think, ‘Oh, okay, this is how it’s supposed to look.’ I think that is very helpful.”

Naomi acknowledged the students’ abilities with this method of documentation by stating, “EMR was the biggest transition. I give all my students credit that they pick that computer up so fast, faster than any employee I ever had. So they just mainly have to learn to use the encounter note, and access that part of it……I don’t consider that part (entering, diagnostic tests, refilling scripts) a valuable teaching experience.”

It is important to note that entering certain aspects of patient care into the EMR was not perceived as a valuable learning experience by many other clinical preceptors. The variances in each electronic documentation program were considered a distraction to the clinical teaching experience, with the belief that once in the role of nurse practitioner, the student would learn the EMR of the chosen practice.

Charlotte maintained: “I think the biggest one (factor) is electronic medical records. It’s a wonderful thing and not a wonderful thing at the same time.” “But I think
students need to write SOAP notes. Because otherwise there is no thought process because a computer gives you prompts and says ‘HEENT, click, click, click and it’s done. There’s no thought process, it tells you what you are supposed to be looking for. I want to know my students know what to look for before they leave.”

Maura also doesn’t see this inputting as beneficial stating, “EMRs have been the biggest factor, for better and for worse….I do not let nurse practitioners (students) chart in the EMR. That’s my rule….Typing on a computer is not learning to be a nurse practitioner. I go over the information, but the actual typing, I do that myself.”

Laurie had discussed the aforementioned situation with the physicians in her practice. She recalled the following scenario, “I have said to my pulmonary doctors, what is your thought process on students going into the EMR, they’re like ‘No, we don’t want them’. We’ve run so many people (students) I kind of agree with them, I just don’t have the time to teach students how to use the record….What I’ll do is I will look up the patients and I would write things down. If they (students) had a second before the patients came in I would have them (students) quickly look at my charts and the EMR.”

Kate has also experienced this and commented, ”I will say the electronic medical records, have made precepting a bit more difficult, because you’re there and you are having to input your note for the patient, which takes some time.” “They (students) usually watch because it is difficult otherwise. You have to know the system and be a bit proficient on it, so I’ll try to review with them as I’m going along. I don’t think they get the same benefit” (as charting or inputting it themselves).

The benefit versus the time constraint with precepting was mentioned as an issue, with Hope reflecting that, “The difficulty (in precepting) came when we moved to
electronic records. We actually had to discontinue our experience with students all together because the learning curve for the electronic medical record was so difficult.”

She added, “When students returned, it was difficult to teach, do the EMR, abstract information from the prior chart and move forward with students, as we have in the very shortened times that we have to see patients.”

*Bess* projected that she can definitely see from what’s going on in health care right now that it’s going to be harder to precept because of the electronic medical record, with the push, especially for APRNs to see more patients, as we become more (a part) of the primary care model, which is happening”.

**b. Time allotment.**

The issue of time allotment, which was introduced within the influence of electronic medical records, emerged with its own impact on the clinical preceptor regardless of the environment in which their practice occurred. Preceptors in a primary care practices explained the constraint.

*Bess* stated “I think it’s going to be harder to precept because of the push to see more patients.” For example, “I interviewed for a job recently, and the expectation was 24 pediatric patients a day for me. I turned that job down. I don’t know how I could teach with that expectation. I think that’s going to be a challenge with students and practitioners. The pace, the expectation is you’re turning out more and more patients and your time is much more micromanaged because it’s all billable hours. I think that’s going to make it difficult to precept”.

*Laurie* supported this belief by expressing, “As an NP I have to see a certain amount of people every day, and precept at the same time is kind of hard….but at the end
of the day, I have to get my charts done. I do a lot of ‘watch what I’m doing’ but I don’t really hand the charts over to the students and be like, you chart or you do or you see that patient by yourself. I don’t. I just don’t have time.”

*Paige* informed the faculty asking for student placements, “The only thing I will tell them (clinical coordinators) is, it’s a very busy office….I don’t have time to teach somebody who isn’t a good strong nurse. If you give me somebody who’s been a nurse for a year, I don’t have time to hold their hand. If they’ve been a nurse for a year or two and they’re strong, I’m good, but I don’t have time in my practice, because I can’t slow down my production”.

Many of the preceptors told how hospital settings and clinics also presented their own challenges to the preceptor-student relationship. For example, *Hope* identified her practice challenge stating, “The difficulties were that we were in a very busy clinic and they didn’t allow extra time for preceptors to take the time with students…They gave us a regular schedule, so we would have to both see the patients and precept at the same time as trying to turn patients over quickly, do our charting and move on to the next patient without any extra time for explanation for education.”

Similarly, *Jacquelyn*, who practices in a hospital environment added, “The time factor impacts the role as a preceptor”. She continued, “I haven’t precepted in over a year because there is too much on my plate at work to be able to take on somebody and start from day one, where you have to walk through and talk everything out that you are doing. I think initially it is always more stressful for me to try to get to know them, see how they are clinically, and fit them into my schedule.”
Ilene, also in a hospitalist role, supports the difficulty with time constraints, reflecting that, “I would say the biggest negative is the time. If it (the hospital unit) goes crazy. It’s not like it’s an office, when I did an office and I brought nurse practitioners (students) in, it was much more controlled…. You had your visit time, you knew what you had to do when you went in, or if I did (cardiac) stress testing, you did that. It was much more controlled, but this is a little bit hard.”

c. Coding and billing.

Both time constraints and electronic medical records were presented as major influences in the precepting experience. One other influence that was introduced by clinical preceptors was that of Coding and Billing, a task that is considered vital to a practice.

Amelia stated, “The other (issue) is the Affordable Care Act (2010) with health insurance, and understanding billing and coding, what is covered and what is not.” She added, “It would be extremely important to make sure that practitioners (students) understand what that looks like and what it looks like going forward in the future, and what it looks like for Medicare and Medicaid patients going forward in the future.”

Francine illustrated this task by showing the student the interactions she had with a certain physician and his billing method. She explained “His (physician) system is more a system review and then assessment and plan, and then convert over to ICD-10 coding. So we’ll (student and preceptor) figure that out, because coding is part of it too…. Looking at ‘what are you doing?’ And ‘what are the codes?’ You just can’t say ‘they (patients) didn’t feel good?’ No, what’s the diagnosis, what are the codes?”
Darcey summarized her rationale for teaching this task stating, “I guess the other issue is the coding and billing, which I think the students need to see as well. I try to give them tips on how to code properly and bill, because I think we need to know how to bill for our services in order to get the most we can for what we do”. She added, “I’m very much an advocate of being paid (for) the work I do. I don’t give my work away.”

This theme showcased the ‘businesses of healthcare’ and how using electronic medical records can have an impact on precepting students. Similarly, billing and coding procedures and the time involved teaching the student both the mechanism and the rationale behind assigning the codes are tasks that was considered important. These stated extraneous factors, although deemed important by the preceptors, are presented as minimal in time expenditure in the student’s clinical experience.

Theme IV: Precepting the Non-Traditional N.P. Student

The non-traditional advanced practice program, was identified by preceptors as a program that enabled students in possession of a baccalaureate degree in a non-nursing major to become Registered Nurses in one calendar year, and then continue into an advanced practice program, completing the requirements for an MSN within a mid-level provider track in an additional two years. For the purpose of this research, the clinical preceptors interviewed spoke of precepting students engaged in the nurse practitioner track in this advanced practice program.

Darcey spoke of the challenge when precepting this type student by identifying the variety encountered. She related, “The students I work with at a university are non-traditional students. They spend their first year studying and then they go for their RN boards and then they do the NP the next year, something like that.” She continued, “I’ve
had these engineers who passed the nursing (boards). They’ve had the training, I guess, but they’ve got no experience. There’s a lot to learn. They’re older students, mature students. They are motivated but there is a lot of variation because of their background…. The (traditional) students are much better prepared because they are already nurses. They are much easier to precept. They have a background. They’ve got some experience”. She added, “When you have those students who have not worked with sick people before, sometimes you’re backtracking just trying to help them”.

Bess had similar feelings, although admitting she had somewhat of a bias. She stated, “I have mixed feelings about the non-traditional students. I do find it’s a big difference in precepting those types of students…. Honestly, I’d rather not do it because I feel like it’s a personal bias of mine….I feel although they are very bright people, and I’m not saying that a non-nurse to a nurse practitioner students can’t make it, but I don’t feel like they have that fear, that innate (gut)…. I feel like not having that can be detrimental because you go from a non-medical background to prescribing medications, there’s a lot to teach a non-nurse practitioner student….And not that they can’t or aren’t capable of doing it, it’s just they haven’t ever grown that part of themselves as a nurse, because you go through that quick accelerated RN program.”

Ilene agreed that these students are intelligent but acknowledged, “The problems I’ve had are with the non-traditional students, and it’s more than just a lack of knowledge base, it’s a lack of comfort. They’re highly intelligent students, and they’re adults, and this is usually a second career, but they’re not seasoned at all, and that really shows….It really shows, unless every now and then there’s an exception to the rule, and you’ve got a very different student. That’s an exception to the rule, but it’s rare, very rare.”
Charlotte offered a unique insight into this type of student by admitting, “I was a non-traditional student, and in hindsight, which is always 20/20, I believe every non-traditional (student) should be mandated to work in a hospital, maybe even med-surg. Working as an RN gives you so much in the way of experience that you can use as a nurse practitioner….It really depends on your job, but I really feel it’s important to work as an RN….RN experience brings a lot of information as well as compassion for different experiences….And there is no emphasis on that. It’s just get through, get your RN, and move on to the Masters. And I don’t like that….I think sometimes when you are book smart you can be very confident, but when you don’t have the experience to back you up, it’s very scary to me”.

Ella commented on the non-traditional students’ limited experience. She reflected, “I’m doing a lot of non-traditional students which are students that have graduate degrees in Psychology or Art or Public Health or Biology or something like this and in spite of that, that wasn’t really what they wanted to be. They really want a more hands on. Even though they are RNs by the time you see them, they’ve had one year under their belt. They do not have a lot of acute experiences and so you are working really hard to try to find them acute experiences and send them on their way”.

No preceptor expressed concern over the level of student motivation, and Olga presented this best by commenting, “I’ve been able to recently have two people who were non-traditional students in the Master’s program for Psych (NP). They seemed to just come in and be ready to work and to function. They were really excited about functioning”.

In conclusion, this theme presented insight into the difficulties of precepting a type of non-traditional student. The predominant challenge presented is the lack of experience
of a basic level of nursing which is usually practiced for an extended period of time before attempting to study and then practice at the advanced level. The discomfort of some of the preceptors stems from their students having little or no experiential foundation to draw from, making teaching and then applying the concept of critical thinking at the advanced level difficult.

Theme V: Stressors Impacting the Clinical Preceptor Role

Although not identified with the word ‘stressor’, various behaviors, tasks and responses from being engaged simultaneously as a preceptor and clinician were described during the interviews by the clinical preceptors. This theme was not in answer to a specific research question, yet every interview was infused with these various challenges that caused disruption while engaged in the role. The subthemes illustrate the major behaviors, tasks and emotional responses to the role as perceived by the clinical preceptors.

a. Negative student behaviors and attitudes.

Francine experienced students who did not respond to the patient population in a professional manner. She described the situation as “This is geriatrics and long-term care and it was a younger graduate student who I don't think was out of school but for maybe three years from undergraduate and I don't know that she had the life experience or the maturity. She was bright in her understanding of anatomy and physiology and what she does but I don't think she was as mature in life experience and interactions. There were times, a couple of times that she's documenting in a pink pen. A document, and it was like no, no, no. We had to tell her. Behind the scenes we called her ‘pretty, pretty princess’ because she'd come all dolled up and, you know. We had to say no, hair back, like the old school, hair back, appropriate clothing, lose the heels. This is the clinical environment.
Another one didn't quite get the type of patient population that we have and she had to be corrected and educated on how to treat them properly with dignity and respect. I had to say to her, "No, they're not adorable. No, they're not cute. They're not sweet and they're not honey. Please use their name, ask them how they'd like to be referred to. ‘May I call you?’ But do not speak down. Do not condescend, you know. They are dignified human beings who happen to be at a different phase in their life….So it's really important. Dignity and respect. They didn't quite get it but I think that it was a maturity issue for those particular students.”

*Hope* also experienced some of the aforementioned behavior and situations. She recalled, “There was a student who came from a very different environment growing up and had a very different outlook on the universe and really had difficulty with the population (inner city pediatrics) that we saw, both from his background of not working with minority populations and attitude toward some racial issues that came up. That was extraordinarily difficult and really should have been teased out before he came to a clinical rotation.”

*Ilene* reflected on an experience with a positive outcome. She remembered. “I had one student that the program director gave me because she was very difficult, no one else could work with her, yet a very smart girl. The problem was that her attitude came off as being very abrasive and ‘I know what I am doing’…. I was able to work with this student and she was able to see, she had a big chip on her shoulder that didn’t need to be there. There was nothing wrong with her intelligence, she could do the work, it was just in her presentation, which we worked on, and she did really well.”
Charlotte stated, “The effort put forth by students can change from year to year…. I think the students have become more high maintenance, more reliant on me for help, for information…. I also feel like the schools of nursing are not making clinical a priority, and the students feeling like they don’t really have to put an importance on that; they come to clinical dressed in jeans, dressed in stretchy pants, forgetting their stethoscope, emailing clinical notes that they’ve cut and pasted, and that’s infuriating to me.”

Bess related, “I also had a couple of students who dressed inappropriately. I don’t know if provocative is the right word, but just not in a professional manner. I remember the most recent student had very skin tight pants on and had underwear that were showing above the waist. I corrected her, and I explained that especially in adolescence, we couldn’t…well anywhere, but especially with teenage boys, you couldn’t have your undergarments showing, and so she didn’t wear anything like that until her last week. That was after her evaluation, so it was like she gave me a little dig…. Very bright, very skilled, but I thought that was interesting and not comfortable to have to talk to somebody about that or about their lab coat being wrinkly or something like that.”

Gianna noted “There is a variation in each of the students. I had one student who was mildly frustrating to work with because I felt that she wasn’t really open to the learning experience, wanted to cut corners when we were talking about a certain topic and I would ask a question and she didn’t know (the answer) and she’s like ‘Just tell me, just tell me’…. I said, ‘No. This you need to look up, you need to research and when you come back next week then you can discuss it with me and you can tell me what you learned about this’.”

Jacquelyn reflected, “I find the longer they (students) were in nursing, the older they are coming into advanced practice, the harder it is to turn their view around to look at
it not from a nursing perspective, but from an advanced practice perspective….I think it’s more challenging for them to step out of that comfort zone, because they are experts, they’ve been in nursing for 30 years…. “I’m having to step back and say, ‘Let’s look at this’. ‘What’s your role?’ Some of them (students) are more challenging than others. I find the younger they are, the more challenging it is, which is interesting. It's my own age probably coming into play, but they're much different. Many of them don't have experience, now. They're going right from their bachelors to their masters, not having that nursing comfort and experience that I had, that most of my colleagues had, becoming a nurse practitioner. You just didn't do that, you just didn't go right from your bachelors to your masters. When nurses ask me, what's the best way to do it, I always encourage them to practice nursing first. Be comfortable as a nurse before you become an advanced practice nurse.”

b. Failing a student.

Maura remembered, “I’ve had one (student) who proved to be not committed, thought she could get away with coming late and leaving early. On her phone more often than not. Would say ‘I think I’ll see this patient’ or ‘I’m too busy right now’. I told her, ‘You do this again and I’m not going to pass you’…. I was up front about the whole thing, but I found her not to be committed and I didn’t pass her.”

Naomi reflected, “Actually there was only one student I ever failed and I've never done that before. That was early on in my precepting. I think she was probably in my second or third year of precepting, maybe second year. You know, I felt so bad about it. She was an RN, to start. She worked in just maternity nursing and she was going through an FNP program, and she had no adult, none... no other, besides maternity experience.
So, I was basically trying to teach her primary care, you know, in a community health setting. I always typically request final semester students, you know, I need someone who's got some background, because I just don't have the time in community health to do all that education for the people (students) who are earlier in the program. But I just couldn't do it, I couldn't teach her primary care and try to teach her how to see patients. It was a little too much, and I... it's the only person I've ever failed. I feel horrible about it. I still feel horrible to this day! But, I mean, at the mid-semester point, we met and I think she kind of knew. I was always giving her feedback about her notes and about the visits…. She had a hard time kind of focusing, how to focus the visits and that sort of thing. She was kind of all over the place. The school they didn't really, they weren't terribly supportive, they were just kind of ‘Okay, we recognize that,’ and I can't exactly remember because it's been so long ago, but I didn't feel like I had a great deal of support from them in the likes of her. And, I just couldn't pass her, my conscience, you know, my consciousness. I explained that to her and she was very professional about it, she said she understood and she moved on; I don't know whatever happened to her. But I just... I felt bad about it, I'm sorry.

_Ella_ added to these experiences recalling “I had one student that was absolutely, I thought, not made to be a nurse practitioner and I picked up on it fairly soon and worked with her, trying to get her a little bit more motivated and to be more involved….Even though she was a pediatric nurse prior to become a nurse practitioner, she just wasn't getting it. I called her instructor and said I'm going to have to fail this student and that school said, ‘Oh, no. You can't do that.’ When I told the student I said, ‘You are not going to pass. I'm not going to pass you,’ and I've never failed anybody They moved her to a different clinical
site thinking it was just maybe a personality thing which I'm fairly easy to get along with. She made it through with a different clinical site and was hired on at a school-based clinic which I was very surprised and they fired her. I think there needs to be some standard as far as the quality and level of education that is necessary.”

*Ilene* also remembered a student “who had just finished a cardiac rotation and he didn't know the difference between congestive heart failure and acute coronary syndrome. He had no understanding of what they were or how you diagnose them, and I tried to teach him, I tried to take him along and stuff, and he just failed every single piece, generally very, very unsafe…. The program manager came and worked with him for about two weeks, did a rotation, and said, "Oh, my god, you're right.' We sat down with him and we drew up a plan, this is what we're seeing, this is what you need to do, this is where you need to be, what can we help you with? Are you having difficulties, what's going on? You're not remembering stuff that you had, that you don't know. We did all of that. He agreed to follow this whole plan and he just failed, failed…. Ilene continued, “We met with him weekly and there was no progression whatsoever. It was extremely difficult because the program manager basically told him that he was failing….Unfortunately, I'm going to tell you, he should have never got to the (academic) point he got to, never…was .My whole thing he's not safe, okay? I cannot pass him and say he's safe, he's unsafe to take care of patients. The program manager recognized that, agreed with me, and it was a very horrible process. Because when he was told that he was failing, he had failed all the remediation. What ended up happening is, he tried to sue her (program manager). You know what I mean? There was a hearing at the school. It was horrible that she had to go through all that, because instructors had passed him prior.”
Ilene concluded, “Not everybody is meant to be a nurse practitioner, there has to be failures in programs, that's all there is, and his safety level, he wasn't even able to diagnose a patient….He wasn't able to prescribe appropriately. He didn't have a great bedside manner, he was a little cold and standoffish, but he tried to sue her (program manager) for discrimination, sexual discrimination because he's a male….That was a pretty bad experience, but at least I didn't have to go through as much as she had to go through, because I was just the clinical preceptor, not paid, just here to whatever…..”

Paige related, “I can honestly say in 17 years-and I don't know, 50 or 60 students that I've had over the years, I think I've only had one really awful one who I was not going to pass. I'm very up front. I don't wait until the mid-semester evaluation. Every week that they're with me I tell them, ‘This is where you stand. This is where you're weak. When you come in this week I want you to work on this.' I give them specific goals to work on. This student just wasn't cutting it.”

She continued, “Every week I had to talk to her about what she was wearing and she had this real elitist attitude. I called up the course coordinator, I told her we were having an issue. She (student) was very rude to my staff; my staff didn't like her at all. You're a guest in my office and you need to have some manners. She was European and she just thought this was all beneath her. When her mid-semester evaluation came she didn't like what I wrote about her and she left that day in a huff. She left the clinical area.”

Paige concluded, “Anyway, long story short, it was like this the whole semester. I didn't like how she spoke with patients. Every week it was really ... I hated when she was coming in. At the end of it I gave her a very middle-of-the-road evaluation and told her
all of the things that she needed to improve on and she refused to sign it. When I went to the course coordinator she referred me to the director of the program and they told me that I had to pass her. Yes. I said that I would never take one of their students again.”

“Because if I wasn't going to get the support from them, this was a danger to the public health. It wasn't about her paying all the tuition. This was about her inability to practice safely. That was it.” “She was one of their star students because she then went into their doctoral program and now she's on faculty with them. I don't know that she's working anywhere but it was awful. I didn't have that support. That was probably the only negative that I've had.”

c. Loss of productivity and increased workload.

Many preceptors interviewed commented on having an increased workload when they precepted NP students. Regardless of whether the preceptor was seeing patients with students or validating students’ physical examinations and treatment plans, there was no doubt that the preceptors had an increased workload.

Charlotte admitted, “My boss isn't super crazy about me having someone because it slows me down. I'm in a very small practice, there are only three of us, but usually there are two of us there on any given day, so I'm taking away from seeing some extra sick people or whatever because I'm with her, and he has to pick up that slack. And so some days he's very tolerant, and other days he's like, ‘You know what, let's go’.”

Paige recalled, “The biggest struggle I have is that there's so few clinical placements that I'm inundated with requests because there's not many of us in primary care. I feel bad saying no but I have to have days when I just practice and not have a student with me... There was one semester when I had 4 students, and I only practice by
myself on Friday and I was so burned out that I said, ‘I can't do this. I have to say no.’ I feel badly saying no but I have to have days where I can just be the nurse practitioner and not be the preceptor”.

Darcey stated, “I don't have any negative experiences. It's just extra work. It takes time. On those days, I'm a little less productive. It's a little more stressful because you're trying to get the students settled and get their needs met, and you're dealing with your other regular duties. That's a little more of a challenge, but there's no real negative except that that I can think of”.

Laurie admitted, “I'm definitely more exhausted at the end of the day when I'm a preceptor. Because I feel like I'm doing two jobs. Because I still have to get those twelve patients in and the twenty phone calls and all the scripts done and talk”. She realized, “I can’t precept semester after semester…it wears on me. Sometimes I need a break”.

Amelia confessed that the greatest challenge is “to have to be on all the time. It's exhausting at the end of the day when you realize you were probably talking twice as much as in a normal day seeing patients”.

Maura related “I've had one to two students a semester. I find having two is too many. They'll alternate days, so I'll only have one on a day, but it's a lot of work. If I had to recommend how many to take, it would be only one a semester. It makes my practice a little busier the day they're here, when I'm seeing patients every half-hour. I've got 14 or 15 patients that I'm seeing, plus doing education with them, plus charting, plus trying to educate the nurse practitioner student. It's a busy day, but that's part of the deal. You get out a little later that day. So what?”
Hope summarized her combined workload by realizing “There are some days everything works. The pace is doable, the students are keeping up and I’m getting everything done. Then there are the times that the multitasking is overwhelming, and I have to say (to the student), ‘Either just follow behind me, or go sit somewhere’, because there are times I just have to get it done. Not teach, not talk, but just get it done.”

The clinical teaching involved in precepting can be very labor intensive when you are trying to provide high quality care coupled with excellent precepting. It can be an intricate balancing act even for the most experienced preceptor.

Theme VI: Personal and Professional Gain from Clinical Precepting

Throughout the interviews, there was recognition of both personal and professional benefit from the clinical preceptor role. These gains were identified with the reflection of positive encounters while engaged in this role, through the preceptors telling of their experiences and the acknowledgement of the satisfactions gained.

Maura expressed that she benefited from the excitement the students brought to the experience. She stated, “I’ve found that the majority of the students are very excited to be a part of the clinical setting. They’re very anxious to learn more in the clinical setting. They pretty quickly learn critical thinking on the spot….Once we hit the halfway point, most of the students are ready to fly out of the nest and do a little bit on their own. That’s very rewarding to me….It’s really exciting to be a part of their care, of their education. It’s fun to watch people grow from point A to point B. Their excitement coming in, and then you’ve seen them take steps forward in the role of a nurse practitioner.”

Darcey also recognized the feelings of enthusiasm and excitement gained by integrating students into her practice. She reflected, “The students bring a certain
perspective that’s refreshing. They’re interested in learning. All my students are very enthusiastic. Everyone I have ever had is very enthusiastic, very interested in everything I could possibly teach them. They always want to know more, and more and more. They’ve always been enthusiastic and hardworking and doing a good job.” She also recognized the professional benefit of staying abreast of advances in the profession by stating, “It keeps me current and I think it helps me just have a younger approach to things.”

Ilene supported this benefit and reflected, “It makes me stay up to date with things that I need to stay up to date with. I learn from the students. It’s a two way street”.

Francine added, “Precepting makes me step up my game. I learn from the students. It makes you reflect on yourself”.

Paige saw the professional benefit of precepting. She stated, “I think it makes me a better nurse practitioner because they (students) keep me on my toes. I have to stay ahead of the curve. I think if I wasn’t teaching concurrent with practice, I don’t think that I would be as on top of things”.

Bess echoed this reciprocal learning by stating, “The students are always up to date on new technology, new studies, new textbooks, things like that. I always feel that I learn from the students.” She introduced a specific professional gain by recognizing “You do get your recredentialing hours which is helpful. That’s how I always explained it to my bosses because they were like, you know it’s going to take you more time. I would say, well, okay, but I need this for my recredentialing hours. Usually I was supported.”

Professional recredentialing was a benefit appreciated by most preceptors, with one preceptor giving summation of its value. Charlotte stated “I get academic (ANCC) credit for it. And that really is a big deal because that takes away from my need to take
away from my practice and my family and go find CEUs more than I would have to”.
She continued, “I like precepting, it keeps me on my toes, and I think it makes me think
‘Why did I do it that way? Oh, because of this or this or this’. It makes you double check
yourself, and we have the opportunity to do CEUs and think about things.”

Although the objective measurement of credentialing credit for the role was
brought forward through a majority of interviews, the subjectivity of how NPs become
better providers through precepting remained paramount in the expressed benefits. As
Hope stated, “You become a better provider when you teach, because it reminds you of
the things that you had learned long ago and you have to go back and review so it’s
always good to refresh”.

Naomi expanded upon this concept with her reflection, “The students are more
prepared, ready to go. You know, it’s exciting to have someone there with that
enthusiasm and wanting to learn. I just noticed on those days that I had clinicals with my
students I had an enthusiasm about the day. They come to you and they want to know an
answer. And if I don’t know it, it’s challenging to say, ‘You know I don’t know the
answer to that, let’s look it up. So I am always up for a challenge, and I love that
challenge in students.”

Laurie’s enjoyment of socialization was expressed when she exclaimed, “Oh my
goodness, I love their enthusiasm. I like to show them my thing (specialty). I’m a social
person, I love the social aspect of it. It’s fun having somebody, especially if they jive
with the office.”

Gianna found pleasure in working with the ones (students) that are fun, motivated,
really here and eager to learn and just enjoying the whole experience and taking it to heart.”

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Speaking about the student’s reaction to what she considers a routine task, and how she thought it would be perceived as boring, Gianna stated, “And I’m feeling badly. I’m thinking ‘Oh my God, they’re probably bored, you know? Then we talk about the patient and the routine of monthlies and they said to me ‘That was awesome’ ‘Really?’ They’re like, ‘Yeah that was so great. We saw so many different things.’ I was like, ‘Oh, okay, I was afraid I would bore you to tears’.”

Two preceptors seem to both personally and professionally acknowledge what the students have provided them in their role. Olga reflected, “They provided an enormous amount of insight to me on what I did. I was able to reflect on what my job was and how I could actually improve my own skills in ways that I guess I wasn’t prepared for….The positivity of having someone with me and actually coming up with things that they may have been taught in their own class and basically are just ready to roll”.

Similarly, Ella observed, “(The students) bring their own life experiences which we learn from. I think a lot of nurse practitioner students don’t realize what a wealth of information and support they are because they’re always apologizing for taking up our time”.

The reflections on the personal and professional gain from the role of precepting point to an intrinsic satisfaction of self that the preceptors experience. Tangible factors such as credentialing credit are appreciated, yet the infusion of enthusiasm, excitement and motivation the students bring to both the preceptor and the clinical practice presents as a paramount professional benefit. Self-reflection of practice, with the rationale behind why tasks are performed, and the student infusion of current knowledge into the preceptor’s frame of reference, also aid in the continuation of the clinical precepting role,
as the preceptors realize the personal and professional enhancement they have received by engaging in this professional relationship.

**Theme VII: Acknowledgement for Clinical Precepting**

The concept of acknowledgement was not one that directly answered any inquiry regarding what a preceptor expected or received from students or university faculty. Instead, it developed from discussions that were in response to the research question, “What has been your experience as a clinical preceptor?” Through these responses, three subthemes emerged based on the relationships in the precepting role: acknowledgement from student to preceptor, academic faculty and university acknowledgement of the preceptor, and suggested acknowledgement by the preceptor.

**a. From student to preceptor.**

*Bess* explained, “I think students should be responsible for saying thank you. I think it’s a learned skill, especially in this generation of learners. I can say that the students who say to me ‘you’ve taught me so much more than I ever….You could cry talking about that, ‘you taught me so much about being a better nurse, a better nurse practitioner, what to expect’ because I never sugarcoated the work….And hearing back from the students is nice, and also very rewarding”.

*Jacquelyn* stated “We all like acknowledgement. I’ve gotten some really nice cards and thank yous. I always ask them for feedback about myself and the whole experience.”

*Gianna* reflected, “Acknowledgement is very subjective. Would it make a difference if I were paid or not paid? No, I’m very happy to do it, because it’s something that makes me feel good that I am able to contribute (to the profession)…. I think the
other thing that is acknowledgment to me is that my students have stayed in contact with me. That to me is great too. I mean, I guess that tells me that, yes, they did take a part of this experience to live with them going forward. That’s a wonderful thing and I appreciate that. Okay, but I also get wonderful presents!”

Both Laurie and Maura mentioned getting gift cards from Dunkin Donuts. Laurie thought “it was cute” and Maura received similar acknowledgement, saying “I did get a thank you note from somebody once, and a gift card for Dunkin Donuts”.

Francine stated, “I’m not looking for the fanfare or the parade or the gifts or whatever. I’m just hoping somebody will take a little bit away in a positive way, maybe treat some other geriatric patients well. My grandma was my favorite person, and if I can teach somebody to respect the elderly the same way, I’m happy. That’s what I’m looking for”.

b. Academic faculty and university acknowledgement.

Ella recalled, “Occasionally a university will have a preceptor’s luncheon and a special preceptor’s education thing. When we first were doing it (precepting) they were inviting us to talk about how to be a good preceptor and ways they could help us and we could help them…. “Nowadays, I get something by e-mail. I’m certainly not one that looks for fame and glory.” She added, “At one university you can use the medical library, and we get a couple of free conferences (held at the university).”

Charlotte recalled a similar experience noting that “One time a school of nursing gave us a lunch, and asked our opinions about the nursing programs. We talked a little bit about precepting and we shared experiences. But that was the only time I’ve been asked to be a part of something like that”.

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Bess mentioned that she received a certificate and a thank you letter from two universities and nothing from a third university. Ilene added she was granted online access to the university library, while another university gave her a coffee mug.

Jacquelyn commented on preceptor recognition, “I think it’s just nice to be thought of for things like this research project, that’s awesome that you thought of me to participate. I think that’s great. It was awesome when a large out of state university called and wanted to send somebody up to our program that wanted palliative care experience. It’s like, okay, so people do know we’re here and we’re out there, and we’re not just kind of floating in space and nobody knows what we are doing. I think it’s just nice to be asked to precept from schools that are outside of where we are, because the schools recognize you.”

Olga stated “I really haven't thought anything about my role and acknowledgement of myself. I don’t remember ever having difficulty with this. I can tell you, though, that when I bring students to facilities, the staff of the facilities, the administration was quite impressed. I think that has been a very positive thing as far as establishing my own experience, as well as competence in what I'm doing. I think that's been very, very positive. I haven't really experienced anything as far as lacking acknowledgement. People have even later said, ‘Do you remember that student that you had? Wasn't she delightful with the patients? Wasn't she this and wasn't she that?’ I would say ‘Yes, I remember. I'll never forget her because she was just so super’.”

Naomi recalled, “At one program the preceptor would get a small stipend, and they actually offered a little bit of training, and they gave us, just like a few webinars on tips how to be a more effective preceptor and that sort of thing….. Even…this sounds
stupid, but a couple of years ago, when I taught at one university, I got a little certificate, a thank you and I kept it. I just went through all my files the other day, and I said ‘Oh my god, I kept this!’ But it just obviously meant something to me that I kept it all these years. It’s just those little things that make you feel part of an institution….Getting those e-mails from the teachers of the school that say thank you”.

**c. Suggested acknowledgements by the clinical preceptors.**

Some of the preceptors participating in this study made suggestions for acknowledgement by students and their nursing programs.

*Darcey* stated, “Money. Money’s always good. It’s nice to get some kind of stipend, even anything like a gift card or anything would be nice”.

*Bess* added, “I can definitely say that payment would have been nice, although I know that’s difficult when I am hired by the hospital and then I am hired by the agency, and then I am getting paid on top of that. Maybe a joint appointment…or a bonus or certificate, or just a letter saying you are on faculty.”

*Charlotte:* “I have thought about switching to a different school of nursing that does pay…when I am frustrated with my students and when I get angry like that I say ‘You know what, I should be paid for what I’m doing’.”

*Ella:* “I think there are certain things they could do without costing them a lot of money. You could audit one class if you precepted one or two students a year….It could be any class, it doesn’t have to be nursing necessarily. It would be exciting.”

*Naomi:* “I don’t think fiscal reimbursement for precepting is going to be the solution to getting more preceptors. I think it’s just….you’ve got to kind of feed into the intrinsic motivation of why people are doing it, you know? And money doesn’t
necessarily play into that. Offer a luncheon once a year, like a thank you, it's a good networking opportunity for everybody who would go, it makes you feel you’re part of something, part of the school”.

Ilene: “I don’t know about that money issue. I wouldn’t do it for money.”

Kate: “I hadn’t given it much thought. They’re (students) coming to me, I’m not traveling anywhere else and it’s still my work day.”

Paige: “I don’t need the extra money. If the university that I work for said, “Well, we’re paying everybody so we have to pay you, I would turn it around and put it in a scholarship because I just don’t believe in it.” She added, “I will say that the school I teach for is one of the first. It’s actually the second in the state that's now paying. I was the one that brought that to the table because it was getting so competitive. Now, don't forget, in the state of Connecticut we have 8 nurse practitioner programs; we have 3 PA programs; and now we have an online PA program so really that's 4 PA programs. We have 3 medical schools. We're all competing for the same 10 clinical sites. It's getting harder and harder because our classes are getting bigger and bigger.”

Paige continued, “I think what's going to happen is all the other schools are going to jump on board. I will tell you that the powers that be at my university were not happy about it but it's the wave of the future. It's happening everywhere else. I think that we're offering less money than other states are offering. Other states are offering upwards of $750 for a semester. I do know that the deans and directors of the nurse practitioner programs all came upon an agreed amount and everybody agreed across the board that we are all going to have the same fee, which I like”.

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“I still think it's a little bit low but I think it's something. For some people that means a lot to them. I take students from my university and I can't take a stipend... To me that's a contradiction for me to take money from the university that I'm teaching at. That's my own, personal belief. Some people very strong about voicing their opinions that we should be paid for what we do. I do agree with that, but on whose shoulders is it going to fall on? The students”

**Summary**

This chapter presented the seven themes and subsequent subthemes that emanated from the interviews of the sixteen preceptors. Although not represented in the dialogue of every theme, each preceptor interviewed was used in balanced proportion to support these themes. The experiences of the preceptors and the telling of their stories illustrated lived examples of how the theme presented and, in some dialogues, interpreted, in relation to the preceptor role.
Chapter 5

Introduction

This final chapter of the study presents conclusions drawn from the data presented in the preceding chapters. It is divided into six sections: summary of the study, discussion of the findings, limitations, significance for nursing practice, recommendations for further research, and conclusion.

Summary of Results

This study was a qualitative design using phenomenological methodology. This methodology, attributed to Edmund Husserl, regards experience as the fundamental source of knowledge, with the lifeworld (Lebenswelt) or lived experience as a way to utilize unbiased observation as a data source. Lifeworld theory postulates that to understand a social experience the researcher must analyze knowledge that the participants express regarding that experience. (Husserl, 1970).

The purpose of this study was to explore the lived experience of nurse practitioners (NPs) engaged in the role of clinical preceptor for NP students. Due to the continuing expansion of NP programs and the vital role the clinical preceptor plays in this education, the need to recruit and maintain competent clinical preceptors makes understanding this role a priority for academic faculty engaged in nurse practitioner education.

A purposive sample of 16 clinical preceptors, initially referenced through a recruitment letter then expanded by the snowball method, were individually interviewed in a naturalistic setting of their choice. The research questions were: (1) What has been
your experience as a clinical preceptor for nurse practitioner students? (2) What has influenced your experience, both positively and negatively, as a clinical preceptor for nurse practitioner students? (3) What newly emerging clinical factors impact your ability to precept in the clinical environment? These questions were posed, during individual interviews averaging 35-55 minutes in duration. The interviews were audio recorded, and then transcribed by a professional transcription service. All participants were given the opportunity to review their interviews and there were no major discrepancies noted.

The major findings resulted from analysis of the interview data, and were formulated into seven themes, with three of the themes having subthemes that increased their clarification. A discussion of the research findings in relation to each theme follows.

Discussion of the Findings

The value of the clinical preceptor as an integral component of educating the nurse practitioner student must be acknowledged. This role facilitates learning by guiding the student toward application of principles of evidence-based practice learned in the didactic setting to their clinical practice. Teaching the skill of making sound clinical decisions based on theory, as knowledge and understanding evolve, is the primary task that challenges the clinical preceptor. This study, through the exploration of the lived experience of these preceptors, reveals that the role is perceived as very rewarding but challenging, as it contains both satisfactions and stressors.

The findings of this study are organized into themes, with the first theme presented as the decision to become a preceptor. This theme resonated with every participant, and the primary reason for the decision to precept was to return something to their profession, or “give back,” as many preceptors phrased it. The responsibility of
giving back was born of their own experience of having “great preceptors” and the knowledge that it had been done for them, so they themselves needed to “pay it forward” and continue the tradition. This belief is supported in the literature by Fulkerson and Wang-Cheng (1997), who commented “Many NP preceptors stated that they felt a ‘duty’ or a ‘responsibility’ to precept because of either professional allegiance to nursing and/or their personal allegiance to their alma mater” (p.106). Barker and Pittman (2010) continued the support with the statement, “Research has supported the notion that for NPs, a powerful influence on the decision (to precept) is personal satisfaction and a desire to ‘give back’ to the students, to repay those who invested in their (preceptors) education” (p.145). The expressed desire to continue the profession, and the notion that NP students should be primarily precepted by NPs, was added by many of the preceptors. Another finding was that the lack of clinical preceptors acted as additional motivation to engage and remain in the preceptor role. The first finding was historically deemed unnecessary, as the precepting of NPs by physicians was thought to garner acceptance of the NP role. This has been disputed through the years due to two major factors, one being the increase in the availability of nurse practitioners to act as role models and the other being that the medical profession has embraced the role of NP. The lack of clinical preceptors is a constant thread through the early literature citing the increasing demands for NP education (Lyon & Peach, 2001), in part due to the changing health care environment which has prompted an increased need for nurse practitioners as professional health care partners and providers (Gibson & Hauri, 2000). Recently the legal autonomy of NP practice has further necessitated an increase in NP education and the need for preceptors.
This first theme also showcased the finding that most NPs hold the belief that their clinical practice is a valuable teaching experience, and through this particular practice they can impart the needed respect and compassion to their specific population. There is limited support in the literature for this finding, but the recognition that the preceptor role includes sharing of professional experiences (Burns et al., 2006; Campbell & Hawkins, 2007; Freytag, 1999) and “does real world teaching in his/her work area” (Freytag, 1999, p.2) gives credence to this finding.

The second theme focused on communication with academic faculty. The findings were primarily negative in regard to the quality and quantity of communication from academic faculty to the clinical preceptors. One of the main concepts expressed was the minimal support preceptors perceived from the academic faculty. Preceptors cited minimal or nonexistent information given regarding the student entering their clinical site, lack of a syllabus or course information to reference, and no guidance in how to gauge student progress or if faculty or course outcomes and expectations were even being met. Hinch et al. (2005) illustrates the value of this communication with a description of an introductory meeting, “The course objectives, dates and times of clinical, and the clinical evaluation tool are discussed……This meeting is an opportunity for the (faculty) advisor to ensure that the goals of the course will be met” (p.243). Gibson and Hauri (2000) echoed the sentiment with a study that confirmed “(preceptors) indicated that they would like more information regarding the student’s clinical strengths and weaknesses, an outline of topics to cover through the clinical experience, and a better understanding of the program curriculum and requirements” (p. 362). One clinical preceptor did voice a
positive experience with continuous interaction with an assigned faculty member being very supportive through the semester.

The lack of site visits and the preceptors’ perception of their importance was a concept presented repeatedly in the interviews. Site visits ranged from none to twice a semester were and events that held much importance for the preceptors. Yet the significance of these visits was not supported by nursing faculty. The importance of site visits is mentioned throughout the literature (Barker & Pittman, 2010; Brooks et. al., 2010; Gibson & Hauri, 2000; Lyon & Peach, 2001). However, none of the interviewees expressed satisfaction with this experience. Another voiced concern was the lack of knowledge or clinical expertise academic faculty had regarding either the actual role of the clinical preceptor or the content of the specialty being taught. Many preceptors felt academic faculty did not understand the responsibilities of clinical practice. One preceptor speculated that the suspected reason for a lack of site visits was that the faculty member was uncomfortable with her lack of understanding of the clinical role. Non-nurse practitioner faculty were identified as lacking the experience needed to understand the clinical preceptor role. Hart and Macnee (2007) supported this belief and concluded:

“NP education should be provided by more clinically competent faculty, who were strong NP clinicians and kept their skills current while teaching…many indicated their NP faculty had little and/or outdated practice experience, which in addition to negatively affecting their credibility, hindered their ability to convey meaningful realistic concepts to students” (p.39).

The last finding to emerge from this theme was many preceptors voiced the lack of formal training they received for the role. Most stated they “just did it” and kept
learning from each precepting experience. Very few received any formal instruction, with
the maximum preparation ranging from attending a seminar on how to precept and
networking with peers, to the minimal support being that no negative feedback had ever
been received so they continue in the same way. An article by Henderson et.al. (2006)
stated that “Although there seems to be a universal acceptance of the importance of
preceptors (Bowles, 1995), it cannot be assumed that practitioners can automatically
function as preceptors (Coates & Gormley, 1997)” (p.131). The suggestion that formal
networking sessions and educational presentations might be developed to support
preceptors was a positive solution offered in many of the interviews.

The third theme dealt with the mechanics of the practice site used by the
preceptors, and evolved from the research question that inquired about emerging clinical
factors in their clinical environment. The predominant impacting factor was the
introduction of electronic medical records into the practice. There was a division in the
extent of value this factor has in teaching the NP student. One belief held was the
electronic medical record (EMR) was valuable for prompting students to assist in
gathering the needed information for clinical assessments. It was felt that templates that
were in place served as prompts for this information, and this decreased the amount of
information the student might lack if left to interview the patient independently. The need
for learning to negotiate through an EMR was also supported by the understanding most
practices and health care institutions now utilized some form of an EMR, so the student
will ultimately be responsible for mastering this task once in practice. The opposite view
was based on the variances within EMR programs, and that it was more beneficial to
focus the student’s time on clinical skills, as the task of learning the EMR will be
mastered once established in a practice. Also, many preceptors felt it impeded the development of certain history taking skills, such as the review of systems, as the student has them available via the template and does not have to commit either the content or a “flow” of questioning to memory. This was felt to impede the development of critical thinking and observational skills. The concept of time management was mentioned when discussing EMRs, as preceptors felt they really did not have the clinical time needed to teach navigation and documentation in the EMR, with one preceptor voicing that inputting information into an EMR was not really a valuable clinical skill.

Time management continued as a factor in the clinical environment with the held belief that the productivity of seeing patients doesn’t allow for spending a great deal of time precepting students. The literature has repeatedly mentioned this as a dilemma (Goolsby, 2000; Henderson et. al., 2006; Stiffler et.al, 2009; Van Leuven, 2014) with the insertion of the education of NP students into the schedule of patient appointments being difficult. Most preceptors admitted that they could not decrease their patient load on the days they were precepting with some stating they could not take a “weak” student who would not be able to “keep up,” while others expressed increased fatigue at the end of the day as a result of doing two jobs.

The final finding within this theme was related to the task of coding and billing practices. This was mentioned by the NPs who were either in a private practice or one that was very dependent on Medicaid and Medicare for payment. The consensus was that students should understand this process, because NPs should be acknowledged and paid for the work they do. The process of educating the student in this task was described by preceptors as one that is relevant to the role, yet very specific to each practice. The
Affordable Care Act (2010) was presented as a base for understanding the future affordability of medical care, and especially how this will impact the increased need for nurse practitioners.

The fourth theme was an unexpected finding, which at the beginning of the data collection process was thought to be very inconsequential. Data analysis revealed that the non-traditional N.P. student presented specific challenges in the clinical setting. Above average intelligence and prior educational background of those students were not identified as challenges; it was the lack of nursing experience that was problematic. The students lacked professional intuition which is needed for the advanced practice role. Thus, the preceptors found this difficult in the clinical setting. The students were described as excited and motivated to learn but had large gaps in clinical knowledge because they lacked experience as a registered nurse. This proved to be detrimental to learning the nurse practitioner role. Most preceptors did not have a favorable impression of the non-traditional advanced practice program. There was one preceptor who was a graduate of the program, yet she admitted that a requirement of prior clinical practice at the registered nurse level should be mandated before commencing an advanced practice role.

The fifth theme captured the challenges of precepting a specific type of student by identifying stressors that impact the clinical preceptor role. These stressors were delineated into three sub themes identified as: negative student behaviors and attitudes, failing a student, and loss of productivity/increased workload.

The negative student behaviors and attitudes experienced by the clinical preceptors ranged from general, such as a lack of maturity and professionalism, to more
specific behaviors, such as unprofessional dress while at the clinical site, displaying a negative attitude toward different cultures within the patient population, and displaying attitudes not conducive to learning. Another behavior that preceptors identified as a challenge was the difficulty some students had in switching from the RN modality into the nurse practitioner role when interacting with patients. An interesting observation expressed by one preceptor was that the more experience the student had in the registered nurse role, the more difficulty the assimilation was into the nurse practitioner role.

The presentation of inappropriate dress was discussed by preceptors with no correlation to the type of clinical site or age of the student. Some students were attending their clinical rotations with rumpled lab coats, high heeled shoes, and revealing yoga pants that were reported as particularly inappropriate for an adolescent patient population. There is minimal literature specific to negative behaviors displayed by nurse practitioner students. The only citation of support mentioned as a potentially contributing factor, is that nurse practitioner students are now presenting with minimal experience as RNs (Brykczynski, 2012). This might be used as rationale for the behaviors, with the excuse that a decreased amount of time in the professional role has not allowed the development of professional behaviors and dress.

The experience of failing a student resonated with many preceptors, even though they admitted to only singular experiences, well remembered due to the residual effects felt. Reasons for the failures included a lack of motivation and commitment to learning by the student, presentation of unsafe practice and lack of skill in the clinical area, and being “just not right” for the nurse practitioner role. This had to be supported by a display of more objective substandard behaviors, which was reportedly witnessed. Most clinical
preceptors when describing this experience used phrases such as “regretful,” and relayed how much extra time and effort they put into the particular student before making the decision. Literature supported these descriptions and validated the expressed concerns as reasons for failure occurring (Hrobsky & Kersbergen, 2002; Mamchur & Myrick, 2003; Miller, 2009; Paton et al., 2009). Faculty support with the decision was communicated as both positive and negative, with a few preceptors experiencing attacks on their ability to relate to students, professional judgement, and precepting ability from either the students or faculty members. The decision to continue precepting with the involved program was also divided by the reporting preceptors, as the awareness of positive patient outcomes was recognized as primary. This outcome, if compromised by a precepting experience, may ultimately impact patient adherence to treatment, with increased potential for litigation towards the provider (Hayes, 2001).

The final subtheme presented as loss of productivity and increased workload. This finding was shared by most of the preceptors with the prevailing attitude of just doing what needs to be done to manage both tasks. The belief that precepting slows a clinician down is understood by all who practice (Barker & Pittman, 2010; Brooks & Niederhauser, 2010; Bryczynski, 2012; Hawkins & Fontenot, 2009). The clinical preceptors interviewed all expressed this understanding, and recognized they also needed breaks in their schedule with days to catch up and “just practice.” Personal and professional fatigue was a factor presented, with preceptors acknowledging the difficulty in juggling the two jobs and, as one preceptor phrased it, “being on all the time.”

Literature supported this by stating, “Preceptors are at risk for burnout if they accept students too frequently” (Stiffler et. al, 2009, p.628), and also cited loss of productivity as
a major barrier to the role (Brooks & Niederhauser, 2010; Burns et.al, 2006; Van Leuven, 2014).

The last two themes were distinct yet the ideas expressed supporting the concepts were fluid, and impacted the preceptors in ways that were expressed with commonalities reflected in both the personal and professional gains and the acknowledgement received for engaging in the clinical preceptor role. Personal and professional gains were primarily reflected in the interactions with students. Most of the preceptors commented on the excitement and enthusiasm the students brought to the clinical environment and the socialization afforded them with the students and academic faculty. They reflected on how precepting increases their responsibility to keep current with the medical advances in their specialty and how they as preceptors learn from their students, a finding also substantiated within the literature (Barker & Pittman, 2010; Henderson et.al, 2006; Neumann et. al, 2004). This increased knowledge as a result of precepting was reported by almost every clinical preceptor, with the management of technology one of the primary areas of expertise brought by the students. Acknowledgements by the students to the preceptors were remembered as thank you notes accompanied by the occasional gift card or small personal gift. These expressions of appreciation were noted by Campbell and Hawkins (2007), who also presented listings of supports and acknowledgements compiled from the literature. These included access to services and programs such as library privileges, reduced price or complimentary admission to lectures and campus sporting events, invitations to luncheons honoring university preceptors and certificates and letters of appreciation. The preceptors interviewed also spoke of receiving some of these acknowledgements from faculty, but the receipt of this appreciation was not
consistent with the length of time they had spent precepting. One of the suggested acknowledgements from the preceptors was the ability to audit courses at the respective university, also supported by the literature as a positive outcome of the preceptor role (Kertis, 2007; Usher et.al, 1999). Complimentary attendance at professional seminars and cultural events presented by the university was noted to be experienced by a few preceptors and suggested by others.

Students keeping in touch with their preceptors was considered both a personal and professional acknowledgement of the success of the preceptor-student relationship, and some preceptors mentioned they solicited feedback regarding the student’s experience as acknowledgement of their role. One suggested acknowledgement, which was also considered a personal and professional gain, was the consideration of the preceptor having a joint appointment as a clinical faculty member. It was felt this would enhance a professional CV and also procure acknowledgement that the preceptor was considered part of the academic environment. Reflection of the preceptor’s ability through student feedback was supported by the literature as another measure of appreciation; as was the identification of clinical faculty as academic professionals an acknowledgement that was highly regarded (Campbell & Hawkins, 2007; Kertis, 2007; Lyon & Peach, 2001; Van Leuven, 2014).

One relatively new form of acknowledgement that was introduced by many of the clinical preceptors was the increasing potential of monetary compensation for precepting. Although this is a practice that historically was not performed, preceptors were experiencing an increase in nurse practitioner programs offering financial acknowledgement for their services. Unexpectedly, the acceptance of this was mixed,
with some preceptors reacting favorably and others feeling it would have no impact on their desire to precept. Concern was voiced over the possibility of students having to ultimately bear the cost of this payment, with one clinical preceptor voicing the plan that if given money for precepting, she would turn it back to the student to alleviate some of the cost of education. Literature is scant on this finding, with one source citing a study that found that the more preceptors perceived there were benefits associated with the performance of the role, the more the level of commitment increased (Usher et. al, 1999). Another source adds that precepting increases a clinicians value, and should be reflected when merit raises are being considered (Stiffler et. al, 2009).

Personal and professional satisfaction with the role of clinical preceptor, achieved by appreciation from both students and academic faculty for performing the role, was a finding voiced by all the preceptor participants. Yet, none stated they would cease to precept if no acknowledgement was offered. It was just another way of presenting that their belief that precepting is an integral part of their profession and their role in the education of their future colleagues was one they had faith in without reservation.

Limitations

The limitations of this study primarily developed from the methodology used and the demographics of the sample. Limitations consisted of:

- **Demographic area of practice**: the sample presented clinical preceptors who practiced/precepted in Connecticut. This was initially unintentional, but due to the snowball technique of data collection, the sample presented as a homogenous demographic. This study could be expanded through the conscious effort of
recruiting clinical preceptors through professional regional or national organizations.

- Sample demographics: although the age of the clinical preceptors (36 to 72 years, with the mean age being 53.3 years), the years practiced (3-33 years) and precepted (1-26 years), and the variance in specialty credentialing all presented as broad, the entire sample consisted of female clinical preceptors. This could be alleviated by making a conscious effort to include males engaged in the role of clinical preceptor with the potential of exploration of differences in role stressors and satisfactions in relation to sex.

Implications of the Findings for Nursing Practice

The findings of this study have shown there are numerous implications for nursing practice regarding the clinical preceptor role in nurse practitioner education. One of the primary implications is that the role of the nurse practitioner is firmly established and recognized as a vital component in the delivery of healthcare. Due to this recognition and acceptance, there arises the need for an increase in academic programs designed to educate the registered nurse to an advanced practice level. The increase in academic programs establishes the need for an increase in clinical preceptors. Although physicians have been, and still are, utilized as clinical preceptors for nurse practitioner students, it is understood that completion of a successful transition to the nurse practitioner role should consist of the opportunity for the student to experience observational learning and clinical task mastery with a nurse practitioner. The blending of nursing care and medical knowledge is a task specific to the nurse practitioner role. This blending, along with the professional socialization of the role with other health care providers and the elevated
interactions with patients, are all tasks best taught by the nurse practitioner in the clinical environment. This leads to the need for academic faculty to be involved in advanced nursing education to increase their understanding of the challenges of the preceptor role along with the awareness of the clinical site at which their students are being educated.

Another implication arises from the accepted structure of nurse practitioner education. This consists of the combination of didactic learning with the application of this learning to the clinical practice. Exploration of the communication methods between these educators (didactic and clinical) utilized to bridge these two methods can increase the clarification for the student of the rationale behind experiences in the clinical area with specific didactic support using discussion of these experiences in relation to learned medical knowledge. Increase in communication, through the understanding of the knowledge needed by the clinical preceptors regarding the academic courses and the faculty expectations of the clinical experiences, can enable the provision of a greater holistic application of knowledge by the student.

Lastly, the implication for nursing practice regarding the preceptor role is to acknowledge the future of the nurse practitioner profession. In order to develop this role for future NPs, the desire to become a preceptor must be cultivated. Through data collection in this study, it was shown that a primary motivation to become a preceptor was due to the positive role models experienced during the preceptors’ own education. Recollection of the nurturing and guidance afforded them, along with the recognition of the professional competence and compassion their preceptors displayed, all helped foster the desire to “give back” to the profession. Through exploration of how satisfaction in the role can be maintained, along with how challenges can be supported, it is hoped the
implications for positive continuation of the role is increased. This is fostered through the understanding that expert nurse practitioner clinicians must be involved in the education of their future peers. The academic faculty must provide needed support, allowing these preceptors to successfully teach their clinical expertise. However, since several participants noted that they had never been instructed on how to precept, the specific processes of teaching and learning in the clinical setting may become another important focus for academic faculty.

**Recommendations for Further Research**

The following list enumerates several recommendations for future research in the area of the lived experience of nurse practitioners in the role of clinical preceptors:

1. A larger sample utilized in either a mixed method or quantitative study, thus increasing the scope of professional demographics and the quantity of preceptors explored.

2. The expansion of the roles to be explored to include all disciplines of advanced practice nursing. Nurse midwives, nurse anesthetists, and clinical nurse specialists are providers whose education requires the combination of didactic and clinical learning. The exploration of these preceptor roles and the diversity of their clinical practice settings can provide a broader presentation of the satisfactions and challenges of precepting.

3. The lived experience of the student as recipient of the preceptor role, and how variances in the preceptor experience, along with the perceived communication between academic faculty and clinical preceptor, impact the learning process.
4. How the collaboration of health providers within a clinical practice is impacted by member participation in the preceptor role.

5. The exploration of the use of monetary compensation as an impact to the quantity and quality of the clinical preceptors engaged in the role.

6. The exploration of the motivation of non-nurse practitioner academic faculty engaged in nurse practitioner education, to become nurse practitioners as a result of the increased interaction with clinical preceptors.

**Conclusion of the Study**

Nursing as a profession is becoming increasingly multifaceted through the recognition that advanced education can afford members of the profession increased role autonomy and the ability to care for patient populations at a more explicit medical level.

The professional journey to become a nurse practitioner requires a combination of advanced didactic and clinical learning experiences. Both areas are interrelated, and must work in conjunction for the student to obtain and master the explicit level of knowledge required to provide healthcare as a nurse practitioner. Fostering increased communication between the academic and clinical roles and commitment to positive acknowledgement and support of the clinical preceptors, by both academic faculty and the students, all contribute to maintaining the positive partnership that is imperative to this education. The professional recognition that clinical precepting exemplifies one of the most challenging methods of education must always be paramount as nurse practitioner programs increase. This increase in programs is expected to help alleviate the anticipated healthcare provider deficit that has become a major societal concern.
This study focused on the lived experiences of nurse practitioners engaged in the role of clinical preceptor. It was conducted with the hope that it will be of value to academic nursing faculty and clinical preceptors, who through the sharing of their expertise are motivated to develop and support the future of the profession through the students they teach. It is only through the sharing of knowledge that we truly demonstrate that we are professionally vested in the future, and support the purpose of advanced practice nursing.
REFERENCES


Rogers, M.E. (1972). Nursing: to be or not to be. *Nursing Outlook*, 20, 42-46.


APPENDIX A

Institutional Review Board Application

Principal Investigator(s): Christine M. Berté
If the PI is a student, Faculty Supervisor: Dr. Cynthia K. O'Sullivan (SCSU); Dr. Mary Ellen Doherty (WCSU)
Department: Nursing
Project Title: The Lived Experience of the Nurse Practitioner in the Role of the Clinical Preceptor.
Address: 144 Old Hasbrouck Road; Bethel, CT 06801 E-mail: bertec@wcssu.edu Phone number: 203-744-1460

Please check any of the following that apply to this proposal:

A. Proposal is an undergraduate student research project. X
B. Proposal is a graduate (doctoral) student research project.
C. Proposal is WCSU faculty-developed research.
D. Proposal is externally-developed research. *indicate "WCSU " sponsor"

Is the research funded/developed with an external grant?
YES NO

If yes, indicate Funding Agency:

I. Purpose of IRB Review
The role of the WCSU Institutional Review Board (IRB) is to review all proposed research at WCSU or by WCSU faculty, staff or students to ensure that the research meets Federal standards for the safety and protection of any human subjects involved in the research. The WCSU IRB operates in compliance with the U.S. Code of Federal Regulations, Department of Health and Human Services (DHHS) Title 45 Part 46. WCSU’s IRB has registered approval (Federal wide Assurance/FWA) from the Office of Human Research Protections (OHRP). To help the IRB fulfill its role, WCSU requires all researchers to submit their protocol for review and approval. Please refer to the Research Application Guide available at www.wcssu.edu/irb for complete instructions. The WCSU IRB is unlikely to reject an application without first discussing its concerns about the research with the investigator. However, applications may be deferred for review at another meeting if substantial issues are present. Researchers are encouraged to attend the IRB meeting of their review - in order to address any concerns directly. Failure to submit complete materials by the published deadlines will delay review processes.

II. Application for IRB Review Checklist
Before submitting your research application for review by the IRB, please make sure the following steps have been completed.

1. Ensure that everyone involved in the research has completed WCSU IRB human subjects research training requirements. WCSU is part of the Collaborative Institutional Training Initiative (CITI) program, accessible on our website http://www.wcssu.edu/irb.

2. Indicate the category under which you believe your study should be reviewed. (See WCSU IRB Guidelines for Researchers)

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<td>If yes, are you applying for?</td>
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COMMITTEE ACTION

Approved through ______ review
Not approved; clarification/modification required IRB Chair’s Approval ______ Date ______
IRB Application for EXPEDITED or FULL Review
Application for Review of Research Involving Human Subjects

All forms must be typed & completed, signed by all investigators & sponsors, and submitted via Email attachment along with the HUM-1 form.

X Initial Submission
☐ Revised IRB, date of original IRB

1. PRIMARY INVESTIGATOR The proposal must involve a non-visited member of WCSU faculty or staff who will serve as “project supervisor” at WCSU. Include all persons who will be 1) directly responsible for the project’s design or implementation, 2) recruitment, 3) obtain informed consent, 4) involved in data collection, data analysis, or follow-up.

<table>
<thead>
<tr>
<th>Last Name: Bertel</th>
<th>First Name: Christine</th>
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<tbody>
<tr>
<td>Dept. or Unit: Nursing</td>
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<td>E-mail: <a href="mailto:bertec@wcsu.edu">bertec@wcsu.edu</a></td>
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(Mark One) ☐ Faculty ☐ Academic Professional/Staff

ADDITIONAL RESEARCHERS OR SPONSOR (attach additional sheet for more researchers)

<table>
<thead>
<tr>
<th>Last Name: Doherty</th>
<th>First Name: Mary Ellen</th>
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<tr>
<td>Phone: 203-837-3927</td>
<td>E-mail: <a href="mailto:dohertym@wcsu.edu">dohertym@wcsu.edu</a></td>
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(Mark One) ☐ Faculty ☐ Academic Professional/Staff

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<th>Last Name: O'Sullivan</th>
<th>First Name: Cynthia</th>
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<tr>
<td>Phone: 203-392-6486</td>
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(Mark One) ☐ Faculty ☐ Academic Professional/Staff

2. PROJECT TITLE
The Lived Experience of the Nurse Practitioner in the Role of the Clinical Preceptor

3. FUNDING Indicate whether/what this research is funded by, or application has been made for, a grant/contract/grant.
N/A

4. RESEARCH SUMMARY: Please summarize, in lay language, the objectives and significance of the research.
The purpose of this study is to identify perceived stressors in the clinical preceptor role in advanced practice education, and to identify methods of support that can be used by academic nursing faculty to promote and maintain professional satisfaction in this preceptor role.

The significance: Advanced practice (nurse practitioner) programs are increasing due to the societal demand of providing medical care for all populations. Preceptors are the vital link for the student to apply theoretical knowledge to the clinical site, and learn the techniques required for diagnosis and treatment of the patient. Clinical preceptors are under a great deal of strain to “give back to the profession” by precepting, yet maintain their professional responsibilities within their practice. As a result many preceptors do not continue a relationship with a university program, thus reducing the quantity of available nurse practitioners to precept the ever increasing amount of students. If methods of support can be identified through this research, and ultimately be provided by academic nursing faculty, the challenges that decrease the satisfaction of the role, and ultimately reduce the amount of available participants, can be identified, and hopefully reduced / relieved, thus maintaining the nurse practitioner in the role with the attainment of professional satisfaction.

IRB Review Form (EXPEDITED & FULL reviews) 03/2014
5. Performance Sites: Including WCSU sites, describe ALL the research sites for this protocol. For each non-WCSU site, describe:

Whether the site has an IRB & your stage in the process of seeking that approval, whether the site has granted permission for this research to be conducted; Contact info for the site; and attach any relevant supporting materials.

The performance sites will be individual meeting places agreed upon by the preceptor and researcher for the interview that will be the main source of data collection for this qualitative study. WCSU will not be used as a site, as the interviewer (researcher) will be going to the participant's (preceptor's) choice of meeting place. These places are expected to be in any setting the participant (preceptor) feels comfortable and is deemed appropriate by the researcher.

6. Participants & Recruitment: Describe who will participate in the research, how many people, and how they will be recruited. Indicate any special or vulnerable classes/populations included in the design. Describe solicitation via advertising (e.g., posters, flyers, and internet), face-to-face interactions, phone, classrooms, registries, referrals, etc. Attach any recruitment/solicitation materials to be used.

There are expected to be approximately 15-20 nurse practitioners from the states of Connecticut or New York which will be contacted through an informational letter, inviting them to participate in the study. The purposive sample will primarily be a snowball sample through professional networking from the initial recipients of the letter, these initial nurse practitioners will be obtained from the researchers' professional network.

6A. Protected Health Information (PHI) The IRB must address the privacy and use of health information that is created, received, or housed by health care providers, health plans, or health care clearinghouses and that identifies or could be used to identify an individual. During either recruiting or data collection, will you use or have access to such information that is related to the past, present or future health or conditions of a living or deceased individual, provision of health care to the individual, or the payment for the provision of health care to the individual?

☐ Yes ☐ No

7. Research Procedures: Using LAYMAN'S LANGUAGE, specifically describe what the participants (treatment groups and controls) will do and where the research activities will take place. Give approximate dates and durations for specific activities, including the total number of treatments, visits, or meetings required and the total time commitment. Address if: any of the researchers are associated with the subjects (e.g., students, employees, patients); include a copy of each of your measures as attachments.

For schools-based research where class time is used, describe in detail the activities planned for nonparticipants and explain where (e.g., in a classroom, in a private area) both participants and nonparticipants will be located during the research activities, and a rationale/method for assuring students who choose to not participate will not be affected in their course standing. Include a concise description of procedures, locations, time commitments, and alternate activities on the relevant consent and assent (for minors) forms.

Individual interviews will be conducted between the researcher and the clinical preceptor in a mutually agreed upon site of the preceptor's choosing that will afford the ability to converse in a confidential manner.

The expected time period for interviews will be in the Spring 2015, with completion expected within a two month time period. The expected interview time will be 1-2 hours. There will be one interview per preceptor and no nonparticipants will be in the area of the interview.

There are no minors, medical patients, students or any other dependent participants in this study.

7. Data Collection: Explain how the data will be collected. Please explain how confidentiality will be maintained during and after data collection. If applicable, address confidentiality of data collected via e-mail, web interfaces, computer servers and other networked information. If anonymous data collection is proposed, provide details of how investigators will not have the ability to trace responses to subject identities. For multiphase data collection or if multiple contacts will be made with subjects, specifically explain the subject tracking and coding systems. Identify if (what) any inducements or rewards will be offered.
Data will be collected through an audio recorder on an individual interview basis. Confidentiality will be maintained during the data collection by having the interview take place in a site that is agreeable to the preceptor being interviewed. Investigators will not have the ability to trace responses as the interviews will be transcribed, then coded, so the review and reading of all transcriptions will be without any identifying information.

8. CONSENT PROCESS: University policy requires the execution of a comprehensive, written document that is signed by the subject (or the subject’s authorized representative) as the principal method for obtaining consent from subjects. The language in the document must be understandable to the subject or the subject’s legally authorized representative. Children must assent (or, voluntarily agree) to participation and a parent must separately consent on behalf of their child (i.e., two different forms are generally required). Children under age 8 may assent either orally or passively, depending on their level of maturity. Children 8-17 years old should sign a written form unless the WCSU IRB approves a different process. Describe steps taken to minimize the possibility of coercion or undue influence. Indicate the language used by those obtaining consent. Indicate the language understood by the prospective subject or the legally authorized representative. Describe when/where consent will be obtained, how often, and by/into whom. Attach all consent/assent forms.

The language of the consent documentation will be in English, as all preceptors that will be interviewed (sample) will be fluent in English as is the researcher conducting the interviews.

There will be no minors, patients or any other demographic that will require assent, with permission given by a responsible person for them.

Steps to prevent coercion or undue influence will be the recording of the interview, which will consist of open ended questions that will be presented by the researcher in an unbiased voice, with no phrases leading to framed responses.

A written document will be provided at the onset of the interview outlining the freedom to respond without any fear of retribution and the additional freedom to end the interview at any time.

9. RISKS: Specifically describe all known risks to the subjects for the activities proposed and describe the steps that will be taken to minimize the risks. Include any risks to the subject’s physical well-being, privacy, dignity, self-respect, psycho, emotions, reputation, employability, and criminal and legal status. Risks must be described on consent forms.

Interviews will be conducted at a site of choice by the advanced practice preceptor being interviewed, thus alleviating the risk of retribution by his/her professional practice site if there are elements of the interview that are complainant.

Privacy, dignity and self-respect of the preceptor will be maintained by only using professional language and allowing refusal of any question(s) during the interview. The interview can be halted by the preceptor being interviewed at any time if necessary.
### 10. BENEFITS:
Describe the expected benefits of the research to the subjects and/or to society.

The expected benefits of the research are:
- Recognition and support of the clinical preceptor role in advanced practice education, thus increasing the number of preceptors and also the longevity of their service in the role.
- Education of the academic nursing faculty regarding identified support methods that can be used to support clinical preceptors.
- An increase in understanding of both the academic role and the clinical preceptor role by each other so there will be continuity in the education afforded the nurse practitioner student.
- The ultimate increase in quality and satisfaction of the students receiving this education as a result of the support and recognition of the clinical preceptor role.

### 11. RISK/BENEFIT ASSESSMENT:
Weigh the risks with regard to the benefits. Provide evidence that benefits outweigh risks.

There are minimal risks to the preceptor, with the only perceived or being the fear of retribution if he/she is negative about her role within the clinical practice. This will be alleviated by affording confidentiality at the interview and assuring all transcripts will be confidential, as there will be coding done before the data is analyzed.

### 12. RESULTS DISSEMINATION:
Detail proposed form(s) of dissemination (e.g., journal, thesis, academic papers/presentations, industry/profession, etc.).

Proposed initial form of dissemination of information will be an academic dissertation, with potential for future professional articles in nursing/academic journals.

### 13. INDIVIDUAL INFO:
Will any individually identifiable information, including images, be published/shared/otherwise disseminated?

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If yes, participants must provide explicit consent or assent for such dissemination. Provide appropriate options on the relevant consent/assent documents.

### 11. INVESTIGATOR ASSURANCES:
The signature of the Responsible Project Investigator is required (scanned or signatures are acceptable). Other investigators are also responsible for these assurances and are encouraged to sign.

- I certify that the information provided in this application, and in all attachments, is complete and correct.
- I understand that I have ultimate responsibility for the protection of the rights and welfare of human subjects, the conduct of this study, and the ethical performance of this project.
- I agree to comply with all WCSU policies and procedures, the terms of its Federal Wide Assurance, and all applicable federal, state, and local laws regarding the protection of human subjects in research.

I certify that

- The project will be performed by qualified personnel according to the WCSU IRB-approved protocol.
- The equipment, facilities, and procedures to be used in this research meet recognized standards for safety.
- No change will be made to the human subjects protocol or consent form(s) until approved by the WCSU IRB.

IRB Review Form (Parent flowering & Full membership) 07/2014

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- Legally effective informed consent or assent will be obtained from human subjects as required.
- Unanticipated problems, adverse events, and new information that may affect the risk-benefit assessment for this research will be reported to the WCSU IRB Office (203-837-8476; irb@wcsu.edu).
- Student and guest investigators on this project are knowledgeable about the regulations and policies governing this research.
- I agree to meet with the investigator(s), if different from myself, on a regular basis to monitor study progress.
- If I am unavailable, as when on sabbatical or other leave, including vacation, I will arrange for an alternate faculty sponsor to assume responsibility during my absence. I will advise the WCSU IRB by email of such arrangements.

I further certify that the proposed research has not yet been done, is not currently underway, and will not begin until IRB approval has been obtained.

Christine [Signature] 2/26/15
Primary Investigator (or Faculty Sponsor, if student project)

Mary [Signature] 2/26/15
Faculty Sponsor
APPENDIX B

Institutional Review Board Approval E-mail

From: Carol O'Connor
Sent: Friday, February 27, 2015 2:26 PM
To: Christine Bertie
Cc: WCSU IRB; Mary Ellen Doherty
Subject: I.R.B. approval

Hello Christina Bertie,

I am pleased to inform you that your I.R.B. protocol number 1415-111 has been approved by expedited review. This email is documentation of your official approval to start your research. If you need a copy of this official approval for funding purposes, please let me know occonner@wrsu.edu. The WCSU I.R.B. wishes you the best with your research.

You have 1 year from the date of this email to complete your research; if you are still conducting that date, you will need to fill out a renewal application. When are you finished with your study please fill out and return via email a Termination/Completion Report (available here: [http://wrsu.edu/irb/forms.asp](http://wrsu.edu/irb/forms.asp)) so we know your study is complete.

Finally – and most importantly! – we have recently learned that current BOR technology policies do not guarantee privacy of any info stored on work computers physically, remotely, or otherwise (i.e., laptop, Dropbox, etc.). As such, to maintain the truth of any anonymity or confidentiality promises you make to participants (consent form, for example), you will need to store all electronic data obtained from those human subjects on a system/computer/file not connected to any CSU system. It is your responsibility as the primary researcher to make sure personal data of participants remains securely private – something not guaranteed in the currently existing CSU system. Rest assured, because it’s ridiculous to expect faculty to store work-related research on non-work-related systems and/or to conduct research where participants are not guaranteed anonymity/confidentiality, we are working to gain an exception for research purposes to this policy. But until then, it’s technically and legally possible for anyone in the system office to access your participants’ data at any time – without your consent or knowledge before doing so... which makes any guarantees made on research documents (e.g., consent forms) deceptive unless info is stored elsewhere.

Thanks,
Jessica Eckstein, Ph.D.
Chair, Institutional Review Board

Carol O’Connor
Psychology/Philosophy Department Secretary
C.E.L.T
I.A.C.U.C.
APPENDIX C

National Institute of Health (NIH) Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that Christine Berte successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 04/14/2014
Certification Number: 1449885
APPENDIX D

Initial Recruitment Letter

114 Old Hawleyville Road
Bethel, Connecticut 06801

Dear Colleague,

I am a Family Nurse Practitioner and member of the Nursing faculty at Western Connecticut State University working toward an EdD in Nursing Education. My research involves the exploration of challenges in the clinical preceptor role in nurse practitioner education, and how academic faculty can provide support to promote and maintain satisfaction in this role.

I am looking for nurse practitioners in practice that have precepted students for at least two years (or a total of 4 semesters, not necessarily in sequence). The data collection will consist of individual, confidential interviews conducted at a time and place agreeable to the nurse practitioner preceptor. A brief consent form allowing the interview to be recorded and used for this research will be presented at the time of the interview, giving the nurse practitioner an opportunity to address any concerns before the interview.

As a nurse practitioner experienced in both precepting and academic practice, I think this research will allow other preceptors to have a voice regarding their experiences in the role, and enable us, as a profession, to positively present the methods needed to reduce stress and increase satisfaction in this very important role within advanced practice education.

If you are interested in being a part of this study, or have any questions, please contact me at cberte@snet.net. I look forward to working with you, and thank you for your consideration.

Sincerely,

Christine M. Berté APRN-BC, CPN
APPENDIX E

Nurse Practitioner Preceptor Demographic Profile

This demographic profile will be used to aid in the analysis of data in relation to the categories listed below. It will, in no way, be used for the identification of the interviewer and will remain with the coded taped interview in a locked confidential storage area within the researcher’s office.

- Gender: M  F
- Age: ________.
- Highest academic degree attained: ____________________________.
- Specialty accreditation (ANP, FNP etc.): ________________________.
- Accrediting organization: ________________________.
- Number of years as a nurse practitioner: ________.
- Type of practice (private, clinic, community setting, etc.): ________
  ____________________________________________________________.
- Number of years in the current practice: ________.
- Number of years as a clinical preceptor in a Nurse Practitioner program:
  ________.
- Academic level of nurse practitioner programs experienced as a preceptor
  (MSN, DNP etc.):
  ____________________________________________________________.

Participant Code: ____________.

Date: ______________________.
APPENDIX F

Consent Form

Title of Study: The Lived Experience of the Nurse Practitioner in the Role of Clinical Preceptor

I have been asked to participate in a study of the lived experience of the nurse practitioner in the role of clinical preceptor. The purpose of this study is to identify and describe the experiences of the nurse practitioner when engaged in the role of clinical preceptor.

This study is being conducted by Christine M. Berté APRN-BC, CPN, as partial fulfillment of the requirements for the EdD in Nursing Education at Western Connecticut State University. She will be the sole interviewer and has explained that the interview will be confidential and occur in a setting that is agreeable to me, where I can be forthcoming with information without any fear of retribution. The recorded interview, which is expected to take approximately 60-90 minutes, and subsequent transcription of the interview will be coded and kept secure in a locked area in the researcher’s professional office.

I understand that my participation is voluntary and I may stop the interview or withdraw from the study at any time. Whether I choose to participate at all or decide not to continue the interview at any point will not be discussed with anyone except the researcher and all record of the interview will be destroyed. I also am aware that the interview will be conducted in English, and I have the ability to understand, converse, read and write in this language.

I understand that a signed statement of informed consent is required of all participants in the study and my signature indicates I voluntarily agree to the conditions of participation. I have received a copy of this form and have had all my questions or concerns addressed in a satisfactory manner.
And so………..

Live as if you liked yourself, and it may happen:

Reach out, keep reaching out, keep bringing in.

This is how we are going to live for a long time: not always, for every gardener knows that after the digging, after the planting, after the long season of tending and growth, the harvest comes.

Marge Piercy

The Seven of Pentacles