EXPLORING THE EXPERIENCES OF NOVICE SESSIONAL CLINICAL NURSING INSTRUCTORS

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DEDICATION

To my parents, who always encouraged me to advance my education, for their hard work to provide me and my sister with a comfortable life and, at the same time, taught us the importance of hard work and demonstrated a positive work ethic.

To my husband, for his encouragement, love, and support and for taking on extra "duties" when I was glued to my computer.

To my daughters, Jill and Heidi, so that I too can be a positive role model and demonstrate the benefits of hard work and a positive work ethic. For their patience during my "busy times" and the hugs when I was consumed with frustration.

ABSTRACT

The purpose of this qualitative descriptive study was to explore and describe the experiences of novice sessional clinical nursing instructors. Ethical approval was obtained from the appropriate ethics review boards. Sampling consisted of nine novice instructors from three educational institutions in Southern Alberta. Data were analyzed using thematic analysis. The identified themes, which outline the experiences of the participants, include professional responsibility, preparation, support, seeking mentors, familiarity, and growth. The resultant findings indicate that the current trend of hastily hiring sessional instructors can result in novice instructors facing many challenges when entering academia. As a result of the findings in this study, formal recommendations were developed that would assist the novice sessional in understanding and performing more effectively in the role of clinical nursing instructor.

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CHAPTER ONE: INTRODUCTION

Canada graduates too few nurses to meet the current and future health care needs

of Canadians (Canadian Nurses Association [CNA] and Canadian Association of Schools

of Nursing [CASN], 2008; "Nursing Graduate Shortfall," 2008, p. 13). CNA and CASN

reported alarming statistics related to the nursing shortage and consequent faculty

shortages. Schools need to graduate 2,500 more registered nurses (RNs) annually to meet

the future demands of Canada's health care system (CNA & CASN, 2008; "Nursing

Graduate Shortfall," 2008). Estimates based on current national trends project a shortage

of 60,000 full-time equivalent RNs by the year 2022 (CNA, n.d., p. 2). One solution to

address this projected shortage is to increase enrolment in undergraduate nursing

programs by 1,000 students per year (p. 3). Consequently, nursing schools have increased

enrollment into nursing programs, which has assisted in decreasing the current nursing

shortage, but the issue of the nursing faculty shortage remains. Between 2000 and 2012,

there was a steady increase of nursing school enrollments, with a 7.8% increase in

enrollments between 2011 and 2012 (CNA & CASN, 2013, p. 6). Although there was a

significant increase in enrollments, there was only a 0.1% increase of nurse educators

between 2007 and 2011 (CNA, 2013, p. 7), with only 3.9% of the nursing workforce

composed of nursing educators (p. 9).

The current shortage of nursing faculty is worldwide, and it exists for several

reasons. In addition to the general shortage of nurses, there is a shortage of doctoral- and

master's-prepared nurses. From 2007 to 2011, the number of master's-prepared nurses

rose from 2.5% to 3.6%, while the number of doctorally prepared nurses remained the

same at 0.2% (CNA, 2013, p. 6). Other contributors to the shortage of nurse educators

include aging faculty and decreases to institutional funding that result in salaries that are non-competitive when compared with those in the practice setting (Brendtro & Hegge, 2000; DeYoung, Bliss, & Tracy, 2002; Shipman & Hooten, 2008).

Although statistics regarding sessional instructors are not available, CNA and CASN (2013) reported that in the 2011–2012 academic year Canadian universities employed 8,192 faculty members (p. 15). Thirty-one percent of these held permanent positions, 19.4% held full-time contracts for one academic year or longer, and 49.6% were employed on a part-time contract basis, meaning less than one academic year (p. 16). With respect to age, 58.4% of faculty were over 50, and 40.4% of permanent faculty were at least 55 years old, with 18.8% being over 60 years of age (p. 16). Faculty in the 55-and-over age category for 2012 comprised 40.4% of permanent faculty, which was 18.0% higher than the same age category in the general RN workforce for 2012. In 2012, 68 permanent faculty members retired, while another 18.8% were eligible to retire (p. 16). Furthermore, schools were unable to fill vacancies, which resulted in a 3.1% vacancy rate. Based on these statistics, CNA and CASN (2013) projected that schools would have needed to hire 217 full-time faculty members in 2013 to manage the number of entry-to-practice nursing students enrolled in nursing programs and to fill faculty vacancies (p. 17). As a consequence of the nursing faculty shortage, nursing program administrators worldwide have been filling the faculty gaps in undergraduate nursing programs with sessional instructors (Halcomb, Andrew, Peters, Salamonson, & Jackson, 2010).

Since 2013, government funding to post-secondary institutions has been dramatically reduced and has resulted in a decrease in student enrollments in nursing schools in the province of Alberta, where this study took place. According to a Program

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Specialist for the undergraduate nursing program at the University of Lethbridge, a decrease in student enrollment is evident with enrollment numbers decreasing from 192 students in the 2012/2013 academic year to 111 students in the 2015/2016 academic year (Program Specialist, personal communication, February 22, 2016). That being said, the practice of hiring sessional instructors to fill clinical instruction needs continues within these nursing programs.

With the documented need for nurses and consequent need for nurse educators, institutions are unable to keep up with recruiting and retaining full-time faculty. As sessional instructors are utilized more frequently, understanding their experiences could shed light on their needs to provide the best learning environment for the student, while at the same time providing a positive experience for the instructor. It was with these aims in mind that this study was undertaken. Terminology used in this report is presented in Table 1.

Table 1. *Definition of Terms*

Term	Definition
Clinical education	"The place where the theoretical begins to make sense, and a great deal of integration of theoretical with practice knowledge becomes possible as students search out explanations for the phenomena they are witnessing in the clinical situations to which they are exposed" (O'Connor, 2006, p. 2).
Experienced	"Having gained knowledge or skill in a particular field [especially a profession or job] gained over a period of time" ("Experienced," 2014, para. 1)
Expert	"A person who is very knowledgeable about or skilful in a particular area" ("Expert," 2014, para. 1).
Expertise	"The knowledge or skill of an expert" ("Expertise," 2014, para. 6).
Novice	Someone having "had no experience of the situations in which they are expected to perform" (Benner, 2001, p. 20). They are required to follow rules to guide their performance (Benner,

2001).

Sessional instructors	"A member of the academic staff appointed by the dean to teach no more than one semester course in a designated semester" (University of Lethbridge Faculty Association, 2013, p. 8). The term *sessional* means an instructor who does not hold a continuing or tenured position and is paid on the basis of hours taught (Halcomb et al., 2010, p. 528).

Background

Clinical learning and the clinical learning environment remain the most important aspects in the development of knowledgeable and capable nurses (Dickson, Walker, & Bourgeois, 2006; Kelly, 2006; Ousey, 2000). Clinical practice allows students to link and apply theory learned in the classroom to real-world settings (Cederbaum & Klusaritz, 2009; Lambert & Glacken, 2005; Ousey, 2000). "Nursing knowledge, arising from practice, should shape our theories, and theories, reciprocally, should direct our practice. Theory, knowledge, and practice should fit together naturally" (Barnum, 1998, p. 45). In other words, "clinical practice is where nursing knowledge is grounded" (Ousey, 2000, p. 116). Practice and theory should go hand in hand, one being just as important as the other. Nursing theories must be applied in practice to link foundational knowledge with practice (Ousey, 2000). Further, exposure to the reality of professional practice and its integration of specific with tacit knowledge is instrumental in producing skilled clinicians and competent nurses (Dickson et al., 2006). Due to the importance of clinical education, nursing students spend approximately half of their time in the clinical setting (Brown, White, & Leibbrandt, 2006).

The clinical instructor is pivotal in guiding, supporting, and facilitating learning in the clinical setting (Brown et al., 2006). The clinical instructor facilitates practical

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knowledge based on student needs and plans clinical experiences that reinforce the content of the theoretical courses (Cassimjee & Bhengu, 2006). Consequently, clinical instructors should be knowledgeable in their area of clinical practice to support and facilitate the student's ability to bridge the theory-to-practice gap (Lambert & Glacken, 2005), and they should have additional education in teaching and knowledge of curriculum to bridge the theory-to-practice gap (Cawley Baird, Bopp, Kruckenberg Schofer, Langenberg, & Matheis-Kraft, 1994).

Clinical instruction is a vital part of nursing education. The various factors that have contributed to the nursing shortage have also contributed to the nursing faculty shortage. This, in turn, has forced educational institutions to rely on the RN whose practice is in the clinical setting to take on the role of clinical nursing instructor in the post-secondary setting. Though RNs may be expert clinicians, this expertise may not extend to their abilities as educators. Many nurses enter academia because of their clinical skills and knowledge, and they expect that their expertise in the clinical setting will make them good clinical educators (Cangelosi, Crocker, & Sorrell, 2009). However, nurse clinicians must learn how to operationalize the nurse educator role, how to teach in the clinical setting, as well as how to function in the university setting (McDonald, 2010). They must be competent teachers as well as practitioners (Little & Milliken, 2007). Because of the limited exploration of this topic, there is minimal information to enable educational institutions to understand the needs of novice sessional clinical instructors and to provide the support they require for success in this role.

Purpose and Significance of the Study

As the shortage of qualified faculty continues, educational institutions are more regularly utilizing sessional instructors to implement their curricula (Andrew, Halcomb, Jackson, Peters, & Salamonson, 2010; Hewitt & Lewallen, 2010; Little & Milliken, 2007; Robinson, 2009). Recruitment and retention of qualified and effective instructors parallel the need for the recruitment and retention of nursing faculty in general. The shortage of support, guidance, and knowledge of the educational system in which they are employed leaves novice instructors susceptible to burnout, resulting in poor retention (Dunham-Taylor, Lynn, Moore, McDaniel, & Walker, 2008; Hessler & Ritchie, 2006). Due to the increased need for and use of sessional instructors, understanding the experiences of these instructors will assist in developing programs to support them in providing the best learning environment and experience for their students during this pivotal period of education.

The purpose of this study was to explore the experiences of RNs in their role of novice sessional clinical nursing instructors and, in turn, to gain an understanding of their needs to better support them. This improved support would, in turn, help novice sessional clinical instructors provide a better learning experience for their students. Better initial support may also lead to greater sessional retention, which would ultimately lead to more experienced and, therefore, more skilled clinical instructors. The information gathered in this study sheds some light on their struggles and triumphs and, in the end, allows for a greater understanding of their needs as novices.

Research Question

The following research question was used to guide this study: What are the experiences of registered nurses who teach nursing students in the clinical setting as novice sessional clinical nursing instructors?

Chapter Summary

With the documented nurse shortage and subsequent nursing faculty shortage, educational institutions are relying more heavily on sessional instructors who are being hired to fill this gap. Although these educators are typically expert clinicians, this expertise may not transcend to teaching expertise. The importance of clinical instruction in nursing demands that educational institutions strive to provide students with clinical education by skilled clinicians as well as skilled teachers. Further investigation into the experiences of novice sessional clinical nursing instructors will increase the understanding of these educators and their needs, ensuring they are prepared and able to function in the clinical setting.

CHAPTER TWO: LITERATURE REVIEW

Although research in regards to sessional teaching has increased, it has not been restricted to sessional teaching in the clinical setting. The body of literature on sessional teaching has focused mainly on classroom teaching and marking by sessional teachers and not clinical instruction by sessional instructors. Literature was found that described the experiences of clinicians entering academia as novices, in a part-time or full-time capacity, but this was not specific to sessional instructors. Though starting in academia in a part-time or full-time capacity may parallel the experiences of those starting in a sessional capacity, both groups often face different challenges. It is important to differentiate between tenured and sessional staff; combining these two distinct groups can disguise the important issues that sessional clinical instructors encounter (Halcomb et al., 2010).

Literature specific to sessional nursing instructors included literature describing sessional teachers' perceptions of their contributions to nursing programs in the classroom setting, issues with evaluating students in the clinical setting, and marking by sessional staff. Andrew et al. (2010), focused on sessional nursing teachers' perceptions of their contributions to a nursing program within one Australian university. This study, however, was not restricted to novices and explored classroom teaching and not clinical instruction. Duke (1996) focused on issues encountered by sessional clinical nursing instructors, particularly issues with student evaluation. No literature was found that specifically explored the experiences of sessional clinical nursing instructors as novices. The literature discussed herein encompasses issues related to the clinician's transitioning to educator as a permanent faculty member, issues related to the casualization of the

nursing workforce, characteristics of sessional instructors in nursing, and issues and beliefs specific to sessional instructors.

Transitioning from Expert Clinician to Novice Educator

Clinicians face struggles when making the transition to novice educator in an academic institution, both in the classroom and the clinical setting. Feelings, professional relationships, socialization, and culture issues have all been identified as factors affecting the clinician-to-educator transition (Anderson, 2009; Anibas, Brenner, & Zorn, 2009; Cangelosi et al., 2009; Dempsey, 2007; Diekelmann, 2004; Hessler & Ritchie, 2006; Kelly, 2006; McArthur-Rouse, 2008; McDonald, 2010; Schriner, 2007; Siler & Kleiner, 2001). Many educators feel they receive inadequate preparation for their new positions and experience a great deal of anxiety related to their performance as educators (Siler & Kleiner, 2001; Roberts, Chrisman, & Flowers, 2013). A lack of confidence in their teaching abilities is a factor that hinders development in the transition from expert clinician to novice educator (Dempsey, 2007; Hinchcliffe Duphily, 2011). This is a concern, as "a great deal of the success of clinical education rests on the shoulders of clinical educators, their own abilities and personal attributes, and the preparation and support they receive" (Higgs & McAllister, 2005, p. 156).

The expectations and culture within educational institutions differ from those in clinical-based settings. Values that guide behaviour in clinical practice are intrinsic to the nursing profession and are different from the values important for success as a faculty member (Schriner, 2007; Siler & Kleiner, 2001). This divergence of values causes many educators to feel insufficiently prepared for their new position and a great deal of anxiety related to their performance (Schriner, 2007; Siler & Kleiner, 2001). Recommendations

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for improvement have been identified that would aid novice instructors in adapting to and excelling in their new role in a new environment with differing values. These recommendations include mentorship, orientation sessions, and training in curriculum as well as theoretical underpinnings of the institution, objectives, and policies (Anibas et al., 2009; Cangelosi et al., 2009; Duffy, Stuart, & Smith, 2008; Hessler & Ritchie, 2006; McArthur-Rouse, 2008; McDonald, 2010; Roberts et al., 2013).

Clinicians have described their transition from clinician to educator using a "sink or swim" or "deer in the headlights" metaphor, whereby clinicians feel unsupported, alone and overwhelmed in their new role (Anderson, 2008; Roberts et al., 2013). Support for these sessional staff members is often less than ideal (Anderson, 2008; Joiner & Bakalis, 2006; Kimber, 2003). Not being educationally prepared for a teaching role results in novice educators doubting their ability as educators, which can lead to lowered self-confidence in their role as teacher (Schriner, 2007). Educational institutions have placed little emphasis on preparing educators for the teaching role (Anderson, 2009; Beres, 2006; Dunphy Suplee & Gardner, 2009; Tanner, 2005), which has contributed to the casualization of teaching in higher education.

Casualization of the Nursing Workforce

Casualization is defined by the *Oxford English Dictionary* as "the transformation of a workplace from one employed chiefly on permanent contracts to one engaged on a short-term temporary basis" ("Casualization," 2014, para. 1). The casualization of teaching in higher education has been a phenomenon since the mid-1990s (DeYoung et al., 2002; Junor, 2004), and its occurrence is worldwide (Bauder, 2006; Brendtro & Hegge, 2000; Herbert, Hannam, & Chalmers, 2002).

Limited resources at the institution level and the urgent need for clinical faculty have resulted in clinical educators being hired with varying levels of teaching experience (Duke, 1996). Despite the importance of clinical education, educational institutions are relying more on the general nursing workforce to teach their clinical programs as sessional instructors (Andrew et al., 2010; Duffy et al., 2008; Halcomb et al., 2010; Little & Milliken, 2007; Robinson, 2009). In Australia and the United States, nearly half of all teaching-related duties in higher education are carried out by sessional instructors. This estimate, however, encompasses everything from hands-on teaching to course development to marking (Andrew et al., 2010; Brendtro & Hegge, 2000; Knott, Crane, Heslop, & Glass, 2015).

The nature of nursing education is that it is a practice-based educational program. This education encompasses clinical practice, laboratory simulation, and theoretical components (Halcomb et al., 2010). Although nursing is a practice discipline, the transition from primarily hospital-based nursing programs to a degree-based education has transformed nursing into an academic discipline (McKenna & Wellard, 2004). Consequently, this transition has placed a strain on the education workforce as more faculty members are needed to teach and develop the different components of the baccalaureate curriculum (Shipman & Hooten, 2008). Nursing education's main components are no longer limited to some core courses and clinical time, but now encompass a multitude of components, such as laboratory time, core nursing courses, clinical courses, as well as course work related to obtaining a baccalaureate degree. The majority of such courses are taught by nursing faculty (Halcomb et al., 2010; McKenna & Wellard, 2004; Shipman & Hooten, 2008).

The move to degree-based educational programs has also created the need for nurse educators to expand their roles to encompass research, scholarship, and community service along with their teaching duties. The demands associated with the academic role have thus resulted in time constraints upon educators, creating the need for clinical instructors to take on the practical portion of students' education (McKenna & Wellard, 2004). Along with this increased need for nurses, as reflected in the increased enrolment in nursing programs, educational institutions have hired greater numbers of sessional clinical instructors to alleviate the burden felt by regular faculty and to fill in the gap that the nursing shortage has created (Halcomb et al., 2010). Casualization of the clinical instructor workforce has alleviated the stress on regular faculty. However, it has also created a situation in which clinical practice in nursing education is being taught by skilled clinicians who are inexperienced teachers (Dempsey, 2007; Duke, 1996; Peters, Jackson, Andrew, Halcomb, & Salamonson, 2011; Porter Lewallen, 2002; Siler & Kleiner, 2001). This situation has contributed to the emergence of a two-tiered academic workforce. The first tier consists of the tenured core with job security, good working conditions, and higher pay, and the second tier consists of casual and part-time staff with no job security and less-than-ideal working conditions (Kimber, 2003).

Sessional Clinical Nursing Instructors

Although limited literature exists on the experiences of novice sessional clinical nursing instructors, some authors identified issues related to sessional educators in general. Literature included (a) characteristics of sessional educators, (b) clinical expertise versus teaching effectiveness, (c) preparation of the sessional instructor, (d) issues with student evaluation, and (e) sessional teacher's perceptions of self.

Characteristics of Sessional Educators

Sessional academics can be placed into four main descriptive categories (Gappa & Leslie, 1993). The first category is the *aspiring academic*. These are academics who have recently completed a higher education program. They build their academic careers by taking on numerous part-time assignments in the hopes of being hired on full-time (Gappa & Leslie, 1993, p. 48). The second category is the *expert*. These are RNs who maintain employment in nursing while teaching nursing and teach for "the love of it", not because of a need for additional income (Gappa & Leslie, p. 48). The third category is the *career ender*. Typically, these are nurses who are retired and want to continue working on a part time basis and those who are near retirement but want to continue working and gradually move towards retirement (Gappa & Leslie, p. 47). Finally, the *freelancer* takes on a variety of part-time or sessional positions to support him/herself and maintains a work-family balance (Gappa & Leslie, p. 49).

Clinical Expertise versus Teaching Effectiveness

Educational institutions are relying more heavily on the casual or sessional workforce to provide clinical instruction, but clinical expertise is not equivalent to teaching effectiveness (Duffy et al., 2008; Halcomb et al., 2010). Clinical education and clinical practice encompass different bodies of knowledge (Duffy et al., 2008; Halcomb et al., 2010). Sessional clinical instructors concentrate on the *real world* of nursing, focusing on and valuing experiential over theoretical knowledge, viewing university learning as the "fantasy world" (Andrew et al., 2010, p. 455). Sessional clinical instructors often criticize the curriculum content as being too theoretical and irrelevant for contemporary nursing practice. These points of view are in direct contrast to

university learning, which focuses on and emphasizes the theoretical aspects of nursing practice (Andrew et al., 2010).

Sessional clinical instructors frequently do not have the education, expertise, or skills to take on the teaching role, despite the fact that they are most often experts in their area of clinical work and often simultaneously engage in teaching and clinical practice (Duffy et al., 2008; Halcomb et al., 2010). They are often hired hastily on a semester-to-semester basis due to an urgent need to find instructors to teach a clinical course, have limited educational qualifications to teach, and often lack teaching skills and knowledge of teaching strategies (Peters et al., 2011).

Preparation of the Sessional Instructor

Issues related to understanding students' learning needs develop from a deficiency of knowledge of the theoretical underpinnings, formal learning objectives, and program curriculum. Appropriate resources are frequently not available to sessional instructors, and so they often struggle to bridge the theory-to-practice gap (Allison-Jones & Hirt, 2004; de Sales, 1996; Diekelmann, 2004; Little & Milliken, 2007; McKenna & Wellard, 2004; Schriner, 2007). There is a general shortage of appropriate documentation of student progress, which can result in failures being overturned as well as reluctance to fail students for marginal performance (Halcomb et al., 2010). These issues create difficulties for permanent educators who work to develop strategies to manage issues within the programs (Duffy et al., 2008; Halcomb et al., 2010). It can be assumed that these issues, at least to some extent, are a result of the sessional clinical instructor's minimal orientation to and knowledge of the documentation and evaluation process. They

may also lack knowledge of the program expectations related to student performance based on learning objectives and the curriculum.

These issues echo the struggles encountered by nursing preceptors, who, like sessional clinical instructors, often take on the role of instructor but lack the teaching background necessary for a preceptor role, especially in the area of evaluation of student performance (LeGris & Coté, 1997; Luhanga, Dickieson, & Mossey, 2010; Luhanga, Yonge, & Myrick 2008). Preceptors find the role of student evaluator challenging and report a deficient amount of support and guidance from faculty, as well as minimal knowledge of curriculum and the evaluation process. This has made the evaluation of student performance difficult, particularly with weak or unsafe students (Luhanga et al., 2008; Luhanga et al., 2010). It may be that sessional clinical nursing instructors and preceptors rely on their previous clinical practice knowledge to teach and evaluate students instead of on the theoretical content learned in the classroom, which can increase as opposed to decrease the theory-to-practice gap. Sessional clinical instructors also display a tendency to be more lenient with students in hopes of better evaluations of their own teaching and to reduce the likelihood of receiving complaints against them. This observation is important when considering that future employment as a sessional instructor is partially dependant on student evaluations (Halcomb et al., 2010).

Sessional instructors also differ from the other faculty members who are hired on a part-time or full-time basis, since they may be essentially hired at the last minute and *parachuted* into their new role and expected to master the art of teaching students within a very short time—often with no preparation or orientation to their new role. With clinical education taking place in a hospital or community setting far from the

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educational institution, the sessional clinical instructor is distant from colleagues and faculty members who could provide support and guidance (West et al., 2009). In addition, they are not required to contribute to faculty life through committee membership or attendance at meetings. They generally do not hold office space at the educational institution and therefore, do not have connections to the academic institution that part-time and full-time faculty have (Kimber, 2003). Sessional educators employed to teach in the classroom are on site at the educational institution and therefore have immediate access to colleagues and faculty members for support and guidance.

Adding to the distinction between permanent clinical nursing instructors and those hired on a semester-to-semester basis, sessional clinical nursing instructors are often not subject to the rigorous recruitment and selection process that accompanies the hiring of permanent staff. They are often hired on an *ad hoc* basis associated with personal relationships with other faculty members as well as urgent needs for staff to fill in gaps (DeYoung & Bliss, 1995; Herbert et al., 2002; Rothwell, 2002). This may result in the recruitment of sessional instructors who have significant knowledge of the particular practice setting in which they are employed, but little to no knowledge of teaching and learning principles (Brendtro & Hegge, 2000; Coombe & Clancy, 2002) or the nursing curriculum.

Issues with Student Evaluation

In a phenomenological study, Duke (1996) explored difficulties experienced by sessional clinical teachers of nursing using both unstructured interviews and by completing written clinical scenarios with 18 participants. With a focus on student evaluation, it was found that many sessional clinical nursing instructors suffered from

low self-esteem, which affected their confidence with the observations they were making about student performance and decision making in the clinical setting. They were uncertain about their teaching abilities in relation to making final decisions about student success. Participants gave the students the "benefit of the doubt", offered alternate explanations for the student's short-comings, and passed them, as they did not feel confident in their skills. The lack of confidence and low self-esteem resulted in participants taking responsibility for student performance, feeling as though the student's marginal or unacceptable performance was due to something they did or did not do as educators.

Role conflict was also identified by Duke (1996), as sessional instructors identified difficulty managing their numerous roles of teacher, role model, student counsellor, nurse, and liaison between the units where they worked and were currently teaching and the educational institutions for which they were teaching. There was often conflict around which role should dominate when evaluating students. Participants identified that their role as student counsellor and their "motherly" and "nurturing" nature often prevailed (p. 412), which resulted in focusing on the wellbeing of the student above the wellbeing of the patients and the profession of nursing. This role conflict contributed to their inability to evaluate students, as they often allowed students to pass, using issues in their personal lives as a reason for their poor performance. Along with this, moral caring—that is the caring they had for their students—hindered their ability to be neutral, and they often passed students for fear of destroying the students' chances at their chosen career.

Educational preparation for the role of instructor was identified as a major contributing factor to participants' issues in Duke's (1996) study. Recommendations included professional development to increase sessional instructor's confidence and knowledge of the teaching and learning process as well support from more experienced faculty (Duke 1996).

Sessional Teachers' Perceptions of Self

Andrew et al. (2010) explored sessional nursing teachers' perceptions of their contributions to an Australian undergraduate nursing program. Twelve participants who taught in the classroom and had varying degrees of experience as sessional nursing teachers were interviewed. Findings revealed that they perceived their primary value as based on their clinical currency and knowledge of current workplace issues. The researchers identified three themes. The first theme was "bringing the reality of clinical practice to the classroom" through "real-life" examples (p. 454). The participants felt that this helped the students bridge the theory-to-practice gap, as they were able to provide real-life examples of the theory being taught. The second theme was that of "privileged experiential knowledge" (p. 455). Here, the participants perceived their role as being a bridge between theory and practice. This role was especially important, since they also believed that the theoretical content taught in the classroom was frequently irrelevant to and not as important as the nurse's work. The third theme was "establishing boundaries with students" (p. 455). Participants described having a strong connection with their students and considered students to be their equals. It is also of note that the participants reported identifying more with their students than with faculty. These findings raise the questions of how sessional teachers assist students in linking theory to practice and how

practice is being linked to theory in both the classroom and clinical setting, particularly when there is a belief that practical knowledge is more important than theoretical knowledge.

Andrew et al. (2010) identified that the focus on practical as opposed to theoretical knowledge can widen instead of narrow the theory-to-practice gap, especially with an inadequate appreciation for and understanding of the importance of the theoretical aspect of nursing. The lack of educational qualifications of sessional teachers and the absence of contributions by sessional teachers to curriculum contributed to this deficit of appreciation and understanding.

Chapter Summary

Although there have been numerous authors who looked at the transition from experienced clinician to novice instructor, the area of inquiry was typically concerned with experienced nurses who are hired into full- or part-time academic positions. The very nature of clinical instruction involves being in a clinical setting, which, at times, is distant from the educational institution and the support of colleagues. Further, with sessional instructors, committee membership and faculty meeting attendance is typically not a requirement of their employment, potentially amplifying their perceived isolation from colleagues and feelings of inadequate support. Therefore, even though many of the novice sessional clinical nursing instructor experiences may overlap with those of novice part-time and full-time clinical nursing instructors, each group is unique and faces different challenges and obstacles.

The literature tended to focus on generic workforce issues in teaching, such as marking by sessional teachers (Coombe & Clancy, 2002) and sessional teaching in the

classroom, rather than in the clinical setting. The two studies that focused on sessional teachers were conducted by Andrew et al. (2010) who explored the experiences of sessional nursing teachers and what the sessional teachers felt they brought to the education of students in the classroom setting, and Duke (1996) who explored the experiences of sessional instructors specific to student evaluation. Although both authors did focus on sessional teachers, they did not focus on the novice experience, but rather on sessional instructors with varying amounts of experience, with one study focusing on the clinical setting and the other on the classroom setting.

Given that the literature review yielded minimal research about sessional clinical nursing instructors, with none that specifically looked at the experiences of these instructors as novices, an exploratory study into this phenomenon will serve to increase knowledge about this group of educators. Since these educators are being utilized more and more frequently to facilitate student learning in the clinical setting, this new knowledge will assist in understanding their experiences and ways in which they can be assisted in their role.

CHAPTER THREE: STUDY DESIGN

The review of the literature identified a gap in relation to the experiences of novice sessional clinical nursing instructors. Although some authors have examined sessional teachers in general, including one study that focused on sessional instructors in the clinical setting, exploration of the experiences of novice sessional clinical instructors was limited. This inadequate understanding and gap in the literature creates challenges for educational institutions that employ novice sessional clinical nursing instructors, resulting in challenges for the instructors and ultimately their students. In this chapter, I describe my descriptive qualitative study, comprising naturalistic inquiry viewed within the constructivist theory of knowledge. The philosophical stance, paradigm of inquiry, research design, including data generation and data analysis strategies, and ethical considerations will be discussed in this chapter.

Philosophical Stance

A constructivist theory of knowledge provided the philosophical foundation for this study. The theory suggests that human beings do not *discover* knowledge so much as they *construct* it. That is, people do not make their interpretations in isolation, but derive interpretations from their shared understandings, practices, and language that form their knowledge of an experience (Schwandt, 2000).

"Epistemologically, the constructivist researcher takes a subjective and transactional approach to examine the phenomena under investigation. This approach involves interaction between the researcher and the participant so that the findings are literally constructed during the process of the study" (Appleton & King, 1997, p. 14). Constructivism supports relativist ontology, wherein beliefs are valid for the person in the

here and now. These beliefs form multiple realities that are tangible mental constructs, and such beliefs are valid only for that person at that time. Knowledge is assumed to be constructed upon an existing foundation of knowledge. This foundation of knowledge is necessary to provide context and ground the development of more complex knowledge (Appleton & King, 1997; Denzin & Lincoln, 2000). Constructivism allows a view of social reality as a series of mental and social constructions derived from social interaction (Guba & Lincoln, 1989).

It is this view that guided the collection and analysis of data to generate themes surrounding the experiences of novice sessional clinical nursing instructors. In this study, I was able to support the participants in an examination of their experience and encouraged them to elaborate on their understanding and their feelings to discover what their experience was really like for them. This allowed participants to reflect, construct their reality, and describe an overall experience as they lived it and interpreted it in a natural setting, through discussion without manipulation from me, the researcher.

Methodology/Paradigm of Inquiry

Naturalistic inquiry is a discovery-oriented approach that minimizes the investigator's manipulation of the study's setting. Furthermore, it places no prior constraints on what the outcomes of the investigation or research will be (Guba & Lincoln, 1982). Naturalistic inquiry maintains that an individual's ideas, language, symbols, and perceptions of the world cannot be separated from the outside world. As with constructivism, knowledge is formed by a person's experiences, how he or she perceives those experiences, and how he or she understands the world (DePoy & Gitlin,

2011). This form of inquiry emphasizes an understanding of one's experience as one has lived it.

Naturalistic researchers stress the ability of humans to create and shape their own experiences and form their own truth as a result of their realities. In contrast to quantitative research, where the instrument measures a variable, in qualitative research, the researcher is the instrument. As such, the researcher is proactive and responsive and is able to be flexible within the demands of the inquiry process (Appleton & King 1997; Lincoln & Guba 1985; Patton, 2002). The researcher is the key person involved in obtaining data from the participants, facilitating interactions where contexts are created and the participants share data about their experiences (Chenail, 2011). Epistemologically, naturalists believe that "individuals create their own subjective reality and thus the knower and their knowledge are interrelated and interdependent" (DePoy & Gitlin, 2011, p. 26).

Naturalistic inquiry also utilizes a dialectic approach that involves obtaining information through discussion to achieve an understanding of the participant's experience (Appleton & King, 1997). The design must be flexible enough to change as situations change and understanding deepens. The data yield information about the experience and what was important to the participants that results in contextually rich and relevant data (Lincoln & Guba, 1985).

When looking at people's experiences, it is important to remember that each person has his or her own knowledge and version of the truth based on life experiences and his or her interpretation to form knowledge. Naturalistic inquiry allowed a deep understanding to develop about the experiences of novice sessional clinical nursing instructors. Further, their experiences were understood through inquiry in a natural

setting without any manipulation from me as the researcher, thus enabling me to understand the experiences that the participants recounted as they interpreted them.

As a nursing instructor, I believe I had knowledge of the subject matter being discussed. With an understanding of the experience of being an instructor and the many aspects of clinical instruction, the participants' experiences resonated with me, and I was able to identify with participants to get a clearer understanding of their experiences. As the data were analyzed, this intricate knowledge of clinical instruction allowed me to connect with the data and understand what the participants were describing. This then allowed me to get a sense of what they described, which allowed me to identify themes and subthemes and to describe their experiences within the themes. To gain a clearer understanding of the participants' reality and what they felt was important, a flexible research design was utilized, which allowed for discussion and the discovery of new information and deeper understanding.

Research Design

Exploratory research designs provide an in-depth exploration of a concept (Woods & Ross-Kerr, 2011)—in this case the experiences of novice sessional clinical nursing instructors. Woods and Ross-Kerr (2011) explained that the word "exploration" indicates that not much is known about the topic in question, that a review of the literature failed to reveal any significant research on the topic, and that as a result there is an inability to build on the work of others. Consequently, there must be an independent exploration of the topic in question.

An assumption underlying this design is that the topic had never been explored (Woods & Ross-Kerr, 2011). The literature review identified a gap in the understanding

of sessional clinical instructors' experiences. Another assumption of this design is that the sample population has experiential knowledge about the topic and that they are able and willing to talk about the topic (Woods & Ross-Kerr, 2011). The participants in this study had experience as novice sessional clinical nursing instructors and were able and willing to discuss their experiences. As exploration is the initial step in developing new knowledge, as well as the fact that not much is known about the phenomenon, this design was well suited for the study.

An exploratory research design also allowed for the discovery of new data and adaptation of inquiry based on deeper understanding of the phenomena. As data were collected, questions were generated that required follow-up interviews. An interview guide was developed that served to encourage participants to think about certain aspects of their experience. As the interviews progressed, participants were able to focus on and discuss different aspects of their experiences that they felt were the most important to them. Further, as my knowledge of the topic increased, I was able to do follow-up interviews with participants to allow them to elaborate on an idea presented in the initial interviews, which allowed for a deeper understanding of those issues. The result of this exploration provided detailed descriptions of the experiences of novice sessional clinical nursing instructors and identified main themes that participants acknowledged as important to their description of their experience. The following outlines the process of (a) sampling and recruitment of participants, (b) data generation, and (c) data analysis utilized in this study.

Sampling and Recruitment

As outlined by Guba (1978), purposeful sampling is an important aspect of naturalistic inquiry. People are selected based on their knowledge of the phenomenon. The information the researcher is looking for can only come from people who have experienced the phenomenon first-hand and have knowledge of it. To obtain participants who have knowledge and experience with being novice sessional clinical nursing instructors, my sample was purposeful.

Novice sessional instructors included those who had been hired as a sessional clinical instructor within the past three years. These participants also met the following criteria:

- They had experience as nurses in the clinical setting; and

- They had minimal or no experience as a clinical instructor, having taught no more than three semesters as a sessional clinical instructor.

Once ethical approval was obtained from the three participating educational institutions, an electronic letter of invitation (Appendix A) was sent to sessional instructors. Respondents were then included in the study or eliminated based on the inclusion criteria. A description of the study to was sent to full-time faculty members, requesting that they alert any sessional instructors with whom they were in contact to participate in the study. Some participants approached colleagues who met the study criteria, and encouraged them to participate. This snowballing technique resulted in an additional person volunteering to participate in the research.

During the initial contact with the participants, demographic information was obtained that assisted in determining eligibility for the study (Appendix B). This included the following:

- length of time worked in nursing practice;

- total number of appointments as sessional clinical nursing instructor; and

- date of first sessional appointment.

With exploratory research designs, the sample number is usually small—fewer than 25 participants (Woods & Ross-Kerr, 2011). Using as a guide previous qualitative studies that have explored experiences of transitioning from clinical practitioner to clinical instructor, most researchers have included six to ten participants. For example, Schriner (2007) looked at the influence of culture on seven clinical nurses transitioning into the faculty role. McArthur-Rouse (2008) explored the experiences of six new academic staff to adult nursing studies. Dempsey (2007) explored the experiences of six nurse lecturers' role transition from clinician to educator, and Dickson et al. (2006) looked at the lived experience of 10 clinical facilitators. Based on these studies, I anticipated data saturation would be achieved by interviewing 10 to 15 novice sessional clinical nursing instructors. A total of nine participants were interviewed once, and six participants engaged in a follow-up interview. Prior to commencing the interviews, each interviewee signed an informed consent form (Appendix C). Interviews were digitally recorded with the consent of all participants.

Data saturation is essential to naturalistic inquiry and involves bringing new participants into a study until the data set is complete. The researcher continues to gather data until nothing new is added to the already existing themes and categories in the data

set: the data become redundant, and at this point, the research should end (Bowen, 2008; Corbin & Strauss, 1990; Hyde, 2003; Morse, 1995). Data saturation must be achieved to verify and ensure understanding and completeness of the data (Morse, Barnett, Mayan, Olsen, & Spiers, 2002). As data were analyzed during the data generation process, I was able to identify numerous ideas that were consistent across the interviews. Follow-up interviews were conducted to obtain more information and encourage these participants to expand on themes that had been identified. Recruitment continued until no new themes in the interviews emerged. As the interviews progressed and data analysis occurred, in discussion with my supervisor, it was determined that redundancy and data saturation had occurred, and recruitment ceased.

Nine participants were recruited for the study which included 8 females and 1 male. Total nursing experience ranged from 2.5 to 18 years, with teaching experience ranging from 1 to 3 sessional appointments. Four participants were recruited from the Lethbridge College, four from Mount Royal University and one participant from the University of Lethbridge. Approaching several institutions increased the number of eligible participants, expanded the data set, and strengthened the rigour of the study. It was also important to obtain the perspective of novice sessional clinical instructors from different institutions to obtain a wide breadth of experiences.

Data Generation

Drawing upon naturalistic inquiry and using an exploratory research design for this study, data collection consisted of conducting semi-structured interviews. Semi-structured interviews are those in which the interviewer uses an interview guide that outlines a series of questions to be asked. This guide allows for flexibility, in that it

outlines important aspects to be covered. The questions are broad and can be asked in any sequence. Based on responses elicited, additional questions can be added based on the interviewee's response. This type of interviewing is designed to encourage the interviewee to interpret and make sense of the issue being discussed (Bryman, Teevan, & Bell, 2009).

As a way of encouraging elaboration and description of ideas, interview probes and verbal directives were used to elicit further information on feelings, values, self-concept, and other personally-centred dimensions of the experience (Levy & Hollan, 1998). Questions and probes can be either focused or closed in nature, such as "What did she say, exactly, that made you feel this way?" They can also be vague or open, such as: "Tell me more about that." This facilitates a wide range of responses for the participant, directed presumably by some private concern as compared to them simply being asked to give a direct answer to a factual question (Levy & Hollan, 1998).

It was important for me to use a technique that allowed for the emergence of data to gain a deeper understanding of the experiences of novice sessional clinical nursing instructors that was not tainted by my agenda. Allowing participants to talk about and describe their experiences and using open-ended questions in semi-structured interviewing as well as probes helped to obtain more detail. This approach also allowed the participant to reflect on his/her experiences and provide a detailed description as the participant understood and interpreted them.

Initially, the questions were broad, which allowed the participants to talk about what was important about their experiences, as opposed to asking questions that guided them to aspects of their experience that I may have thought were important. Questions

encouraged the participants to think about and discuss both good and bad aspects of their experience. The interview guide can be seen in Appendix D.

As themes emerged during data generation and analysis, interview questions were added that helped to clarify statements made, to invite participants to elaborate on ideas, and to assess if similar ideas emerged across the interviews. As data analysis occurred, ideas that some participants consistently expressed were presented to other participants in the form of a question to see if they had similar experiences, and if they did, how they interpreted those experiences.

During and following the interviews, notes were taken that outlined possible ideas that could be presented in subsequent interviews. The location of the interviews was chosen by the participants, because they may have been reluctant to discuss experiences as an employee within the physical space of their employing institution (Levy & Hollan, 1998). Initial interviews ranged from 30 to 60 minutes in length. Follow-up interviews lasted 10 to 30 minutes, and were held in person or by telephone. Data analysis was conducted concurrently with interviewing, which assisted in identifying themes that needed further exploration with follow-up interviews. Upon completion of the interviews and follow-up interviews, data analysis continued, which resulted in the formation of six themes, three of which contained subthemes.

Data Analysis

The process of data analysis takes place concurrently throughout the data generation process (Streubert & Rinaldi Carpenter, 2011). This strategy enabled gaps to be identified and questions to be developed for follow-up interviews. I transcribed the first two interviews; a transcriptionist was hired to transcribe the remaining interviews as

well as follow-up interviews. A statement of confidentiality (Appendix E) was signed by the transcriptionist prior to her commencing work. I checked the accuracy of the transcripts against the digitally recorded interviews.

In keeping with naturalistic inquiry utilizing an exploratory design, inductive thematic analysis was utilized. As described by Braun and Clarke (2006), thematic analysis is a method of analysing data whereby patterns or themes within the data are identified, examined, recorded, and reported to describe the phenomenon being investigated (p. 135). Liamputtong (2009) described the two steps of thematic analysis as (a) reading through each transcript and (b) making sense of what is being said. It is a process of finding repeated patterns and meanings across multiple interviews, not just one.

Coding is an essential step in thematic analysis. Initially, the researcher must deconstruct the data by reading the transcripts line by line, without making any attempts to interpret the data. Notes about anything particularly interesting, important, or significant should be made. The data should be read again, and notes about significant categories that emerge from the data should be documented. Identifying relevant words or segments of the sentences and giving them a name or a label is referred to as a code (Liamputtong, 2009, pp. 134–135). Once this is complete, the researcher reconstructs the data by finding links between codes and then constructs some general concepts or themes from the codes (Liamputtong, 2009). Making connections between main categories and their subcategories allows the researcher to identify themes within the data. The steps of reconstructing the data are discussed in the following paragraphs.

In this study, analysis was undertaken by reading and re-reading each transcribed interview a minimum of three times to become familiar with the ideas present in the transcription. Using Microsoft Office features, each transcript was colour-coded. Pseudonyms were assigned to maintain confidentiality.

After reading the interview several times, comments were made on a paper copy of the transcripts, identifying main ideas and concepts contained in each statement. Using Microsoft office, a separate document was created that contained statements and segments of statements that were copied and pasted from the transcripts. These became codes that were then organized into subthemes and themes. Throughout analysis, the subthemes and themes were modified to reflect my thinking and understanding of the participants' experiences. Thus, a constant comparative method was followed, as were the steps for condensing and categorizing the data as outlined by Lincoln and Guba (1985). Rules of constant comparative methods dictate that when coding an incident for a category, it should be compared with the previous incidents in the same and different groups coded in the same category. If the category is incomplete and imperfectly defined, coding should stop, and a memo of ideas should be documented to uncover the properties of the category.

Condensing consisted of identifying units of information from the observational and interview notes, documents, records, and notations, which served as the basis for identifying categories. The following steps were used to categorize the topics and reconstruct the data (Lincoln & Guba, 1985):

1. I went through each condensed statement identified in the sorting process, making notes about the contents and placing them in an unnamed category.

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2. Each statement was reviewed, noted, and placed in categories with other statements or separated to form a new category if it was not similar to existing categories.

3. Once all statements were categorized, I reviewed the contents of each category, making a statement about the properties that characterized the category.

4. Each statement was reviewed to assess if it met the inclusion criteria of the statement and captured the essence of the category. Statements were moved to new categories or miscellaneous categories if they did not meet the rule of inclusion. This was done until all the statements were reviewed and categorized.

5. I then reviewed the miscellaneous category to ensure if any of the statements would fit the rule of inclusion for any of the identified categories.

6. Each category was reviewed to examine it for possible relationships among the categories. Examples of this can be seen in Appendix F.

7. I then reviewed each category to ensure that nothing was overlooked and that each statement added to the category followed the rule of inclusion.

Ryan and Bernard (2003) described the building of codebooks as follows: include a detailed description of each category, list inclusion and exclusion criteria, and list exemplars of real text for each category (p. 276). As categories are being developed, over-inclusion is acceptable as a means of ensuring that no information is missed. I developed a codebook again using Microsoft Office to identify categories and maintain organization of the data. Excerpts from my codebook can be found in Appendix G.

Inductive data analysis involves developing and formulating themes in the data of each case and then performing cross-case analysis to see what themes develop over all of the cases. When inductive thematic analysis is used, statements such as "themes emerged from the data" are utilized (Norwood, 2009, p. 350). I completed the analysis of the data, with input from my supervisor, to ensure dependability. As themes emerged, interview questions were adjusted and follow-up interviews were conducted to confirm ideas and themes identified in the data.

Once the themes and subthemes had been identified, I took the subsequent step of writing a detailed description of the phenomenon of the study, outlining the experiences of novice sessional clinical nursing instructors. The connections between the themes and subthemes were described in detail, generating meanings of the data.

Rigour

It is important to point out that in both quantitative and qualitative research, the researcher must strive for rigour (Boswell & Cannon, 2011). The goal of rigour in qualitative research is to accurately represent the participants' experiences (Streubert & Rinaldi Carpenter, 2011). The methods for ensuring rigour in qualitative studies are linked with reliability and validity checks. Rigour or trustworthiness of the data was assessed using the following criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; McBrien, 2008; Streubert & Rinaldi Carpenter, 2011). These procedures are outlined in the following sections.

Credibility. Credibility is the primary validity criterion in qualitative research. Credibility is ensured by establishing a match between the constructed realities of the participants and the realities presented by the researcher (Lincoln & Guba, 1985).

Member checks are one of the most robust ways of ensuring credibility in qualitative studies (Guba & Lincoln, 1989; McBrien, 2008). Member checks involve the researcher seeking the participant's views on the interpretation of the data to verify that the researcher's interpretation is an accurate account of the participant's experience (Guba & Lincoln, 1989; Schwandt, 1996). Member checks were conducted with five of the nine participants in the study to ensure that interpretations were an accurate account of their experiences. A member check was performed with at least one participant from each educational institution. It was not possible to perform member checks with each participant due to delays in the research process and the availability of participants.

Credibility can also be established by the use of triangulation (Lincoln & Guba, 1985). Triangulation can be described as the combination of two or more theories, or methods of investigation, or data sources in one study of a single phenomenon as a way of ensuring confirmability and completeness of the research findings (Lincoln & Guba, 1985; McBrien, 2008). Data from different sources in qualitative research can confirm the truth about the phenomenon under investigation (Jones & Bugge, 2006; McBrien, 2008). Data source triangulation was utilized in this study, as instructors from three different educational institutions were interviewed. Having participants from different institutions supported the inclusion of different experiences related to each institution's recruitment and hiring procedures. Lastly, credibility was enhanced by making links between my findings and the findings of other studies in the literature.

Transferability. Transferability can also be called *fittingness*, when the findings *fit* into contexts in other groups or settings. It is a generalization of the data to ensure their external validity (Lincoln & Guba, 1985). Transferability is always relative, and it

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depends entirely on the degree to which outstanding conditions overlap or match. Transferability implies that results of the research study can be applicable to similar situations or individuals, that knowledge obtained will be relevant, and that investigators who carry out research in another context will be able to use certain concepts that were developed. The major technique to accomplish transferability is the generation of thick descriptions through data saturation and thematic analysis. Thick descriptions are found in the following chapter. As well, some of the findings fit with those of other authors who looked at the experiences of expert clinicians entering academia as novices in a part-time and full-time capacity, sessional educators in a classroom setting, as well as clinical experts who take on the role of preceptor (Anderson, 2009; Andrew et al., 2010; Anibas et al., 2009; de Sales, 1996; Cangelosi et al., 2009; Dempsey, 2007; Duke, 1996; Hinchcliffe Duphily, 2011; Luhanga et al., 2010; Luhanga et al., 2008; McArthur-Rouse, 2008; Peters et al., 2011; Schoening, 2013; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013). Transferability is also achieved if researchers can use the findings of this study in research of other groups or settings.

Dependability. Dependability or auditability is the degree to which other researchers are able to reach the same conclusions (Lincoln & Guba, 1985). An audit trail is a record of the steps taken in the research process from beginning to end. It includes decisions made throughout the process, which helps to explain and detail the research process (Barusch, Gringeri, & George, 2011). This is an important step in allowing the researcher to defend his or her interpretation and allows others to follow the research and understand the reasons for theoretical, methodological, and analytical choices (Guba & Lincoln, 1989; McBrien, 2008). An audit trail was utilized to provide an element of

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rigour to this study. I maintained a filing system for the data, memos, digital recordings, personal notes, and transcribed interviews for subsequent analysis. Continuous discussion and collaboration with my supervisor and committee regarding decisions being made also provided an element of rigour.

Confirmability. Confirmability represents freedom from biases. The data analysis must be completed in a way that ensures that the researcher's assumptions and biases are kept separate from the analysis (Lincoln & Guba, 1985). Confirmability was enhanced by maintaining a reflective research journal throughout the research process. This journal served as a means for me to reflect on my observations during the interviews and any biases I identified following each interview. This allowed for recognition and acknowledgement of my own values and beliefs in relation to the research questions and outcomes. Because I am a nurse educator, being aware of and recognizing my own values, beliefs, and biases was an important step in ensuring confirmability of the results. Reflexivity is an important process during the audit trail, but for the purposes of this study, it will be discussed as part of confirmability.

Reflexivity involves the researcher's acknowledgement that his or her decisions and actions during the research process will impact the meaning and context of the experience that is being explored (Porter, 1993). It relates to the degree of influence that the researcher exerts on the findings, whether intentionally or unintentionally. The researcher must be aware of his or her own values and how these can influence research findings (Jootun, McGhee, & Marland, 2009). Because my own nurse educator experience parallels that of the participants of this study in many ways, reflexivity was an important aspect of the research process to ensure rigour. I maintained a reflective journal

to document my thoughts, feelings, and values following each interview to decrease their effects on the interview process. This reflection allowed me to be more aware of any issues that may have impacted me and how I interacted with participants in subsequent interviews. Allowing my own feelings to guide the interviews would have biased the results and, ultimately, my research findings. In addition, ethical considerations were identified prior to and throughout the research process to ensure the integrity of this study.

Ethical Considerations

Ethics approval was obtained from the Human Subjects Research Committee at the University of Lethbridge and two other nursing education programs in Southern Alberta, resulting in permission to conduct interviews at three educational institutions in total. Criteria of the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (Tri-Council; 2010) guidelines for human subjects research were followed. The letter of informed consent outlined the purpose of the study. Each participant read the consent at the beginning of the interview. Once all questions were answered and the consent was read, the participants signed the form before beginning the interview. Consent was also obtained for any follow-up interviews. Every effort was made to ensure that participants' consent was given freely, without coercion, and was based on a clear understanding of what participation involved.

Data were stored in a locked cabinet in my office at the University of Lethbridge and will be destroyed in five years. I took the written data, paper copies of the transcripts as well as the hard drive used to store digital information home, where they were kept in

a secure area. All electronic documents were kept on a password protected computer. Participants were made aware of their right to withdraw from the study at any time without penalty or consequence, and they were told that any information they provided in the form of notes, contact information, transcripts, and taped interviews would be confidentially destroyed if they chose to withdraw. None of the participants withdrew from the study.

Risks and benefits were explained and were outlined in the consent form. Though there were no known physical risks to the participants, discussing personal experiences could have provoked negative feelings that required support or counselling. Had this occurred, I would have ensured that the participant received immediate assistance if they had reported any stress or emotional turmoil that required intervention. None of the participants became upset during the interview or reported any distress following that would have required counselling services.

Participants' confidentiality was achieved by providing each participant with a pseudonym. Every effort was made for their identities to remain anonymous to the administrators at all institutions.

Because the participants may have felt a sense of discomfort while talking about their experiences as a sessional clinical nursing instructor at the institution where they were employed, the interviews took place at a location that was comfortable for the participants. This also assisted in maintaining anonymity.

Chapter Summary

Utilizing constructivist theory of knowledge as the foundation for this study and naturalistic inquiry as the paradigm of inquiry, the experiences of nine novice sessional

clinical nursing instructors were explored. Semi-structured interviews were conducted to gain information about the participants' experiences. Inductive thematic analysis allowed for the formation of themes and subthemes describing the participants' experiences. Participants were recruited using purposeful sampling, as well as snowballing, until data saturation occurred. Rigour and trustworthiness were ensured using credibility, transferability, dependability, and confirmability. Ethical approval was obtained through each institution following the criteria of the Tri-Council (2010) guidelines for research with human subjects.

Utilizing naturalistic inquiry, with an exploratory research design, allowed for an in-depth exploration of the experiences of the nine novice sessional clinical nursing instructors in this study, which increased knowledge and understanding of the phenomenon. Through the process of data analysis, themes and subthemes emerged from the data and provided a thick description of the participants' experiences, which are described in the following chapter.

CHAPTER FOUR: FINDINGS

Six main themes emerged from the data, three containing subthemes that assist in describing the experiences of the nine participants in this study. These themes and subthemes include: (a) motivators, which consist of the subthemes of professional responsibility, finances, and personal desire; (b) preparation, which contains the subthemes of skills and knowledge, hiring practices, orientation, and understanding; (c) support; (d) seeking mentors; (e) familiarity; and (f) growth, which includes the subthemes of both personal and professional growth.

Theme 1: Motivators

The theme of Motivators describes the factors that influenced participants' decisions to take on the teaching role. As described by Ryan and Deci (2000), being motivated to perform a task involves being activated towards an end. People are moved to act by different factors such as valuing or being interested in an activity, being coerced or bribed, because of fear, or because of personal commitment. Participants in this study identified professional responsibility, finances, and personal desire as reasons for taking on the role of novice sessional clinical nursing instructor.

Professional Responsibility

Professional responsibility denotes the sense of obligation participants felt to get involved and bring about positive change within the nursing profession. Participants believed that some of the new graduates they encountered were often unprepared emotionally and educationally, were not aware of the complexities of nursing, and frequently took on tasks they were not equipped to deal with in the clinical setting. By teaching, they could try to increase student's understanding of the intricacies of nursing

and ensure that new graduates were providing safe and competent patient care, thereby

sustaining the integrity of the nursing profession:

> It's like they don't understand how acute situations can be and what their
> limitations are. . . . I found the new group graduating very unsafe in their practice
> at times, and so I wanted to get involved and see changes. The only way you are
> going to make a change is if you start it yourself. I felt that if I went to the root of
> the problem and I got involved in teaching students when they were in their first
> couple of years of school that I would lead them in a positive way, and maybe
> they would take that initiative and really understand what nursing is and what it's
> about. (Corey)

> I think lots of students go into nursing not knowing what nursing is really all
> about. I wanted to be an instructor to pass on the good things of nursing and
> change how students felt about nursing. (Dawn)

Participants also believed that by sharing their love of different areas of nursing,

they would assist in decreasing stigma associated with these areas. This, in turn, would

ensure that students had an understanding of and respect for every area of nursing, even

ones that had a negative connotation associated with them:

> I like the idea of endorsing the nursing profession and changing the stigma of
> certain areas of nursing, like geriatrics, so the student really understands the
> different areas of nursing and the opportunities each area has. (Melanie)

In addition, it was believed that by sharing their passion for nursing, they could

inspire this passion in others. In so doing, they would be producing caring and

compassionate nurses and positively impact the nursing profession:

> I think I am very passionate about nursing, and I always thought I would love to
> instill the kind of passion and that drive for the nursing profession that I have in
> other people. (Gina)

> I do enjoy teaching the students and instilling a passion for nursing and learning,
> lifelong learning with nursing. Sharing your passion is exciting. (Colleen)

Finances

The subtheme of finances outlines monetary motivation for deciding to teach.

Although monetary incentive typically motivates people to seek employment, the idea of

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supplementing their current income was only mentioned by three of the participants: "I was able to make a little bit of extra cash which was nice and was a real bonus" (Gina). One participant initially applied to be a sessional clinical instructor due to financial need, as she had been laid off from her regular nursing position and required the work to support her family: "I had been laid off from my job, and so I just threw my name in everywhere because I needed to work" (Rhonda).

Even though the financial aspect of teaching acted as a motivator for some, it was secondary to the opportunity to make a positive contribution to the nursing profession. As stated by Lisa,

> It is the definitely not for the pay cheque that I do it. I am not doing it just for that. . . . I put far more effort in than any paycheque that the University could ever give me. You need to find something in yourself about why you love to teach. I like the influence I have over future nurses. I would love to work with them in the future and would happily say that I was their clinical instructor.

This was reinforced by Rhonda, who reported that even though she did apply to teach out of financial need, by the time she was hired, she had already found employment in a regular nursing position, but took on the extra responsibility of teaching because of her desire to get involved and make a difference:

> I found a job in Palliative Care and then they called me saying they needed an instructor and I was tickled pink because it intrigued me and I really wanted to teach and share my knowledge like my instructors had done for me.

Personal Desire

Personal desire identifies any internal motivation that prompted participants to take on the teaching role for individual gain or fulfillment. It was the anticipated sense of accomplishment that also acted to motivate participants to teach: "Whether it's patient teaching, family teaching, or helping out a coworker, I thrive on it. It is something that makes me feel good inside about it" (Rhonda).

The idea of trying something new and having the opportunity to challenge themselves to grow and learn also acted as an incentive:

> I think that it's always a really good experience to step outside of yourself and do something new. (Gina)

> I always said it was my teachers that made me think, "This is where I want to end up. I want to stand up in front of a group of people and tell them things that they need to know. I want to be good at it." (Dawn)

In addition, encouragement from colleagues reinforced their belief that they could teach and acted to increase to their desire:

> I was encouraged to apply by a friend of mine. She said, "It's easy, you'll love it, it's great. You'll be really good at teaching. You're good at talking to people. You care about other people." (Dawn)

> I had my preceptor student and the teacher that came to check in on her a couple of times a year and do our evaluations, gave me a lot of positive feedback. And when I had an undergrad, she had to fill out an evaluation and it was good. So, that's what made me really consider it, and I thought maybe teaching is something I should explore a little bit further. (Corey)

All of these factors prompted participants to take on the role of instructor. They believed that along with the desire and responsibility to teach, their nursing knowledge, experience, and the information and training they would receive from the educational institutions would prepare them to teach in the clinical setting.

Theme 2: Preparation

Preparation comprised anything actual or perceived that contributed to participants' readiness to teach as well as what they felt assisted or hindered them in the clinical setting. How prepared each participant felt varied and was related to several factors, which are outlined within the four subthemes of (a) skills and knowledge, (b) hiring practices, (c) orientation, and (d) understanding.

Skills and Knowledge

Skills and knowledge outline any abilities, personal qualities and nursing skill or knowledge that participants felt prepared them for clinical instruction. These included teaching experience, nursing skill and knowledge, clinical currency, and personal skills.

Some participants felt that because of their experience teaching in the clinical setting with patients and families and informally with students as staff nurses, they had the teaching experience required to take on the instructor role:

> My job is 90% teaching and talking and making sure parents really understand. Why do we have to humidify the air? Why do we have to weigh them every day? Why do we feed them the way we do? So I thought teaching students would be the same. The only difference with students is being there for them and empowering them so they feel confident. (Dawn)

> I thought it was a good match for me because I have been a clinical educator before as well and taught in a variety of programs. (Colleen)

One of the participants had been enrolled in an education program, which provided her with additional information about teaching and learning:

> I did two years of education. I didn't complete my degree, but in those first couple of years, I got some of the fundamentals of teaching and learning, so that helped me immensely as far as how to approach teaching. (Annie)

Another participant had experience teaching outside of the clinical setting while doing volunteer work, which he believed enhanced his teaching knowledge further:

> When I was overseas, there was always teaching involved. We did a lot of stuff on health and hand washing, and so those little opportunities to teach made a big difference. (Jack)

Corey had preceptored students while working as a staff nurse, which she felt provided her with additional experience and prepared her to teach in a sessional capacity with a group of students:

> I had a preceptor student two years before, and it helped a lot in getting an idea of how to teach. I think it made a big difference. . . . I got a lot of positive feedback

from her and from my preceptor's supervisor, and so through that experience, I knew what type of questions they would be asking, what they would need help with. So I thought I could anticipate their needs.

All participants believed that by engaging in nursing practice while teaching, they would be were aware of the demands of nursing, such as changing policies, procedures, new treatments, and dealing with difficult patients. They felt this clinical currency would allow them to bring the "reality" of nursing to the students:

> I think clinical currency is absolutely necessary. Although what you learn in school, to an extent, you should be carrying through in your practice, there are so many different aspects that you need to be aware of and all of the different policies and protocols within the region and all of the different technology within the region that are not taught in school. If you didn't work on the unit, you wouldn't have that ability to teach it. You wouldn't be comfortable with it. (Corey)

> Teaching about seniors is quite progressive, and there are a lot of programs, provincial and otherwise, that faculty aren't even aware of, so absolutely it brings that to augment the experience for the students. (Melanie)

> By keeping my clinical skills up to par, I am very in touch with the current demands of nursing and what the demands of the units are, so I feel like I can deliver that realistically to the students. . . . You know how practices are actually practiced. Even the creative ideas of how to cope with a patient with dementia who is crawling out of bed—you can learn all of the techniques in a textbook, but showing them the things that your current practice has shown you that work is huge in the student's learning. (Lisa)

Clinical currency enhanced their teaching and increased participants' credibility among their students, as the students knew that their instructor had provided the nursing care they would be providing:

> I think the work experience helps them [referring to nursing students] because different nurses have different practices, and I can share that this is what I would do in this situation. For them to know that you've experienced this, they are less scared. I think that's the biggest asset—just having experience on the unit. They know that I've been through it, and that I've made mistakes too, and how I learned from them. (Jack)

Their knowledge of nursing and their ability to provide patient care equipped participants

with the nursing skill needed to teach these skills to others:

> I know how to be a nurse. I know how to teach them a head-to-toe assessment, and I know how to teach them how to do a bed bath and how to talk to patients and what to look for. (Dawn)

> Drawing on your nursing skills, knowing what I know as a nurse, I could teach those skills to someone else. (Melanie)

> In addition, participants believed they possessed many personal skills that would

benefit them in the clinical setting. Communication, assertiveness, confidence, and

advocacy skills assisted in not only providing an optimal learning environment when

organizing learning opportunities for the students with nurses and doctors, but also

assisted participants when engaging with the students themselves:

> I have a very strong personality, enough to hold my own. . . . I feel I am confident and have good people skills. . . . You need to be able to give constructive feedback to the students. You need to have a strong communication background with all disciplines because you are dealing with doctors who might want to borderline tear your students apart on the phone, and you need to be able to stand up to the doctor and say "This is who I am, and this is the learning process." So being able to stand up to all disciplines. (Lisa)

> I think you need to be confident and have the ability to stand up and advocate for your students and for the patients. You need to be calm and cool-headed to help the students to calm down and think through the process. (Corey)

With the belief that they were prepared to teach because of their nursing knowledge,

clinical currency, personal skills, and their experience teaching within and outside of the

clinical setting, participants felt they had a good foundation to take on the teaching role.

Hiring Practices

Hiring practices outlines the process of recruiting, screening, and employing

participants, how these practices impacted participants' ability to prepare as well as how

this affected them throughout their experience. Due to an urgent need for instructors, five

of the nine participants in this study were hired within a few days of starting to teach. As

a result, they did not participate in an interview, which would have not only allowed the

educational institutions to screen participants, but would have also allowed participants to

gather more in-depth information about the expectations and parameters of their

employment:

> I didn't have an interview. They were looking for someone because they were so short for clinical instructors, so they approached my manager and said, "Do you have anybody on your staff that might be willing to do it or you think would be a good candidate for this position?" She approached me and asked if she could give my name, and I said, "Sure." So it was very quick and kind of unexpected. (Annie)

> The instructor that was teaching where I was working knew that she was leaving, and so when she had to go, she approached me and said, "Is it alright if I put your name in?" I said, "Absolutely, I'm available, if they need somebody to teach," and that's how it came up. I took over for her in the middle of the semester. (Jack)

> As sessional instructors, participants were hired only for the semester, and

consequently, they took on the responsibility of teaching in addition to their current

positions as staff nurses. Being hired at the last minute contributed to their inability to

organize their work schedules to accommodate their teaching assignment, which resulted

in some participants working more than full-time hours, affecting their ability to maintain

a good work–life balance:

> It would have been a lot easier for me if I could have had more time to prepare. That way, I could have made arrangements to trade some shifts with a co-worker. (Rhonda)

> I did find it difficult to maintain a work–life balance because I was full time at the hospital and was teaching on top of that. My manager did allow me some LOA days when my teaching conflicted with my work schedule, which helped, but I still ended up working many days in a row and working more than full time, which was hard. (Annie)

The insufficiency of time to prepare personally contributed to two of the participants

feeling burnt out. This was reinforced by Rhonda, who reported,

I ended up getting influenza because I was so burnt out. That was probably one of the most difficult parts. Working non-stop, and when you are not either working at your regular job or in clinical, you're marking papers or doing research.

Some participants were not working full time in their nursing positions and were therefore better able to organize their schedules, even at the last minute. As a result, they were able to maintain a work–life balance despite the additional workload: "I had to cut down on some of my personal projects that I wanted to do, but I wasn't working full time at the hospital. So, I found I did well maintaining a work–life balance" (Jack).

Being hired at the last minute also restricted participants' ability to engage in preparatory activities set up by the educational institution. As a result, participants began to teach, not even realizing they were not prepared until they were well into their clinical rotation:

> I think my first semester was really challenging. They hired me the day before we were to start clinical, and so I didn't get an orientation, and I was basically thrown in. I found it challenging to figure out all of the paperwork and everything I had to do. I had to learn as I went, which was a little bit unnerving because I like to be really organized and in control of the setting, and I couldn't. So, I didn't really like that. (Corey)

> Sometimes, when you're thrown into something and you're so busy, you're so focused on just trying to get things set up so that you can go today, that you don't think, "Oh, I'm missing this information." (Annie)

Although most participants were not hired with adequate time to prepare, some were hired with enough time to attend orientation sessions set up by the educational institution, which were offered in an attempt to prepare them to teach.

Orientation

The third subtheme of Orientation highlights the induction process that participants engaged in and how this did or did not assist in preparing them; it also includes any resources provided aimed at assisting them in the clinical setting.

Participants anticipated that they would be prepared to teach by the educational

institutions through orientation. This expectation was reinforced to them when they were

hired. As reported by Dawn:

> I told her I was an NICU nurse; I was nervous. I said, "I don't really know exactly what I'm getting myself into, but there will be training right?" She said "Yes, don't worry. See you at orientation."

> Only four participants were hired early enough to participate in an orientation.

These participants reported that these orientation sessions did not increase their readiness

to teach in the clinical setting, as it only provided them with general information:

> The orientation had good information, but I don't think we had enough practical knowledge to go through what you really might expect. Truly, I felt on my own. It was like, "Here's your place, here's your address, figure it out, and here's your eight students. Here's your agenda, here's your syllabus, there you go." . . . I think you're left floundering on your own a bit. (Colleen)

> The orientation was basically . . . these are the things that you have to cover in your orientation day with students, fire safety, and lifts. You know the liability stuff. (Gina)

> That was not an orientation. It was just . . . you are going here and this is the number of the manager, here's the sheets that you use to assign patients, and some of the handouts and paperwork we needed. (Dawn)

Although the orientation did little to prepare participants, for one participant, it did give

one participant the opportunity to connect with another instructor who offered to provide

the information she needed:

> At the orientation, I said to another instructor, "I'm a little overwhelmed that this is all the orientation we get," and she said, "Don't worry, here's my card. Email me if you have any questions. Don't bother with anybody else, just phone me, and I'll help you out." (Dawn)

> As part of preparing, all participants were expected to engage in an orientation to

the units on which they would be teaching. These orientation shifts were conducted by

the staff working on those units, and as a result, the focus was on unit routines, staff, and

clientele on the units and did not include information about clinical instruction:

> I set that up myself to orientate there. . . . It wasn't the educational institution
> setting it up; it was just the employees at the facility. They don't care that I don't
> know what I'm supposed to do. All of a sudden, I'm responsible for all seven of
> these students. No one said to me, it's a good idea to keep them all in the same
> pod or how to handle the students to be more organized. There was so much chaos
> trying to figure out how to organize it and where to put them. (Dawn)

> It's the instructor going to the floor, and you're paired with the staff nurses.
> You're not actually paired with an instructor, doing instructor things. (Annie)

> Regardless of whether or not the participants were provided with an orientation,

the educational institutions attempted to ensure that instructors were adequately resourced

by providing them with text books, lab class outlines, syllabi, student evaluation forms,

and theory class outlines:

> They gave me a syllabus, outlines of the student's assignments and said go on the
> Blackboard and all of your stuff is there. (Colleen)

> It was just a blue binder of their policies, CARNA, the standards of care, the
> syllabus of what they expected every week from the students. (Rhonda)

> I was given an outline and a textbook. That's it! (Dawn)

Unfortunately, some did not receive these resources until they were well into the

semester, which eliminated their ability to utilize the resources to prepare: "Initially, I

had no resources because everything was on the teaching website and because I was a

last-minute hire. It took about two weeks for them to set me up to access the resources"

(Corey).

Although resources were provided, which resources each participant received

varied, and there was a general shortage of understanding about how to use the resources,

given there were no explanations provided with them. In addition, there was inadequate

understanding of the expectations of clinical instruction in regards to spending their own time preparing, navigating the resources, and assigning meaning to them.

Understanding

Understanding for participants meant being able to comprehend and make sense of the information they were given. This encompassed making sense of the resources, comprehending how to be effective when resources were not provided, and understanding some of the expectations of their role. Within this subtheme, participants identified anything that aided or could have aided them in increasing their understanding as well as how they compensated for their insufficient understanding.

Even though participants were provided with resources, for some, vital resources were absent. This resulted in difficulties when it came to performing certain aspects of clinical instruction. For those who did not receive the information about the sequencing and scope of theory being taught, there was inadequate understanding of how to link theory-to-practice in the clinical setting:

> The students were learning things in their theory class that I didn't know that they were learning, so to try and tie it all together to make it simpler for them was really difficult. (Dawn)

> Your sessional instructor doesn't understand what's going on in the rest of the theory courses, and they're not linked up with the faculty at all, and they don't know exactly what is being taught in school. They know what they know from working on the floor, but not from what is being taught in theory. (Corey)

> As a sessional instructor, I have no idea what the curriculum entails and what is being covered in theory. How much detail do they go into in theory? With any area, you can go as detailed or a general as you want. So, depending on what they are learning in theory, it would affect what you are doing and expecting from them in clinical. . . . So, it would be nice to have more direction as to what's being done in the classroom so there is continuity for students between theory class and clinical. (Annie)

For others, the information provided assisted them in understanding the general concepts the students were learning, but it did not increase their understanding of expectations of specific theoretical knowledge based on class content:

> I got a syllabus of the dates of what they were doing, but I didn't get specific information, just a calendar. I wasn't sure about what exactly they were taught about the topic. . . . How specific was it? If I had more specifics, I could have helped to prepare them for their tests by covering things in clinical that would help them pull it together. (Colleen)

Corey was provided with information on the laboratory portion of the students' theory course, which allowed her to focus on the skills being taught. However, this information did not assist her in understanding what theoretical knowledge was expected:

> They kind of went over it, not super well. They did do more of what they did in lab. They told us each week what they are doing in lab so that we knew what they were able to do in clinical. It would have been helpful, I think, if there would have been a synopsis. This is what they learned on Monday and Tuesday, and then I could have said, "Here are the examples in clinical, and how do you take what you learned in theory and apply it in clinical?" So, I tried to do some of that and get a general idea of what the theme was, but it wasn't laid out for me.

Of note, one participant indicated that even though it would have been nice to have more information about theory, she felt that the theory component was not always relevant to the area in which she was teaching; that practising the skills was more beneficial than the theory behind them. Therefore, for her, the theory being taught in the nursing courses was irrelevant to clinical practice, and understanding the sequencing and scope of theory was not necessary:

> A lot of that classroom, depending on what it is, we can't link it because it has nothing to do with clinical. I am on a trauma unit. Some of that stuff has nothing to do with the trauma surgery unit, so I don't think there is any advantage to knowing nursing frameworks. Like, if I don't talk about one of the theoretical frameworks, they are not missing out on anything because no one is ever going to test them on that framework after that class. (Lisa)

Without an understanding of the sequencing and scope of theory being taught, it was difficult for participants to thoroughly evaluate students and assess if the students were in fact meeting course objectives based on expected theoretical knowledge or if they were functioning at the level they should be for their level of education:

> We are given their evaluation tool, and we are told to say they are competent or they are excellent in certain areas, but that's according to what? That's very subjective. It's subjective to what's happening in their level of education and what exactly are they learning theory. Well, where's that outline? Where should they be in third or fourth year? (Jack)

Although all participants were given the evaluation tool, not all of them were provided with an explanation of the evaluation process. Therefore, most did not have a good understanding of how to use the tool in general or how to use one tool for every level of the student's education, making student evaluation difficult:

> The evaluation tool used for first year students was the same evaluation tool that they used for fourth year. So for me, one of the most difficult aspects was evaluating a first-year student based on a fourth-year tool. I think that was probably the hardest part, and that was the part that I really struggled with. Because, based on the tool, you're not competent. You don't do that consistently. (Gina)

> It would have been helpful to know the procedures. How do I mark papers, and how do I mark these students? I try to follow those evaluation tools, which I think are totally stupid, because I can never understand them. (Rhonda)

As a result of the deficiency of understanding the evaluation tool, participants identified that they used their "gut feeling" when evaluating students. As stated by Lisa, "My gut intuition, I can figure it out pretty quickly if a student isn't at the level they should be." Although gut feelings and nursing knowledge were used to evaluate students, having an understanding of the evaluation tool would have acted to reinforce what participants felt about student performance. Two participants were orientated to the

evaluation tool and, as a result, were able to back up their gut feeling when evaluating

students:

> They went over the evaluation tool when I first started, outlined the different criteria, and explained what I needed to do if anybody was unsatisfactory. With one student, I could see that she wasn't at the level she should be even before I looked at the criteria on the evaluation tool. So I did not pass her based on the criteria set out in the evaluation tool. (Annie)

Participants identified that along with explanations of the resources, clarification

of aspects of clinical instruction, such as conferencing, managing multiple students,

dealing with sick calls, or marking, would have assisted in developing a deeper

understanding of how to fulfill some of the duties of their role:

> If I had just one day with an experienced clinical instructor to come in and say to me, "This is how I do it," that would have made a big difference. (Dawn)

> How are you supposed to know what to do? You get a PowerPoint presentation and a duo tang. I am not a student. Actually, pair me up with somebody, and let's talk about the reality of it. Give it to me flat out. What do you want the students to do? (Lisa)

> It would have been helpful if the coordinator had sat down with me and explained the flow of the semester and maybe give me some sort of a guide on how to do anecdotal notes, for instance, or even final evaluations and when they were due, and what the semester would look like, and when you should be considering things like learning contracts and what you should do if a student calls in sick. A little like teaching 101 sort of thing. (Corey)

> I think that somebody sitting down with me and saying, this is what the assignment expectations are. Here's an example of a really good care plan. This is what we are looking for and then on the rubric, saying, this is a 0–3. You would dock marks for this. This is a 5-7, you would dock marks for this. This is a 7-10. So I had an idea of how to mark their assignments. (Gina)

Two participants were provided with the opportunity to connect with another

instructor prior to teaching, who gave details about different aspects of clinical

instruction, such as student evaluation, instructor expectations, clinical resources, and

"tips" about clinical teaching. This information aided in increasing participants'

understanding of the resources and how to function more effectively in the clinical setting:

> I was paired with another instructor, and she was very helpful at giving me information, tips, course outlines, and expectations. She provided me with an orientation package for the students, and that was very beneficial. (Annie)

> I didn't get an orientation, but another instructor met with me, and she went over what she looks for. She gave me her forms. She explained how she assesses the students based on what they are learning in class, the criteria. She gave me teaching materials. (Jack)

Participants also identified that they did not have an understanding of some of the expectations of clinical instruction. Although they expected that they would have to devote some personal time to instruction-related duties, they were unprepared for the amount of time this actually took:

> The amount of work you had to do outside of the clinical. The marking, the reading, the research, getting everything organized for that clinical week. I was very surprised at the amount that was extra. (Rhonda)

> I think the workload outside of clinical was more overwhelming than I initially expected. (Corey)

In addition, there was an expectation by the educational institutions that participants would prepare on their own time, but this was not explained and, therefore, not understood by participants. For example, the majority of participants were not provided with specific information about what the students were learning in theory, but were provided with the textbooks that the students used in theory class and were expected to read them to ascertain what was being taught. It was felt that sessional instructors were paid hourly and were expected to do a great deal of work related to teaching outside of clinical time, which decreased their ability or willingness to devote even more time to reading a textbook, even though they acknowledged that undertaking this task would have reinforced their ability to be effective instructors:

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They would give you what they were reading for the semester, but it was more up to the instructor to pick up a book and read it to really understand what they were going through. You, the instructor, had to do a lot of work, which sometimes is a challenge. I mean, to be honest, instructors do a lot of work to begin with, and so asking them to also read the textbook? (Corey)

In addition, they wanted me to read Godfrey. Godfrey is a 300-page textbook. I am not doing that on my own time to make me a better clinical instructor. (Lisa)

The additional responsibilities of clinical instruction, which were not explained, nor fully understood, in addition to this participant's regular nursing and personal responsibilities contributed to feeling overwhelmed:

As much as it sounds ridiculous, I just didn't have time to make appointments and meet people. Not to mention, I have two kids, a husband, and a house and an NICU course that I'm taking and my job. I had just enough time to figure out what I needed to do and mark, and figure out what the students needed, to just continue with the six weeks. (Dawn)

Being hired and sent into the clinical setting without adequate preparation and resulting lack of understanding amounted to "being thrown to the wolves" for two participants (Dawn and Rhonda). Dawn felt deceived and angry about the minimal amount of training and time given to prepare, which she felt left her ill-equipped to function in the clinical setting. She believed that the educational institution was aware of the challenges that novice sessional instructors would encounter, but they allowed her to start teaching without the preparation and understanding she needed. This feeling was reinforced when she approached her supervisor:

There were many days that I wanted to just sit in her office and be like: "How could you not prepare me to do this?" I was really angry for the first three weeks, like really angry. . . . When I approached my supervisor, she said, "I could tell everybody maybe that this is a really, really, really difficult six weeks, but that would just scare everybody away, now wouldn't it?" . . . I felt that everybody knew what I was getting myself into but me. (Dawn)

In contrast, one participant reported that despite not receiving any preparation, she felt that being placed in an area where she had 16 years of nursing experience provided

her with familiarity with the staff and clientele as well as the expertise needed to teach in that area. In addition, she had frequent contact with students where she worked as a staff nurse and, therefore, understood how to function in her role. As a result, she did not experience the difficulties that others did:

> There wasn't an orientation for me, but nevertheless, I think teaching is very autonomous. . . . You have to work pretty independently, and I had lots of student where I worked before, which helped. I mean, in my case, I didn't feel like I was thrown in the deep end. (Melanie)

For all other participants, the shortage of preparation and resulting issues with understanding was a major factor that contributed to the type of experience they described. To deal with this, participants sought out the support they needed.

Theme 3: Support

Support was identified by participants as the aid and assistance they felt they needed and ultimately sought out to increase their understanding of how to function effectively in their role. This included institutional backing of participants' decisions in the clinical setting about student performance. Participants requested various amounts of support from their superiors at the educational institutions based on their needs. This support, however, was not readily available to all participants and often did not assist in increasing their understanding:

> I think, theoretically, I was supposed to have some guidance and help, but the support on the other end, it was there, but it wasn't timely in some ways. They were hard to get a hold of. When I did talk to them, there was direction, but it wasn't a lot, and it wasn't very detailed. (Annie)

Despite the fact that support was not always readily available or timely, it was enough for some participants: "The contact that I had with the course coordinator was enough support for me, and she did eventually help me, but the number of emails I had to write until I got the help" (Lisa).

For others, the process of seeking support and information and not getting it in a timely manner or being referred to others resulted in frustration. When this happened, they stopped asking, and consequently, they did not get the information they needed to increase their understanding:

> If I ever emailed the clinical coordinator with a couple of questions, it was like, "Talk to this person, talk to this person, here I'll forward your email to this person." I didn't really find that she ever really answered any of my questions, ever. They got forwarded to other people, so then I just stopped asking her. (Dawn)

The desire for support went beyond getting information to increase understanding, but also encompassed support for the decisions being made in the clinical setting. Some participants felt they were not supported and were even questioned about decisions to fail students or implement learning plans. This sense of being questioned was attributed to their sessional status and not being "known" to the faculty members:

> I was a little bit questioned because they don't know me. So, it's almost like I have to sell my issue when I needed to put a student on a learning plan. (Lisa)

> The process of dealing with struggling students and implementing learning plans wasn't as seamless as I guess I had thought it would probably be or supported even sometimes. (Annie)

Although support was available for most when it was sought out, some participants felt that it should have been offered, rather than each instructor having to seek out what she/he needed:

> There were a few times that I called them about things, and they were really great about coming to the unit. The course coordinator came to the unit and helped me out. It's a tough one because I think that they are available. If you call them and seek out their assistance, they would try their best to help you, but at the same time, I think that there could be more support available, that maybe they could have a mentor sessional instructor that could come around and offer to help you out or answer your questions. (Corey)

As a result of the need for ongoing support, all participants who were not paired with a formal mentor sought out mentorship to get the support and understanding they needed.

Theme 4: Seeking Mentors

The fourth theme of Seeking Mentors outlines the techniques participants utilized in pursuing relationships with more experienced and knowledgeable instructors, and how this benefited them in the clinical setting. Participants identified mentors as necessary to enhance their knowledge, increase their understanding of the resources and of clinical instruction, and to feel supported in the clinical setting. As noted by Annie, "Being paired with another instructor that is going to be a good mentor, somebody who is available for you to touch base with is very important."

Although two participants were paired with another instructor for initial explanations, Annie was the only participant assigned to a formal mentor with whom she had contact throughout her experience, and she found this support invaluable:

> The instructor I was paired with made the world of difference . . . and so it was wonderful. She was very helpful at giving me the information I needed. She is the one that gave me all of the resources. . . . She was always there and available for me to talk to. Definitely, her help was really beneficial. She really went out of her way to make sure that I had the information that I needed. She has quite a lot of experience, and so she recognized the value of needing to do that, and she recognized that the program itself didn't offer that for most new instructors, and so because she had been given the opportunity to do it, she did, which made a world of difference in the end.

However, mentors were not readily available to most participants. Therefore, being proactive was necessary in seeking out the assistance they needed:

> There are a lot of emergency nurses that do sessional instruction on their own. So, I found those people, and I paired up with them and found constant ideas, I asked questions, but that was me being proactive that I want to be a good sessional instructor. (Lisa)

> There was one girl that I used to work with that was an instructor. So, I took it upon myself to contact her just to get an idea of how she did things in clinical. (Rhonda)

For one participant, this process increased her stress and frustration as she experienced guilt about bothering other instructors who had their own work to do. She believed she was burdening others, but also felt it was necessary to get the support she needed:

> I found the support I needed in other instructors who it wasn't their job to support me. So you feel bad even emailing them. How many emails are they answering a day? They don't need me to ask them questions. So I felt bad that I had to do that. (Dawn)

Mentors provided participants with a sense of support, and assisted in increasing their understanding, which they felt made them more effective in the clinical setting:

> I was given a booklet, and there is 50 pages of the role of an instructor, but you can read through that, and it's just a bunch of words a lot of times. To have someone beside you say, "This is also what we are looking for as well and this is how to do it. If you want to write plans, these are the resources we have so you can create a plan." (Jack)

> She was able to help me with the timelines, the flow of the semester, I could call her and she would help me as much as she could so it was really nice to have that available to me. (Corey)

> Jack was able to build rapport with faculty members who had previously taught on the unit where he worked. He was comfortable seeking out these faculty members as mentors from the beginning of his experience. As a result, he did not feel as overwhelmed as others who did not have this same support and guidance until further into their experience:

> I was fortunate enough that I'm in contact with the other instructors on the unit. I know them, I've worked with them, and so I can just easily approach them and say, "Hey, this is what's happening, what should I do? What do you think? How should I approach it?" But if someone didn't have a rapport with other instructors, it would be a lot harder. (Jack)

Jack attributed his ability to find mentors to his familiarity with the unit where he was teaching. He had been in contact with other instructors who taught on the unit while he was working as a staff nurse, and so when he began to teach, he was able to use these relationships for support and mentorship. The concept of familiarity went beyond the ability to seek out mentors and was identified as an essential component of clinical instruction for all participants in this study.

Theme 5: Familiarity

Familiarity is the state of knowing something very well. The theme of familiarity outlines how participants' knowledge of the unit, clientele, staff and their level of expertise in the clinical setting impacted their comfort, confidence, and perceived ability to fulfill some of the duties of their role. Not all participants were placed in areas known to them, which resulted in increased stress, as they were not only new to teaching, they were also in a new clinical area where they had no experience, expertise, or support from staff. For those placed on familiar units, current clinical knowledge of nursing in these areas provided them with the complex knowledge they needed to teach in the clinical setting. Relationships with unit staff acted to enhance their teaching, assisted in the process of student evaluation, and provided them with support, all of which acted to increase their comfort and confidence.

Familiarity with the units allowed participants to use their intricate knowledge to their advantage. They were aware of and comfortable with the routines, programs, and technology used on the units and could, therefore, relay this knowledge to their students, giving them a more well-rounded experience:

I have very up-to-date knowledge of what goes on, on the floor. So if there is a new piece of equipment that is brought in or if there is a new policy, I know that first and foremost. (Annie)

I'm comfortable with how we do things on the unit because I work there. I'm very familiar with our policies and procedures and with all medications. (Jack)

Teaching on familiar units meant that these participants had knowledge of theory for that practice area, which assisted them in helping students make the theory-to-practice link:

I taught on a unit where I had experience, so I had the knowledge I needed. If I had been a nurse from labour and delivery teaching on a renal floor, it would have been a lot harder. How am I supposed to teach students things that I don't even understand? (Corey)

Participants felt they were better received on units where staff members were familiar with them. They felt supported by staff, which gave them confidence and a sense of comfort:

I think the staff are more receptive of instructors who have worked in the area than instructors who haven't worked in the area. If I'm bringing a group of students to a unit where I have no experience, they would look at me and be like "Well, when have you ever worked here?" I think that when staff knows that you have experience in the area, they have a trust in you and your abilities, and so they are more confident in allowing you to take students into their territory and work with their patients. (Annie)

I could walk in there, and I felt like they knew who I was, and they supported me. They knew what kind of a nurse I was. (Lisa)

The relationships with the staff on the units allowed them to use the staff as a resource, augmenting their teaching by increasing learning opportunities for the students:

On the units where I didn't work, the nurses didn't seek me out as much and say, "I have this to do, can you help me out with this?" I could get a student to do that skill. (Lisa)

So being a staff member on that floor, you know the personalities of the staff better, and once you get to know your students, you can possibly better pair them so that they can have a better experience. (Annie)

Having that rapport with staff helps because if the students have a question I don't know the answer to, I can direct them to someone who would know. It makes a big difference. (Jack)

Relationships with staff also played a role when it came to evaluating students. They were able to use the staff as a resource and, thus, evaluate students based on combined knowledge and information:

I even talked to some of the staff to see what they felt about these students and how they felt that they were coming along or anything that they may need to work at. (Rhonda)

There were concerns that were brought to me from the nurses she worked with. As instructors, we rely on their feedback as well, because they'll go with their nurses and do things with them, and those nurses will often come to us and say, "This student might need a little work in that area." Then I would go with that student, work with them, and assess them on my own to see where their needs were. (Annie)

Knowledge of the units and the staff was so significant that participants reported they would not, and in fact, could not teach in areas where they had no familiarity:

If they asked me to teach on psychiatry, I wouldn't teach. I have no psychiatric nursing background. I will only teach in areas that I feel comfortable with and have experience in. . . . If I was placed on a renal unit to teach, I would be a deer caught in the headlights. I don't have the knowledge base to teach on a renal unit, and I don't think I could have learned it fast enough as a sessional instructor. (Lisa)

I think compared to some of the other sessionals that were hired who didn't have the knowledge in the area where they were teaching, I could totally understand the anxiety that would come with that because for me, that's stuff that I could do with my eyes closed at this point. (Gina)

For three of the participants in this study, the experience of being a sessional instructor was fraught with difficulties from the beginning, given that they were placed in unfamiliar areas to teach. This acted to increase their stress, as they were not only dealing with being novice clinical instructors; they also lacked expertise and were deficient in their knowledge of and comfort in the clinical area:

The first three weeks were so stressful. I don't even feel like I was physically doing what I was supposed to be doing. . . . I would never again want to teach anywhere I hadn't worked. If I worked in long-term care for 10 years, it would have been a totally different story . . . . I've been an NICU nurse for four years. I really didn't know the patients or the area. I am in a different world where I work. The last time I worked in long-term care was when I was a student, and I barely remember that. . . . When I think back to teaching students now, I would be so much more confident and more comfortable teaching where I work: 100%. (Dawn)

Challenges presented themselves when linking theory to practice in the clinical setting, given that some participants did not have the expertise that came with teaching in a familiar area:

I couldn't even prepare my students properly for what to expect because I didn't know all of the patients either. So it has a lot to do with having that knowledge and being comfortable with it. If you teach where you work, you have much more knowledge to share with them. I'm confident in my skills and knowledge where I work now, but it took a long time to get there. (Dawn)

These participants did not have the same sense of support in the clinical setting, as they did not have the added benefit of using their relationships with staff to increase learning opportunities for their students or to assist them when evaluating students:

The staff weren't overly happy about getting teachers last minute, so it made for a little bit of challenges. It was definitely not optimal. (Corey)

If I went onto the medical floor with a group of students and I said I'm bringing a group of students, they would look at me and be like "Well, when have you ever worked here? Do you know how we do things here?" I think that sometimes when the staff knows that you have experience in the area, they have a trust in you and your abilities, and they are more comfortable allowing you to take students into their territory and work with their patients. (Annie)

Consequently, these participants had to work on forming relationships with staff to ensure a positive experience and acceptance in the clinical setting. This meant that instead of focusing on teaching, they were focused on developing relationships with the staff:

Even more than being familiar with the unit was being familiar with the staff. Getting along with staff and knowing what staff to use as a tool that was a huge thing. I didn't know anybody in long-term care, so I was trying to bridge that gap with staff while teaching students. I felt like I was doing two things at once. (Dawn)

Regardless of where participants were placed to teach, what resources they received, whether or not they received an orientation, or what struggles they encountered, all identified personal and professional growth as an end product of their experience. The growth in both these areas went beyond their ability to gain experience and skill at teaching. It made a positive impact on their nursing practice and affected them at a personal level as well.

Theme 6: Growth

The last and final theme that emerged from the data analysis process was the theme of Growth. Within this theme, the subthemes of Personal Growth and Professional Growth were identified, wherein participants outlined the personal and professional learning that occurred through their experiences. By dealing with and overcoming the challenges they encountered, participants grew on a personal level. As stated by Dawn, "Overall, it was a really good experience for me personally, for my own personal growth, but I just found it really challenging."

Personal Growth

Participants believed that they possessed strong personal skills, but found that being challenged enhanced these skills further. This had a direct impact on their personal growth, which they felt would benefit them in both their personal and professional lives:

I'm really not assertive, but it sure taught me how to be assertive—assertive with health care aides who weren't treating students properly, assertive with students who weren't doing what they should have been doing. I would be way more adamant about what I needed to be prepared. (Dawn)

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I learned how to communicate quite a bit better. I'm so used to my daily life, nursing, just doing, and it's quick, and it's easy, and it's second nature to me. I found my communication skills got a lot more well-defined when I was teaching because you have to think about every step of the process and explain it in a way that the students understand, and so you can't just say what you are thinking. (Corey)

Their ability to persevere and overcome the challenges increased their confidence and provided them with a sense of accomplishment:

I feel like I conquered a big thing. It was very rewarding for me, but it was one of the most stressful, emotional things I've ever done. It was a confidence thing. . . . It was good for me to have to come out of my shell a little bit and be that go-to person for the students. It's a huge confidence booster. (Dawn)

Teaching those students and having them actually learn something from me, that was probably the best part, and to see them develop from week one to the end, that they could do their assessments and to know that I was a part of it. I just felt great just even being a part of that, even if it was just a little part of it. . . . That was the most rewarding thing for me. (Rhonda)

Participants found that being put in a situation where they had to adapt or fail forced them to figure out how to be effective, thereby fostering their growth and independence:

I figured out that I needed to stop worrying about how uncomfortable I felt, about what I didn't know, and turn around and just say, "It's not even about me. It's about them. So what do you need from me?" The one thing you learn in nursing is to figure out how to find the answer. Nobody is going to hold your hand and tell you how to do anything. Didn't we all learn that? I should have known that. (Dawn)

Professional Growth

Having the opportunity to teach as a sessional instructor, while still working as staff nurses, made many of the participants more aware of their own practice. Students challenged them and encouraged them to do things the right way—and not necessarily the easy way. This experience prompted them to take this newfound realization into their daily practice and not just when students were present:

It keeps you on your toes. I think I really enjoy that, to be constantly up to date of the new practices that are coming out, new policies that are starting to evolve, and starting to be put into place. It has helped me to be more attentive to how I practice. You can get into habits. You understand what policy is, but it takes too much time to do it this way, and you do little shortcuts, but then all of a sudden, when you have students asking you how to do it properly and you need to be an example of that, then you start putting that into practice too and, ok, no more short cuts. . . . I just feel like I have more integrity now as a registered nurse. (Jack)

I think students challenge you to be a better nurse, and they challenge you to think about things more thoroughly and be more aware of the steps you take to do any task, because you have to explain everything down to the very basics, and it makes you more aware of your practice and the things you are doing. (Corey)

What I ask the students to do, I have to do in my own practice. I can't be asking them to do something that I don't do or if I don't believe in it. (Lisa)

Their perceived successes reinforced participants' confidence and left them feeling more comfortable and competent with their teaching skills. As noted by Gina, "I'm not going to be the same teacher this year as I was last year. . . . I think I learned a lot of what not to do, how not to go about it." This, in turn, made them feel better equipped and prepared to teach again in the future. Rhonda stated, "Each semester, I learn, and I'm ironing out the kinks for me so I can be a better instructor."

The students' growth and learning emphasized for participants that they did, in fact, honour their professional responsibility to make a difference, thereby ensuring the integrity of the nursing profession:

I did feel like, in the end, that I gave them a really good experience. I figured it out, and through all of the tears and the crazy frustration at the beginning, to end up saying, "I think I actually did a good job and that it went well in the end." When you have your students telling you that they really enjoyed their clinical and that they felt like they learnt what they needed to, it was wonderful. (Dawn)

All participants identified that the growth and learning that occurred on a personal and professional level, the sense of accomplishment, and their belief that they did contribute in a positive way to the nursing profession ended up motivating them to think

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about teaching again. As Dawn stated, "I would do it again because they need good instructors. They need people that care, right? Isn't that the most important thing about nursing?"

Chapter Summary

Even though some participants experienced fewer challenges than others, the sense of being unprepared was shared by the majority of participants. Challenges presented themselves right from the beginning for three of the participants who were placed in areas where they lacked any experience, expertise, or relationships with staff. For others, these challenges became more evident as time went on, as they were trying to figure out how to function effectively in the clinical setting.

Regardless of the challenges that participants encountered, all participants sought ways to increase their knowledge and understanding and get the support they needed. Mentors played an essential role for all participants as a means of support, guidance, and knowledge, and assisted them in understanding aspects of clinical instruction. Some participants reported that mentors were available to them from the beginning of their experience. As a result, they were less overwhelmed, as they had the support and guidance they needed.

Having experience and expertise in the area where they taught was a major influence on the amount participants struggled with linking theory to practice and student evaluation. Having expertise in the area provided them with intricate knowledge of the units and the clientele and, thus, an understanding of what students should learn in the clinical setting.

Familiarity with staff provided participants with the support they needed and provided some with mentors, as they had access to those who could support them in their teaching role because of prior relationships that were strong and firmly established. This familiarity also assisted some in student evaluation, as their relationships with staff allowed them to request information about student performance.

Participants reported that while this experience was frustrating and stressful, it was being challenged that prompted them to figure out how to go about teaching in such a way as to provide students with a positive learning experience. Being challenged also afforded them the opportunity to grow and learn as instructors as well as nurses. Professional integrity, enhancement of personal skills, enhancement of teaching skills, and the internal sense of accomplishment made this a rewarding and educational experience. All participants identified that it was their own growth and learning and the impact they had on their students and the nursing profession that made the experience worthwhile, fostering their desire to teach again in the future. The findings of this study will be discussed in the following chapter and compared to findings of other studies that looked at sessional instructors as well as novice educators, in general, transitioning into academia.

CHAPTER FIVE: DISCUSSION

The purpose of this exploratory descriptive qualitative study was to explore and understand the experiences and needs of nine RNs in the role of novice sessional clinical nursing instructors to gain an understanding of their experiences and, in turn, an understanding of their needs. The results of these interviews provided some insight into this phenomenon. A discussion of the findings and subsequent recommendations for nursing education conclude this chapter.

Research about role transition in nursing education has focused mainly on the transition from student to graduate nurse and clinical nurse to educator in the academic setting in a part-time or full-time capacity (Anderson, 2009; Dempsey, 2007; Siler & Kleiner, 2001; Weidman, 2013; Young & Diekelmann, 2002). Literature regarding sessional educators included (a) how educational institutions should reconceptualise their teaching teams to include sessional staff (Coombe & Clancy, 2002), (b) perceptions of what sessional teachers felt they brought to the classroom in an Australian nursing program (Andrew et al., 2010), (c) how part-time adjunct faculty describe their role and their needs related to fulfilling their role (Roberts et al., 2013), (d) issues experienced by sessional teachers with student evaluation (Duke, 1996), (e) the experiences of continuing academics working with sessional teachers (Peters et al., 2011), (f) evaluation of competency of sessional clinical educators (Robinson, 2009), and (g) identifying quality and uncertainties in the marking of university assignments by sessional staff (Smith & Coombe, 2006). Other literature reviewed issues related to utilizing sessional teachers, the casualization of the academic workforce (Kimber, 2003), and their training and support (Herbert et al., 2002). Although these researchers outlined issues with sessional

educators, they did not focus on the experiences of novice sessional clinical instructors or their transition to the role of educator in a sessional capacity.

Although many of the experiences of participants in this study paralleled the experiences of other clinicians who took on the role of novice educator (Andrew et al., 2010; Anibas et al., 2009; Dempsey, 2007; de Sales, 1996; Duke, 1996; Kelly, 2006; McArthur-Rouse, 2008; Peters et al., 2011; Roberts et al., 2013; Schoening, 2013; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013), there were also differences. Participant discussion focused on (a) preparation and orientation, (b) role ambiguity and enculturation, (c) theory-to-practice link, (d) student evaluation, (e) the expert to novice journey, (f) familiarity with the units, staff and clientele, (g) support and mentorship, and (h) personal and professional growth.

Preparation and Orientation

Preparation and understanding were key concepts that affected participants throughout their experience. Having time to prepare is an essential component of starting in a new role and assists in increasing understanding. The novice educator should have time to (a) network, (b) shadow others performing in the same role to gain an understanding of the responsibilities of clinical instruction, (c) review the philosophy of the school and the curriculum, (d) gain an understanding of the job description, and (e) thoughtfully prepare for the teaching role by gaining knowledge and understanding of course sequencing and the amount of knowledge that students should be bringing from previous courses (Culleiton & Shellenbarger, 2007). For participants in this study, the components of successful preparation were absent for a variety of reasons.

Given that five of the nine participants in this study were hired at the last minute, often within days of starting to teach, they did not have time to engage in preparatory activities. Participants described feeling like they were "thrown in" and "overwhelmed," often lacking an orientation, resources, explanations of the resources they were provided with, and an in-depth understanding of the expectations of their role prior to teaching.

This experience mirrored other studies that have identified that sessional instructors are often hired "at the 11th hour," which affects their ability to prepare and collaborate with faculty (Peters et al., 2011; Roberts et al., 2013). As with participants in this study, the sense of being "thrown in" (Schoening 2013, p. 169) or having to "hit the ground running" (Anibas et al., 2009, p. 211) were common themes in the literature related to the quick hiring of sessional educators, which often resulted in sessional educators feeling overwhelmed and less than confident in their role (Anibas et al., 2009; Dempsey; 2007; Schoening, 2013; Siler & Kleiner, 2001).

This urgent hiring and resulting deficient preparation resulted in inadequate understanding of some of the expectations of their role: specifically, that they would need to engage in preparatory activities on their own time. Given that five of the participants were hired at the last minute by "word of mouth" and not by responding to a job posting, they did not participate in an interview, which limited communication between them and the educational institutions, thus affecting their ability to gather information about the parameters of their role.

The expectation of self-preparation was not communicated to participants, and as a result, there was misunderstanding about how to proceed. It was felt by participants that because they were only financially compensated for their orientation and clinical shifts,

they should not be expected to prepare on their own time. After researching collective agreements from four institutions in Alberta, I found that the wages for sessional clinical instructors range from $60 to $84 per hour. According to the United Nurses of Alberta (2013) collective agreement, the wage for RNs with a baccalaureate degree, which was the educational level of all participants, is $37.03 to $48.21 per hour (pp. 58 & 300), depending on the number of years worked. It is evident that clinical instructors are financially compensated well above the rate of a regular staff nurse. It could be argued then that they are, in fact, being paid for performing preparatory activities and instruction-related duties outside of clinical time, but the problem lies in the fact that this was not explained nor understood by participants.

The participants anticipated that the orientation the educational institution offered would sufficiently prepare them to teach This expectation was reinforced when they were hired as they were reassured that they would get the training and the information they needed to take on this new role.

Although five of the participants were not hired with enough time to participate in an orientation, the other four participants were hired early enough that they were able to attend this preparatory activity. These orientation sessions were offered by the educational institutions as a way of preparing them for the teaching role.

Orientation is an essential component of the transition from clinician to educator, in any capacity. Whether the novice educator is hired into a part-time, full-time, or sessional position, orientation assists in preparing new educators for teaching, as it aims to provide novices with the information and resources they need to have to teach (Gazza & Shellenbarger, 2005; Hewitt & Lewallen, 2010).

Formal orientation should include a multitude of components, such as an orientation to the mission, goals, structure, curriculum, policies, and procedures of the institution (Hewitt & Lewallen, 2010; Peters & Bolyston, 2006); a clearly stated job description (Hewitt & Lewallen, 2010); as well as the student evaluation process and documents (Hewitt & Lewallen, 2010; Roberts et al., 2013). Novice educators should receive information about the instructional process, lesson plans, and suggestions for clinical teaching and handling student issues (Bell-Scriber & Morton, 2009), and should also be able to build relationships with faculty members and be supported and encouraged in their efforts (Hinchcliffe Duphily, 2011).

For participants in this study, the orientation sessions offered were general in nature and did not cover aspects of clinical instruction that participants felt they needed, such as information about values, goals, expected student outcomes, course objectives, and policies. In addition, it did not provide information about aspects of clinical instruction, such as curriculum, theory, pedagogy, student evaluation, managing multiple students, dealing with struggling students, and dealing with student issues such as sick calls and unprofessionalism. Consequently, participants had to determine how to deal with the challenges that the minimal amount of preparation created. Roberts et al. (2013) reported similar findings, where sessional educators who received an orientation felt that their orientation did not assist in adequately preparing them, as the sessions were too general in nature and lacked specific information about theory and teaching.

Role Ambiguity and Enculturation

Role ambiguity occurs for novices as a result of the insufficient preparation, orientation, mentorship, and socialization to a new role in academia (Schoening, 2013).

In Kahn, Wolfe, Quinn, and Snoek's seminal work (1964), role ambiguity was identified as "a direct function of the discrepancy between the information available to the person and that which is required for adequate performance of his role" (p. 73). Role ambiguity occurs when the role that a person is expected to perform within an organization is not fully communicated. If a person lacks the necessary information to perform in his/her role, the person will exhibit coping behaviours, which include attempting to solve the problem and avoid the stress that role ambiguity creates. The person may experience anxiety and will ultimately perform less effectively. Even though participants in this study were aware of the expectation to teach, there was limited understanding of the behaviours that would lead to the fulfillment of their role. As stated by Dawn, "I know my nursing skills. So, teach me all of the things that I need to be a good clinical instructor so that I can teach them how to be a nurse."

Enculturation is a process that decreases role ambiguity and assists with socialization, as it ensures that the new employee performs in a way that *is in line with* the values, beliefs, and norms of the institution. It has been defined as "the process whereby individuals learn their group's culture through experience, observation, and instruction ("Enculturation," n.d., para. 1). The transition from clinician to sessional, part-time, or full-time faculty requires enculturation, as the culture within academia is vastly different from that found in hospital-based settings (Hinchcliffe Duphily, 2011; McDonald, 2010; Schriner, 2007). Strategies to ensure successful enculturation of new educators include connecting them with mentors and providing a routine orientation that delivers an overview of policies, procedures, expectations, curriculum, grading, professional development opportunities, and academic and student policies as well as

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personnel policies. This orientation allows new educators to figure out how to get things done in the new culture and how to navigate in an environment where values, beliefs, and political structure are typically different from that of the practice setting (Gazza & Shellenbarger, 2005).

For participants in this study, the combination of the absence of an extensive orientation, being hired at the last minute, as well as being hired to teach in the clinical setting that occurs in a hospital or community setting and not directly at the educational institution, as would be the case with classroom teaching, contributed to their inability to connect with others. Consequently, the process of enculturation was not initiated, and therefore they were not socialized to academia which resulted in role ambiguity for some.

The insufficient understanding of the academic culture can cause internal dissonance, as there can be conflict between the two cultures. If there is inadequate understanding or awareness of the new culture, the clinical culture guides behaviour rather than the academic culture (McDonald, 2010; Siler & Kleiner, 2001). As a result, the instructor will then guide clinical situations based on what is valued and believed in the clinical culture, such as performing skills and completing tasks to *get the job done* focusing on the *how* of providing quality patient care by the process of *doing.* In contrast, the academic culture emphasizes theory and educational outcomes (Elliott & Wall, 2008), which encourages understanding the *why* when providing quality patient care. This limited understanding can therefore impact the instructor's ability to evaluate students based on theoretical knowledge and when assisting the students with linking theory-to-practice in the clinical setting.

Theory-to-Practice Link

Students, generally, are not able to make the theory-to-practice link independently, so the task of applying the theory learned in the classroom to the clinical setting falls on the clinical instructor (de Sales, 1996; Wong, 1987). The debate continues about how this link is made, and although it is desirable to eliminate the gap between theory and practice, the change in nursing programs from hospital-based to university-based has created a situation where there is a further separation between those who teach and those who practice (Ousey, 2000), increasing the practice-to-theory divide (Cave, 2005). So even though clinical teaching may be undertaken by those who teach theory, more and more often, sessional clinical nursing instructors are hired to teach practice-based courses.

Sessional clinical instructors do not typically participate in discussions regarding curriculum design and implementation; therefore, they are generally not as familiar with the curriculum as more experienced regular faculty (Allison-Jones & Hirt, 2004; de Sales, 1996; Little & Milliken, 2007; Peters et al., 2011). Although students must learn how to perform skills in the clinical setting, it is an understanding of the *why* that acts to enhance nursing knowledge. Therefore, insufficient enculturation can have a direct impact on the instructor's ability or willingness to link theory to practice in the clinical setting. This was reinforced by Lisa who reported, "A lot of that classroom stuff, depending on what it is, we can't link it because it has nothing to do with clinical."

Unfortunately, as in the case of the study participants, the inadequate understanding of the curriculum and knowledge of the scope of and sequencing of theory may mean sessional instructors struggle with making the theory-to-practice link. As a

result, they may be focusing on tasks rather than the ability to make decisions about patient care based on theoretical knowledge.

Of particular concern, one respondent in the current study reported that she did not feel the theory portion of the student's education was relevant to the area in which she was teaching. Andrew et al. (2010) also found that sessional educators often view the theoretical portion of nursing education as the "fantasy world" and the clinical portion as "the real world" (p. 455). The lack of appreciation for the theoretical aspect of nursing education, possibly due to insufficient enculturation, can result in a decreased understanding of the importance of linking theory to practice in the clinical setting.

Student Evaluation

Although nurse educators in the classroom setting assess students' theoretical knowledge (de Sales, 1996), clinical instructors are in the position of assessing practical knowledge: that is, the student's ability to apply theoretical knowledge. The ability of clinical instructors to evaluate student performance in the clinical setting is one of the main characteristics necessary for effective clinical instruction (Gignac-Caille & Oermann, 2001). Student evaluation in the clinical setting is a process that is complex and time consuming and should include a multitude of components (e.g., observation, care plans, concept maps, participation in clinical conferences, clinical journals, presentations, clinical logs, and learning contracts) to ensure a thorough evaluation of student learning, knowledge, and functioning in the clinical setting and to confirm they are providing competent patient care (Oermann, Yarbrough, Saewert, Ard, & Charasike, 2009). Evaluation tools help both students and instructors determine how well students are meeting course objectives, verify that students are safe in practice, provide

opportunities for feedback, and explicitly state criteria so that all who use the tool are aware of and understand what is expected (Krautscheid, Moceri, Stragnell, Manthey, & Neal, 2014). Clinical evaluation tools are not only designed to assess a student's knowledge, skill, and attitudes in relation to program and course outcomes and professional nursing standards, but they also assist in determining the student's progression within the curriculum and validates competency (Krautscheid et al., 2014). Thus, an understanding of student evaluation processes is a necessary part of a thorough orientation to ensure that instructors are able to accurately assess student knowledge and practice (Hewitt & Lewallen, 2010; Roberts et al., 2013).

Difficulties with student evaluation arise when trying to determine if students are making practice decisions from their knowledge base and their ability to integrate cognitive, affective, and psychomotor skills, or if they are simply competent at performing a task (Woolley, Bryan, & Davis, 1998). It is important to ensure that student assessments are a true reflection of the knowledge base of the student, rather than a simple check-list of practical skills (Clifford, 1994; Murray, Gruppen, Catton, Hays, & Woolliscroft, 2000; Ulfvarson & Oxelmark, 2012).

Without knowledge of the multiple components of student evaluation, curriculum, and theory, the clinical instructor, whose job it is to assist the student in making the theory-to-practice link in the clinical setting, is unable to do so and may, in turn, assess procedural skills as opposed to knowledge and critical thinking skills. Difficulty with this aspect of clinical instruction for participants in this study, as a result of the insufficient knowledge of the specific curriculum and theory students were taking concurrent with

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clinical practicum, correlated with other studies that have identified issues with student evaluation by novices (Duke, 1996; Kelly, 2006; Weidman, 2013).

While the concept of using the same evaluation tool for every level of a student's education was not identified in the literature, it was a concern for some of the participants in this study. There was incomplete understanding of how to use the tool as well as how to use the same tool to evaluate students at different levels of their education. Given that the scope of theory taught in year one is more limited than the theory in year four, having knowledge of curriculum and sequencing of theory, along with knowledge of how to use the tool effectively, would allow the instructor to assess if the student is functioning at the level required for their level of education.

Unfortunately, only two participants were made aware of how to use the evaluation tool effectively. Consequently, participants in this study identified using their gut feelings when evaluating students in the clinical setting. As reinforced by participant Lisa, it was her "spidey senses" that often alerted her to struggling students. This finding was consistent with Duke's (1996) findings, where sessional clinical nursing instructors relied on their nursing experience, knowledge, and "gut feelings" to assess student performance. This can be problematic when students are failed and there is little evidence to back up the instructor's gut feeling.

As a way of dealing with their limited understanding of the evaluation process, participants used their relationships with staff to assist them with student evaluation. Staff provided information about student performance and acted to supplement the participant's own knowledge of how students were functioning in the clinical setting. Despite the fact that the use of staff to supplement novice instructors' teaching and

evaluation of students was not found in the search of the literature, it was significant for participants in this study. Like the participants, staff members in the clinical sites most likely did not have knowledge of the sequencing of theory, curriculum, expected student outcomes, or the evaluation process. Therefore, it was unclear if thorough and accurate evaluations were being completed.

Since the majority of participants taught in areas where they had expertise, they felt confident knowing they had the clinical skills and expertise to evaluate students. However, without an understanding of the evaluation tool, sequencing of theory, and the ability to use a variety of techniques to assess student performance based on theory, it is unknown if the students were being evaluated fairly or if they were merely being evaluated on their ability to perform skills. This insufficient understanding of the different aspects of student evaluation is problematic, as it could result in incompetent students making their way through the nursing program (Larocque & Luhanga, 2013), competent students being under rated in their performance, or competent students being inadvertently failed. In addition, the deficiency in understanding could result in the decision to fail a student being questioned; as there would be minimal information on which to base a participant's decision other than gut feeling.

Duke (1996) found that sessional instructors exhibited low self-esteem, which affected their confidence when making decisions about student performance. They gave the students "the benefit of the doubt" and took on the responsibility of student performance, attributing it to something they had or had not done as instructors. So, although the participants in Duke's study felt their observations were valid, they did not have the confidence to act upon them. They experienced role conflict, as they had

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difficulty separating their relationships with the students, the staff, and the universities for which they were working. So, even though they felt angered when student mistakes compromised patient care, their teaching role took precedence over their nursing role and as a result, their feedback to the student was generally mild. A sense of moral caring influenced their decisions to fail a student, as there were concerns about their ability to alter the career choice of students by not allowing them to continue on their chosen career path.

In contrast to Duke's (1996) findings, participants in this study reported that they felt an ethical obligation to fail students who were not competent. In fact, several of the participants did fail students based on the student's performance and did not allow their personal feelings to influence their decisions. This was articulated by Annie, who stated, "Emotionally, it is hard to fail a student, but I feel that as a nurse and as an instructor, it's my ethical obligation. I mean, you can't allow people to pass who are unsafe."

Participants in this study also indicated that they believed they had strong personal skills, such as assertiveness, confidence in their nursing skills, and a passion for and dedication to the nursing profession, which may have influenced their ability to do the right thing when it came to failing students. As Corey explained, strong personal skills were necessary to stand by one's decisions: "No one came back when I failed a student and said, 'No, you have to pass the student,' but I did feel pressure to pass them. But I think I have a fairly strong personality and could defend my decision to my supervisor."

Expert to Novice

Despite being expert clinicians, which allowed participants in this study to deal with the challenges of linking theory to practice and student evaluation, they were novice educators. Sessional instructors are most often hired because of their expert clinical status, but being an expert nurse does not automatically make that same nurse an expert nurse educator. Not only were the sessionals in this study hired for a minimal amount of time, which limited their ability to become totally immersed in teaching, they had limited knowledge of teaching pedagogy, did not feel fully prepared to teach, and were dealing with learning a new role as novices after considering themselves to be clinical experts.

Patricia Benner's (2001) work has been frequently utilized to describe how nurses acquire nursing skill and knowledge within the clinical practice setting. Novice-to-expert theory describes the following five levels of proficiency as nurses progress from novice to expert: (a) novice (i.e., no experience); (b) advanced beginner (i.e., marginally acceptable performance); (c) competent (i.e., moderate, specific experience); (d) proficient (i.e., moderate, broad experience); and (e) expert (i.e., extensive experience, intuitive) (Altmann, 2007; Benner; Ulrich, 2011). Benner maintained that progression from novice to expert reflects changes in three areas. First, the person must move from reliance on abstract principles to one's own past concrete experience. Second, the person must be able to distinguish between all relevant information in a situation to distinguish levels of importance. Lastly, the person becomes an involved performer rather than a detached observer.

Within Brenner's (2001) model, one of the key concepts is that an individual can be an expert in one area, but novice in another, such as an expert clinician, but a novice

educator. Furthermore, Benner's theory stresses that experience is a prerequisite for becoming an expert. Foreknowledge is required for the construction of new knowledge, and "only when the event refines, elaborates, or disconfirms this foreknowledge does the event deserve the term 'experience'" (p. 8).

Gaining experience that will provide knowledge to build on existing knowledge and the ability to become experts in the academic role is affected by the time the clinician or faculty member has to become immersed in teaching (West et al., 2009). When placed into a new role, it is unrealistic to expect that an expert clinician will become an expert educator instantaneously (Spencer, 2013). To progress through the stages of novice to expert, the novice and advanced beginner need support in the clinical setting (Ulrich, 2011) and require the information needed to relearn as novices (Weidman, 2013).

Just as a student learns to practice based on his or her theoretical knowledge in the clinical setting, the teacher too must have initial theoretical knowledge of teaching to build further knowledge and move from novice to expert. In addition, expert clinicians believe that their clinical knowledge and skill automatically make them good educators; knowing how to be a nurse is equated to being able to teach nursing (Zungolo, 2004). Despite their nursing experience and expertise, very few sessional instructors have teaching qualifications that would meet the requirements to teach (Coombe & Clancy, 2002; Duffy et al., 2008). Even though clinical competencies, such as the ability to care for patients in real situations and possessing strong clinical skills, are main features of an effective instructor, the ability to teach is equally important (Gignac-Caille & Oermann, 2001), and how teachers teach is a powerful predictor of how much students will learn (Peterson, Kromrey, Lewis, & Borg, 1992).

Only one participant in this study had any educational pedagogical training and knowledge, as she had completed two years of a university-based education program. All participants in this study were considered novice educators, with three participants having one sessional appointment, five participants having two sessional appointments, and one participant having three sessional appointments. In addition, five of the participants had five years of nursing experience or less, which would indicate less informal teaching experience in the clinical setting as compared to their counterparts, who had 11 to 18 years of nursing experience and more informal teaching experience. None of the participants was provided with any information about clinical pedagogy that focused on how teachers teach in the clinical setting, which would have provided a stronger base of knowledge to build on and move out of the novice stage (Peterson et al., 1992).

To deal with the move from expert clinician to novice educator, participants sought out the support they needed. Mentorship was a way for participants to connect with more experienced instructors and get the support and understanding they needed.

Support and Mentorship

All participants who were not paired with a formal mentor sought out mentors for the additional support and understanding they needed. Mentoring has been extensively investigated as a positive, beneficial, influential, and essential way of supporting novice educators (Cangelosi et al., 2009; Dunham-Taylor et al., 2008; Hinchcliffe Duphily, 2011; Schoening, 2013; Siler & Kleiner, 2001; Spencer, 2013). Interestingly enough, although the benefits of mentoring have been well documented (Anibas et al., 2009; Cangelosi et al., 2009; Dunham-Taylor et al., 2008; Hinchcliffe Duphily, 2011; McArthur-Rouse, 2008; Schoening, 2013; Schriner, 2007; Siler & Kleiner, 2001;

Spencer, 2013; Weidman, 2013), only one participant was paired with a formal mentor, while all other participants engaged in informal mentorship relationships by seeking out their own mentors.

Teacher mentorship, as defined by Podsen and Denmark (as cited in Vierstraete, 2005), is the process of "helping novices speed up the learning of a new job or skill and reduce the stress of transition, improving instructional performance of novices through modeling by a top performer, and socializing novices into the profession of teaching" (p. 383). A successful mentorship relationship strengthens the novice's confidence and, at the same time, affirms his or her talents and increases the probability that the novice will function ethically and responsibly and will develop a strong professional identity (Johnson, Huwe, & Lucas, 2000). According to Ragins and Cotton (1999), mentors have two main functions (p. 530). First, they provide career development and help the novice to "learn the ropes" of the new institution. Second, they provide psychosocial functions that enhance the sense of competence and self-efficacy as well as personal and professional development.

Formal mentorship programs are a way of ensuring that a novice is paired with a mentor, objectives are set out by the institution, and the focus is on career goals. Despite the fact that there are numerous positive aspects to a formal mentorship program, there can also be the issue of poor matches between the mentor and the mentee. These poor matches are not uncommon and result in short-term orientation, and they do not facilitate any long-term support and guidance (Gazza & Shellenbarger, 2005). In informal mentorship relationships, the goals develop over time and are adapted based on the needs of the novice and not of the organization. Mentors and mentees are more likely to be

compatible if the mentor and mentee choose each other, and mentors are typically more motivated because they have volunteered for the job (Ragins & Cotton, 1999). Informal mentorship relationships have been reported as the most effective approach, as they develop spontaneously and are typically a good match, given that the mentor and the novice migrate to one another (Gazza & Shellenbarger, 2005).

The participant who was paired with a formal mentor found this experience invaluable while transitioning into the role of novice sessional clinical instructor. The mentor provided her with support, resources, and information about student evaluation and teaching strategies, which increased her understanding of what being an instructor meant. For all other participants, mentors were seen as necessary and were sought out to provide support and to increase their understanding.

This finding was similar to that of Roberts et al. (2013), who found that adjunct faculty who were paired with a formal mentor identified mentorship as a support strategy that was extremely helpful when dealing with clinical issues. Those who were not paired with a mentor felt "just out there" and lacked a sense of connection to formal resources or support (p. 299).

The need for mentorship was necessary for participants in this study as a way to deal with and overcome some of the challenges they encountered throughout their experience. Given that most participants were not provided with time to prepare and, as a result, had limited understanding of the instructor role, mentoring relationships, both formal and informal, became even more important in providing them with the support they needed to increase their understanding.

Familiarity

The concept of familiarity was extremely important for participants in this study. Those who were placed on units familiar to them were able to use their expertise to assist in linking theory to practice and to evaluate students in that clinical area. Additionally, the relationships they had with staff increased their comfort and confidence in the clinical setting. These relationships assisted them with their teaching and increased their knowledge of student performance. This familiarity allowed them to focus on teaching rather than spending their time orientating themselves to the units, staff, and clientele.

Those who were placed on units unfamiliar to them experienced increased stress and feelings of being overwhelmed. Expertise develops over time, and expert knowledge in one nursing area does not automatically translate to expert knowledge in a different area. Therefore, these participants experienced a sort of "double whammy," as they were now both novices at teaching as well as novice clinicians. As a result, confidence in their ability to teach was negatively affected. In addition, they were unknown to the staff and thus did not have the same level of support when teaching and evaluating students and did not feel as accepted as participants placed in familiar areas. Familiarity and connections with staff were documented in the literature as a form of support for sessional clinical instructors (Roberts et al., 2013).

Although no literature examined how the use of nursing expertise is utilized to teach in the clinical setting, it has been identified that nursing expertise is necessary when teaching in the clinical environment and assisting students in linking theory to practice (Andrew et al., 2010; Beres, 2006; Peters et al., 2011; Spencer, 2013). The ability of participants to use their expertise to guide the student's experience and assist in linking

theory to practice has reinforced the need for sessional instructors to have expertise in the nursing practice area where they are teaching.

Growth

The participants in this study felt that they were able to overcome the struggles they encountered, which resulted in growth and learning for them. They utilized various techniques to navigate the new experience, which allowed them to grow as educators and nurses. There was a greater understanding of what was expected of them as they progressed through their experience, and their role ambiguity decreased as a result. Through the process of encountering struggles and seeking out support and knowledge, they were able to develop a deeper understanding of clinical instruction, as well as the resources and how to use them effectively. By the end of their experience, they felt more comfortable and confident, believing that their teaching skills had improved. Their growth and learning made all of their frustrations worth it, and they all identified that they wanted to teach again in the future, with their acquired knowledge and understanding. Not only did the experience increase their abilities as educators, it also impacted their nursing practice in a positive way, and they believed they were better nurses because of the experience. It made them more aware of doing things the right way, and not the easy way, within their own practice.

The personal growth that occurred and the realization that they had accomplished what they set out to do (i.e., to teach and make a positive contribution to the nursing profession) were rewarding and provided participants with a sense of accomplishment. They gained knowledge and skill throughout the experience that not only impacted their professional lives, but also impacted them on a personal level. The attributes identified as

reasons that participants felt they could teach, such as confidence, assertiveness, and communication skills, were further enhanced by their experience, making them better people, better teachers, and better nurses. All participants felt they learned and grew from the experience, and in the end, this growth was yet another motivator to teach again. This mirrors other studies that have identified that the growth that occurs as educators, the formation of an educator identity, the love of teaching and making a positive contribution to student learning are reasons to continue in the teaching role (Hinchcliffe Duphily, 2011; Schoening, 2013).

The findings of this study have provided some insight into the experiences and, in turn, the needs of the novice sessional clinical nursing instructor, which were used to establish some recommendations for nursing education.

Recommendations for Nursing Education

The findings of this study, as well as others that have examined the transition of clinician to novice part-time and full-time instructors reinforce the need to re-examine hiring practices, preparation, orientation, support, mentorship, and placement of teaching assignments for novices. Participants identified that the following created a situation where they could not focus on and learn the teaching role: (a) being hired at the last minute, which often eliminated the opportunity to prepare or receive an orientation to curriculum, theory, student evaluation processes, and clinical teaching itself; (b) limited understanding of resources, processes, and expectations of their role; (c) the deficient socialization and enculturation; (d) insufficient connection to the faculty; and (e) being placed in areas where they had no experience or expertise.

Herbert et al. (2002) noted that although educational institutions have identified the need to train and support sessional staff to ensure long-term quality of sessional teaching, very few have invested the time and resources needed to ensure that such support occurs. With this in mind, the following recommendations and strategies are offered:

1. sessionals should be hired with enough time to be thoroughly prepared for and understand the expectations of their role;

2. sessionals should be provided with orientation sessions and resources to increase their understanding of clinical instruction and initiate the enculturation process;

3. sessionals should be provided with alternate methods of communication as a way to connect with other instructors and faculty members

4. sessionals should be provided with mentors to provide ongoing support, increase understanding, and ensure further enculturation; and

5. sessionals should teach where they have familiarity, experience, and expertise.

6. educational institutions should engage in efforts to collaborate with health care institutions to support sessionals with teaching assignments

Recommendation 1: Ensure Time for Preparation

Being hired at the last minute did not allow many of the participants in this study to prepare personally as well as professionally; they were not able to engage in any preparatory activities that were offered by the educational institutions. Consequently, some participants felt overwhelmed and in turn they had limited time and energy to dedicate to figuring out what they should be doing in the clinical setting. Most

participants did not have a thorough understanding of the expectation that they would be required to dedicate some personal time to preparation. This expectation, however, was unrealistic as they simply did not have time to prepare prior to starting their teaching assignment.

As a way of ensuring effective communication between the sessional and the educational institution, interviews should consistently take place to ensure that the instructor is a good fit, is provided with information, and has the opportunity to inquire about the expectations and parameters of the role. In addition, the expectation that instructors are required to spend some of their own personal time to prepare and enhance the knowledge gained at the paid orientation sessions should be explained in relation to their wage. This would ensure that they have a thorough understanding of the fact that they are being paid for this time commitment.

Furthermore, instructors should be hired with enough time to be able to thoroughly prepare. The ability to prepare would allow them to organize their schedules and avoid working more than full-time hours or numerous shifts in a row, which may contribute to burnout and the inability to achieve a healthy work–life balance or to perform effectively.

Preparation, however, goes beyond organizing schedules and includes providing meaningful resources that would increase the novice's knowledge and understanding of clinical instruction, thereby increasing their confidence in the clinical setting. Having time to prepare would allow the novice to research, read the resources, seek out information, and ask questions of others, which could assist them in developing meaning and understanding of the resources and their role.

Recommendation 2: Ensure Thorough Orientation Sessions

Orientation has been identified as a key aspect of preparation and successful enculturation and should aim to alert novices to the differences between nursing and academic cultures and initiate the enculturation process. In addition, a thorough and extensive orientation should provide the novice with initial information about teaching pedagogy, focusing on key components related to teaching in the clinical setting, such as an orientation to evaluation forms and teaching resources that would assist with teaching and evaluating students. This would in increase their understanding and provide a preliminary base of knowledge upon which to build on and would aid in moving from the novice stage.

Orientation should provide information about the curriculum, including the sequencing of courses. This would allow novices to understand where students are in their education, and they could adjust their expectations of student performance based on this knowledge. They also require knowledge of the theoretical component of the student's education to help him/her link theory to practice and guide clinical experiences based on what he/she is learning in theory class. This would also assist in student evaluation, as there would be an understanding of the theory used to guide practice, ensuring that students are made accountable for utilizing theory to support their practice and not just performing skills.

Additionally, an orientation to the components of thorough student evaluation would help to ensure that students are being evaluated on knowledge as opposed to merely skill. This orientation would include providing information about student evaluation that would aid in understanding the evaluation process: for example, how

concept maps, learning plans, nursing care plans, journals, and other tools can be used by the instructor to assist with student evaluation. If standardized evaluation tools are being utilized that do not differentiate expectations based on year of education, orientation to the evaluation tool is required. Providing scenarios of clinical situations or role playing would also allow the novice instructors to experience different situations that may occur in clinical settings and would allow them to practice making decisions about student performance.

Recommendation 3: Ensure Mentorship

Mentorship has been identified as an effective way of supporting novice educators and assisting with the enculturation process. As was identified by participants in this study, both formal and informal mentorship played a significant role in their ability to deal with the challenges they encountered. It was their mentors who provided them with the resources, understanding, support, and guidance they needed. It was evident that participants required the support of mentors to assist them in the adjustment to the role of novice sessional instructor.

Thus, orientation sessions should include not only novices, but also more experienced educators. As it has been identified that informal mentoring relationships are often more effective than formal ones, more experienced instructors who are willing to take on a mentee should be encouraged to attend orientation sessions. Given that mentoring is a time-consuming process that increases the work load of the mentor, consideration should be given to compensating or recognizing the mentor for taking on this extra workload. The attendance of more experienced instructors at orientation sessions would identify their willingness to take on a mentee, and this initial introduction

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would open the door for novices to seek out mentors. Connecting with others would assist in enculturating novices to academia by allowing them to collaborate with others who are performing in the same role.

When it is not possible for the novice to seek out a mentor, educational institutions should ensure that a member of the faculty or the teaching team is assigned to take on the mentor role. Despite the fact that informal mentorship relationships are more effective than formal mentorship relationships, mentorship of any kind is beneficial and should be provided.

Recommendation 4: Social Media as a Way of Offering Support and Mentorship

Given the identified need for support and mentorship, utilizing innovative ways to ensure supportive mentoring relationships should be explored. All participants identified that they sought out the support they needed in a variety of ways, most often by seeking out mentors and asking questions of their superiors and other instructors. Considering the current popularity of social media and the ease of connecting with others at the touch of a button, utilizing social media as a way of connecting novices with each other and with more experienced instructors should be investigated.

By developing a main social media site that could be accessed by instructors, each educator, regardless of experience level would have the opportunity to connect with others as a way of receiving or providing ongoing support. Following the media site throughout the semester and having ongoing dialogue with more than one instructor, could provide novices with different perspectives, ideas, and allow them to gather information about what other instructors deal with in the clinical setting, which could assist them when encountering similar situations. Considering the time commitment

required by the mentor, this approach may alleviate some of the burden of the mentor, as it would allow for more than one mentor to provide support to the novice instructors utilizing the site. It could also be organized in a way that one experienced faculty member monitor the site, thereby allowing one mentor to provide support to many novices and as a result would decrease the need for multiple mentors. This ongoing dialogue and sharing could also aid in adding a sense of comfort, knowing that others may be experiencing similar issues. In addition, these online relationships could provide an element of feeling connected to colleagues and the educational institution.

Recommendation 5: Appropriate Placement

Expertise played a major role in dealing with and overcoming the challenges participants encountered in the clinical setting. Those who were placed on units where they had familiarity with the units and staff were able to figure out how to be effective, resulting in increased confidence. For one participant, this familiarity also provided him with mentors who assisted in overcoming challenges and increasing his understanding. Those who were placed on units where they lacked any familiarity or expertise in the area had more challenges to overcome and had more difficulty overcoming them.

Novice sessional clinical instructors should teach on units with which they are familiar, since expertise is essential when teaching in the clinical setting. Furthermore, expertise can increase their confidence and comfort and can assist them in helping link theory to practice and when evaluating student performance. Familiarity also allows the novice instructor to focus on learning the teaching role, instead of being overwhelmed with learning about the new unit, policies, staff, and clientele in addition to learning the teaching role. In addition to providing comfort and confidence, they are better received

and feel supported in their teaching by the staff with whom they have pre-existing relationships, which can subsequently provide more learning opportunities for students.

Findings of this study yielded useful data that assisted in understanding the experiences of novice sessional clinical instructors. Recommendations for educational institutions were developed based on the information gathered. It is hoped that these recommendations could aid RNs transitioning to the role of novice sessional clinical instructors, thus increasing their understanding of their new role and how to function in that role. However, this study also had limitations, which affected the type of and amount of data gathered as well as the results.

Recommendation 6: Collaboration between Educational and Health Care Institutions

Issues presented themselves right from the beginning of their teaching experience for many of the participants as a result of being hired at the last minute and not having time to prepare personally or professionally. This resulted in burn out as there was no time to organize work schedules to avoid working more than full time hours.

Developing agreements (for example secondment agreements) between educational and health care institutions would allow for sessional instructors to take on the teaching role with the support of the health care institutions for which they work. This would ensure time off to accommodate teaching schedules and would allow sessionals that are interested in teaching on a more regular basis to gain experience and skill at teaching, resulting in educational institutions hiring more experienced instructors and would ultimately decrease the need for orientation and preparation.

Limitations

There are several limitations to this study. First, the number of novice instructors who were willing to participate in the study as well as the number of willing participants who met all of the inclusion criteria resulted in a relatively small sample size. Increasing the number of participants may have uncovered a broader range of experiences. That being said, participants from three different educational institutions were interviewed, which did allow for a reasonable understanding of novice sessionals' overall experience. In addition, of the nine participants in this study, only one participant was male. Increasing the male perspective may have identified any gender differences between males and females and shed more light on this topic.

Implications for Nursing Research

This study has presented the novice sessional clinical nursing instructor perspective. Research into student perspectives would also be valuable and might shed some light on the benefits and disadvantages of using novice sessional clinical instructors. In addition, a student perspective may be able to provide some insight into the differences between novice and more experienced sessional instructors.

Because participants' struggles centred on their lack of preparation and understanding, often due to their hasty hiring, one recommendation would be to conduct an institutional ethnography. As outlined by Smith (2006), institutional ethnography provides valuable information about how current processes within institutions affect the experiences of those functioning within the institution. Indeed, this approach would provide analytical descriptions of institutional processes that shape the teaching setting thus increase our understanding of the participants' experiences.

It is suggested that the knowledge gained from this study be disseminated to educational institutions and faculty members to increase their awareness and understanding of the needs of these educators. I plan on presenting the findings of this study at nursing educator conferences, and develop manuscripts for publication in peer reviewed nursing journals. I have also accepted an invitation to be a member of a committee at my University to develop a thorough and meaningful orientation for new faculty members. This sharing of knowledge could be a first step in promoting some positive changes when hiring, preparing, and placing novice sessional clinical nursing instructors.

Summary

In this study, I explored the experiences of nine novice sessional clinical nursing instructors. Clinical learning is the most important aspect of producing competent and capable nurses (Dickson et al., 2006; Kelly, 2006; Ousey, 2000). Given the importance of clinical learning in the context of the nursing shortage and subsequent nurse educator shortage, which has resulted in increased use of sessional instructors, exploration of this topic was identified as necessary to increase knowledge and understanding of the novice's needs. This increased knowledge could aid in ensuring success for them and ultimately their students. The literature surrounding the experiences of novice sessional clinical nursing instructors identified gaps in the literature, as few researchers have explored the experiences of sessional clinical nursing instructors, particularly novice instructors. The findings of the study outlined issues with the preparation, understanding, and placement in the clinical setting. These issues were discussed, recommendations were provided that would assist the novice sessional clinical nursing instructors in

gaining a more in-depth understanding of their role and how to function in that role, and implications for educators and the educational institutions are identified.

This study emphasized the need for thorough and timely preparation and support of novice sessional clinical instructors. Also reinforced is the need for novices to teach in areas where they have familiarity and expertise, which assists them with multiple aspects of their role such as linking theory to practice and student evaluation. In addition, familiarity allows the novice to focus on teaching and provides a sense of comfort and support. Further research that looks at the hiring and preparatory practices at the institutional level would increase knowledge of what is currently in place as well as what could be done by the educational institutions to better prepare and support novice sessional instructors in their new role. Future novice sessional clinical nursing instructors and, in turn, their students, may benefit from the findings of this study and the recommended changes.

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APPENDICES

Appendix A: Letter of Invitation to Participants

Dear _____,

My name is Karen Ander. I am a registered nurse teaching at the University of Lethbridge. I am also a student at the University of Lethbridge in the Masters of Science program. I am conducting a study called "The Experiences of Novice Sessional Clinical Nursing Instructors". The purpose of this study is to develop an understanding of the experiences of sessional clinical nursing instructors as they begin teaching. My hope is that by developing an understanding of these experiences, guidelines can be put into place in the future that would allow for a more efficient transition into the role of instructor.

I am inviting you to participate in this research because I need your experiences and perspectives. As the nursing shortage continues, academic institutions are relying more heavily on sessional instructors to fill gaps in the nursing faculty. Your insights would prove very useful in developing strategies to help orientate sessional clinical nursing instructors.

If you are willing to take part in this study, I will provide you with further details. Your participation is completely voluntary. You may leave the study at any time without providing a reason. Information for this study will be gathered through interviews lasting between 1-2 hours, with the possibility of a brief follow-up interview. All information gathered will be kept strictly confidential. You will not be identified in this study.

If you would be willing to participate, or have any questions about the study please call Karen Ander at [phone #] or email me at: [email address]. If you wish to speak to my supervisor, please contact Dr. Monique Sedgwick at [phone #]. For general inquiries and questions regarding your rights as a participant in this research, you are invited to contact The University of Lethbridge, Office of Research Services at [phone #].

Thank you for time and consideration of this request.

Sincerely,

Karen Ander, RN, BN

Graduate Student, University of Lethbridge

Appendix B: Demographic Sheet

Gender _____

Educational level

 Baccalaureate Degree (What discipline) _____

 Master's Degree (What discipline) _____

Main area of clinical practice _____

Length of time you have worked in your main area of clinical practice

_____

Number of sessional appointments _____

Date of First sessional appointment _____

Clinical Area of sessional appointment _____

Date of last sessional appointment _____

Currently employed as a clinical instructor _____

Years of total nursing experience _____

Appendix C: Letter of Informed Consent

Date: _____

Dear _____,

      You are being asked to participate in an interview with Karen Ander as part of a Master's thesis research study on "The experiences of novice sessional clinical nursing instructors". The purpose of the study is to explore the experiences of novice sessional clinical nursing instructors. The findings will contribute to improving the orientation of novice sessional instructors.

      Participation in this study will consist of an in-depth individual interview lasting 1-2 hours. This interview will be digitally recorded to ensure accuracy of information collected. Data will also be in the form of notes made by the researcher during the interview process. If you so desire, you will be provided with a summary of the findings in the form of a written report. Your real name or other identifying information will not be used on any forms or notes, during any presentations or as part of the research results. All the information collected will be kept in a locked cabinet and destroyed upon my successful thesis defense. Only the researcher, thesis supervisor and transcriptionist (if used) will have access to collected data. The transcriptionist will sign a confidentiality agreement to ensure privacy and confidentiality.

      Participation in this study would be greatly appreciated and is entirely voluntary. You are under no obligation to participate in this study. If you decide to withdraw from the interview, simply verbalize your desire to end the interview. There are no consequences for not answering a question or withdrawing from the interview. If you choose to withdraw, all information gathered up to that point will be destroyed. Although there are no direct benefits to you for participating in the study, you will be providing valuable information which may benefit future sessional instructors hired at the University. There are no known physical risks for participating in the interview. However, you may feel emotionally uncomfortable if reflecting on an unpleasant experience. If this happens, let the interviewer know when this has occurred during or after the interview. The interviewer will provide you with names and contact information of counseling and/or mental health services available to you.

      If you require any further information about this study, or would like to speak with me, please feel free to contact me. Karen Ander, RN, BN, Master's student, at [phone #], by mail at The Faculty of Health Sciences, University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, T1K-3M4, or by e-mail at: [email address]. You may also contact my supervisor, Dr. Monique Sedgwick, Assistant Professor, at The Faculty of Health Sciences at [phone #]. For general inquiries and questions regarding your rights as a participant in this research, you are invited to contact The University of Lethbridge, Office of Research Services at [phone #].

I have read the preceding information regarding the study entitled "The experiences of Novice Sessional Clinical Nursing Instructors". I consent to participate in this study as described in the letter dated _____.

_____ (Printed Name of

Participant)

_____ (Signature of Participant)

_____ (Date)

_____ (Printed Name of

Interviewer)

_____ (Signature of Interviewer)

_____ (Date)

Appendix D: Interview Questions

The following questions will guide this study:

1. Can you tell me about your experience of being a sessional clinical instructor?

2. Tell me what initially appealed to you about the idea of teaching.

3. Were there any surprises about your experience of being a sessional clinical instructor? If there are, can you explain or describe them.

4. What would you say was the most beneficial aspect of your experience as a sessional clinical nursing instructor?

5. What support do you think might have been offered for you to transition into a sessional instructor?

6. What do you feel made you prepared to start and work in this new role?

7. What did you find the most difficult about assuming this new role?

8. What were the terms of your employment? That is, did you participate in an interview or hiring process or were you hired on an "ad hoc" basis? If so, how did you hear about the position?

9. Did you receive any orientation in preparation for this role?

10. If you received an orientation, did you find this helpful? What do you think should be included in orientation that would have been beneficial for you?

11. What do you think would be important for novice sessional clinical nursing instructors to know before they take on this role?

Appendix E: Statement of Confidentiality

I attest that I do not know any of the participants in the study or anyone involved
in any of the situations described in the Master's thesis study, "The experiences of
Novice Sessional Clinical Nursing Instructors". I agree to respect the confidentiality of
the information that I receive through the interviews related to this study. The researcher
has reviewed with me all the necessary measures to ensure the confidentiality of
participants while I am acting in the capacity of transcriptionist, and I agree to abide by
all such measures. All information that I acquire will be provided to Karen Ander, the
principal investigator of the study, at the end of my commitment to the project.

_____   _____

Signature   **Witness**

_____   _____

Printed Name   **Date**

Appendix F: Excerpts from Codebook to Identify Relationships

Advantages for students (original code)

Let's be honest, not all of the nurses on the floor are ideal candidates to put a student with. Some have stronger personalities than some students could go with but others wouldn't necessarily have that positive of an experience with their nursing on that floor right? (Annie 723-727)

I think this speaks to familiarity and the importance of familiarity when teaching. Her familiarity allowed her to enhance the student's learning experience but it also assisted with her teaching. She was able to send the students with staff members that would help her teach the students. This may also say something about student evaluation. If she is sending the students with nurses to increase their experience and assist in her teaching, it would stand to reason that they would also help her evaluate how the students are doing. This also speaks to the importance of familiarity. Annie was able to use her familiarity with the staff to her advantage and the advantage of the students. This might fit under a few sections, but I think I will include it under the importance of familiarity and how she was able to figure out the challenges she encountered with teaching and student evaluation.

I think the work experience helps them, because different nurses have different practices and I can share, this is what I would do in this situation. What do you think would be best for you in this situation? But for them, to know that, oh, you've experienced this, it doesn't scare them. Because psychiatry a lot of times they say they are afraid to come you know, there are moments where things can be unpredictable and that type of thing. And I think that's the biggest asset, is just having experience on the unit. (Jack 233-240)

This is talking about clinical currency. While it is an advantage for students, I think it says a lot of other things too. It talks about preparation to teach. Jack was familiar with the unit he had current clinical knowledge that he felt prepared him to teach. It also talks about the fact that the clinical currency is a benefit for the students, and that it is necessary to teach because the students have more confidence knowing that Jack has done the things he is expecting them to do and if they run into trouble he can help them it gave him credibility. So it also speaks to skills needed to teach. I think this will fit with preparation and what participants felt prepared them to teach because his clinical currency and familiarity with the unit is something he felt he needed to teach and it benefited the students at the same time.

Rewards/Benefits of Teaching (original code)

I enjoyed just endorsing the profession, in particular seniors health and the opportunities that nurses have to work with seniors and that they are not all long term care. Unfortunately that is a stigma with the geriatric population. (Melanie 24-27)

This to me is talking about professional responsibility to change the stigma of certain areas of nursing. She is passionate about nursing and about seniors. I think that being able to change stigma is a professional responsibility because increasing knowledge assists in decreasing stigma which ultimately has a direct and positive impact on the nursing profession, New graduates would have a greater understanding for certain areas and as a result this would benefit the nursing profession. Knowledge is power and the more knowledge about all areas of nursing practice the better it is for the nursing profession.

Disadvantage for Students

As a sessional instructor, I have no idea what the curriculum entails and what is being covered in theory. How much detail do they go into in theory? With any area, you can go as detailed or a general as you want. So, depending on what they are learning in theory, it would affect what you are doing and expecting from them in clinical. . . . So, it would be nice to have more direction as to what's being done in the classroom so there is continuity for students between theory class and clinical. (Annie)

To me, this speaks to understanding. This instructor knows how to nurse and knows what she needs to know to work on the floor, but when it comes to linking theory to practice, there is limited understanding about how to do that without all of the information she needs. How detailed is the theory? How does she then help the student in the clinical setting when she doesn't have a full understanding of what is being taught, in what order and in how much detail?

Appendix G: Building of Codebook

Motivators

As I read through the interviews and even when I was doing the interviews, why participants decided to teach became apparent. Professional responsibility and personal desire were concepts that seemed very important. As I went through the interviews and pulled out comments that spoke to what motivated participants to teach, it became apparent that their professional responsibility was one of the main driving forces to teach. Personal desire was also evident as participants identified that along with an obligation to make a difference, they also wanted the opportunity to grow and learn and feel a sense of accomplishment. There was a general consensus that it was their obligation to the nursing profession to teach in the first place, to overcome challenges they faced so that they were effective and were actually teaching the students what they needed to know. It was also their obligation to the nursing profession to make sure that students who would jeopardize the nursing profession because of marginal or unacceptable performance did not pass and enter the profession. This theme includes all reasons that participants decided to teach including personal as well as professional motivators.

Code	Definition	Example from Text
Professional Responsibility	Anything that affected their decision to teach that went beyond the desire to try something new but indicated an obligation to make a difference.	It's like they don't understand how acute situations can be and what their limitations are. . . . I found the new group graduating very unsafe in their practice at times, and so I wanted to get involved and see changes. The only way you are going to make a change is if you start it yourself. I felt that if I went to the root of the problem and I got involved in teaching students when they were in their first couple of years of school that I would lead them in a positive way, and maybe they would take that initiative and really understand what nursing is and what it's about.(Corey) Endorsing the profession, in particular seniors health and the opportunities that nurses have to work with seniors and that they are not all long term care. Unfortunately

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Code	Definition	Example from Text
		that is a stigma with the geriatric population. (Melanie)
		I feel like nursing is such an important job and it should be full of people with integrity and I just felt like there was none of that. (Dawn)
		I think lots of students go into nursing not knowing what nursing is really all about. I wanted to be an instructor to pass on the good things of nursing and change how students felt about nursing. (Dawn)
		I think I am very passionate about nursing and I always thought I would love to instill the kind of passion and drive for the nursing profession that I have in other people. (Gina)
		I like the idea of endorsing the nursing profession and changing the stigma of certain areas of nursing like geriatrics so the student really understands the different areas of nursing and the opportunities each area has. (Melanie)

Code	Definition	Example from Text
Personal Desire	Internal reasons for wanting to teach that directly impacted them on a personal level.	Whether it's patient teaching, family teaching or helping out a coworker, I thrive on it. It is something that makes me feel good inside about it (Rhonda)
		I think that it's always a really good experience to step outside of yourself and do something new. (Gina)
		I always said it was my teachers that made me think, "This is where I want to end up. I want to stand up in front of a group of people and tell them things that they need to know. I want to be good at it." (Dawn)
		I was encouraged to apply by a friend of mine. She said, "It's easy, you'll love it, it's great. You'll be really good at teaching. You're good at talking to people. You care about other people." (Dawn)
		I had my preceptor student and the teacher that came to check in on her a couple of times a year and do our evaluations, gave me a lot of positive feedback. And when I had an undergrad, she had to fill out an evaluation and it was good, so that's what made me really consider it and I thought maybe teaching is something I should explore a little bit further. (Corey)
		I always had students where I worked, and I enjoyed it when they would come, so I thought I would like teaching students (Colleen)