

2006

The lived experience of nurses working with student nurses in the acute care clinical environment

Donna Coffey Hathorn
Louisiana State University and Agricultural and Mechanical College

Follow this and additional works at: https://repository.lsu.edu/gradschool_dissertations



Part of the [Human Resources Management Commons](#)

Recommended Citation

Hathorn, Donna Coffey, "The lived experience of nurses working with student nurses in the acute care clinical environment" (2006). *LSU Doctoral Dissertations*. 545.
https://repository.lsu.edu/gradschool_dissertations/545

This Dissertation is brought to you for free and open access by the Graduate School at LSU Scholarly Repository. It has been accepted for inclusion in LSU Doctoral Dissertations by an authorized graduate school editor of LSU Scholarly Repository. For more information, please contact gradetd@lsu.edu.

THE LIVED EXPERIENCE OF NURSES WORKING
WITH STUDENT NURSES IN THE ACUTE CARE CLINICAL ENVIRONMENT

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
In partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

In

The School of Human Resource Education
And Workforce Development

by

Donna Coffey Hathorn
B. S. N. Northwestern State University, 1977
M. S. N. Northwestern State University, 1986
December 2006

©Copyright 2006
Donna Coffey Hathorn
All Rights Reserved

ACKNOWLEDGEMENTS

I wish to acknowledge the members of the graduate faculty committee, M. Burnett, PhD; E. Johnson, PhD; G. Johnson, PhD; K. Machtmes, PhD, and T. Page, PhD. I owe special thanks to the Chairperson of the committee, Dr. Krisanna Machtmes, who was always there for me as an advocate and advisor. I appreciate the support, guidance, encouragement, mentorship, wisdom, friendship, and timely humor that Dr. Machtmes provided for me. Dr. Machtmes had faith in my ability and like all great teachers and leaders inspired me to have faith in myself. This self awareness and personal enlightenment motivated me to work to my full potential to accomplish difficult tasks. Like a coach Dr. Machtmes urged me to reach down deep and apply the utmost rigor to produce a dissertation that I could be proud of. Most importantly, she treated me with genuine respect and collegiality. I will never forget her acts of kindness and empathy on several occasions when the going got rough. She and her family, Roland and Ryan, are very precious to me.

I wish to thank my dear colleague, Kenneth Tillman for being a sounding board, study partner, carpooler, and friendly competitor throughout the past four years. As in any race, Ken was like a pace car that kept me from slowing down too much and getting behind. We spent hours together at the local coffee shop discussing, debating, studying, answering questions, and encouraging one another to continue on until our goal was reached. I appreciate his patience with me as I frequently interrupted him to say “let me read this to you.” We never realized what we were getting into that day when we both agreed to get our Doctor of Philosophy degree together. I also want to thank his wonderful family for the meals and study time in their home.

Another colleague that I wish to thank is Dr. Jeanie Ricks Harper for her encouragement and help with qualitative research. Jeanie’s talent as a qualitative researcher was an inspiration to

me. I also wish to thank my teaching partner Dr. Lorinda Sealey who always altered my work schedule before I even asked so that I could have time to meet important deadlines regarding my program of studies. I appreciate the fact that she recognized that it was my turn to work on a Ph.D. and she offered understanding and encouragement.

I am grateful to my husband Jeff for his willingness to make sacrifices to allow me to fulfill my academic dream. He tolerated me staying up late nights, being away at the coffee shop studying, and attending all those night classes. He has always been proud of me and supported me in my academic endeavors. To my sons Jeffrey, Jared, Jason, Joshua and to C.C. my new daughter in law, a special thanks for their understanding and patience. I hope that my achievement will be an inspiration for each of them to reach their full potential and calling in life.

I acknowledge the members of Holden Baptist Church for all their prayers and encouragement as I pursued this great academic achievement. They understood how important this accomplishment was for me and cheered me on to the end. My faith in God helped me to be strong because I knew this was the right time and the right place. I give ultimate thanks to Jesus Christ my savior and my Lord!

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	vii
LIST OF FIGURES.....	viii
ABSTRACT.....	ix
CHAPTER	
1 INTRODUCTION.....	1
Problem Statement.....	2
Definition of Terms.....	3
Limitations.....	3
Significance of the Study.....	3
2 REVIEW OF THE LITERATURE.....	6
Clinical Environment as a Learning Environment.....	6
Professional Socialization Attitudes.....	12
Nurses' Motivation and Incentives to Work with Students.....	18
Role Theory and Professional Socialization.....	19
Collaboration between Nursing Education and Nursing Service.....	20
Legal Considerations in Nursing Education.....	25
3 METHODOLOGY.....	29
Qualitative Research.....	29
Phenomenology and Phenomenological Method.....	30
Phenomenological Processes.....	33
Epoche.....	33
Phenomenological Reduction.....	34
Imaginative Variation.....	35
Synthesis.....	35
Data Collection Preparation.....	36
Conceptual Model.....	36
Researcher Role.....	37
Guiding Questions.....	40
Credibility.....	41
Sampling Strategy.....	42
Informed Consent, Confidentiality, and Selection Process.....	44
Pilot Study.....	45
Data Collection.....	46
Interview Process.....	46
Ethical Dilemmas.....	47
Organization, Analysis, and Synthesis of Data.....	49

4	ORGANIZING, ANALYZING, AND SYNTHESIZING DATA	52
	Horizontalization.....	52
	Meaning Units.....	52
	Themes.....	79
	Thematic Textural-Structural Descriptions.....	80
	Kate.....	81
	Jenny.....	86
	Sarah.....	92
	Tommy.....	98
	Natina.....	104
	Cindy.....	110
	Composite Thematic Textural-Structural Descriptions.....	116
5	SUMMARY, OUTCOMES, AND IMPLICATIONS.....	127
	Summary.....	127
	Outcomes.....	130
	Implications.....	136
	REFERENCES.....	140
	VITA.....	144

LIST OF TABLES

1. Themes and descriptions of the lived experience of nurses working with student nurses...80

LIST OF FIGURES

1.	Conceptual Model of the Experiences of Nurses Working with Student Nurses.....	38
2.	Conceptual model of Kate’s experience of working with student nurses in the acute care clinical environment.....	85
3.	Conceptual model of Jenny’s experience of working with student nurses in the acute care clinical environment.....	92
4.	Conceptual model of Sarah’s experience of working with student nurses in the acute care clinical environment.....	98
5.	Conceptual model of Tommy’s experience of working with student nurses in the acute care clinical environment.....	104
6.	Conceptual model of Natina’s experience of working with student nurses in the acute care clinical environment.....	110
7.	Conceptual model of Cindy’s experience of working with student nurses in the acute care clinical environment.....	116
8.	Conceptual model of composite experiences of working with student nurses in the acute care clinical environment.....	126

ABSTRACT

The purpose of this phenomenological qualitative study was to describe the lived experience of nurses' who work with baccalaureate student nurses in the acute care clinical environment. Because of the nursing shortage nursing education is challenged with equipping a safe qualified workforce while preventing or reducing student attrition. Students may choose to leave the profession or receive less than optimal learning experiences when exposed to negative socialization behaviors of nurses while in the clinical environment. Findings from this study can be used to foster collaboration between nursing education and nursing service in the development of positive clinical environments for nurses and nursing students.

The methodology used for data collection was one-time, in-depth semi-structured informal audio taped interviews of staff nurses who worked with student nurses in an acute clinical setting. Saturation of the data was determined after six interviews. Data analysis was conducted according to the modified van Kaam method. The following themes emerged: beliefs about nursing education, role expectations, communication structure, motivational factors, deterrent factors, and professional socialization attitudes.

Findings from this study revealed that nursing education and service should establish more effective communication between staff nurses by providing them with job descriptions and role expectations while working with students. Staff nurses also need to be informed of the student's learning objectives, and competencies. Staff nurses need to be empowered to change the clinical environment and resolve conflicts that may arise as a result of having students in their work environment. Most importantly the staff nurses need to be educated about their legal liability and responsibilities when working with students. Students should also be informed of their legal responsibility for nursing practice before attending a clinical course.

Implications for research are to increase qualitative and quantitative studies on staff nurses who work with baccalaureate student nurses in all areas of clinical practice. Studies related to the nurses' educational preparation and faculty perceptions of staff nurses working with students are needed. Future research is also needed on the effects that clinical practice models used in baccalaureate nursing education and collaborative educational reforms have on nurses, students, and faculty.

CHAPTER 1

INTRODUCTION

The nursing shortage has presented nursing schools with the challenge of equipping a safe, qualified workforce of nurses to reduce the shortage; yet, retention of students is a major issue in meeting this challenge. Wells (2003) stated that inability to retain nursing students in nursing programs negatively impacts the supply of registered nurses to meet the demands of the nursing shortage. “High rates of student attrition can be prevented by identifying critical points for intervention” (Wells, 2003, p. 230). One critical point for intervention is in the area of clinical practice experiences. Negative attitudes of nurses toward nursing students in the clinical practice setting has the potential of obstructing student learning and therefore threaten student progression and retention within the nursing program (Chan, 2002).

The clinical environment is a learning environment where students are socialized into the profession. Since nursing is a practice profession, it is imperative that the clinical environment offer students opportunities to develop skills necessary for nursing practice. However, the clinical environment can be very stressful for the nursing students and nurses who work with them. Working with nursing students may add to the existing stress of a staff nurse. Staff nurses who work with student nurses must cope with staffing shortages, demanding patients, administrative and liability issues while incorporating a student nurse into their work routine. Staff nurses share their patients with the student nurses and often relinquish patient care responsibilities to them. Amid the environmental stress, the schools of nursing expect the clinical environment to be a teaching environment that supports and nurtures nursing students while maintaining the highest standard of practice.

For the staff nurse the clinical environment is a work environment. In this work environment the staff nurse who works with student nurses has the responsibility of being a role model for the students. This added role may place additional stress on the staff nurse and foster negative attitudes toward nursing students. In a study by Hayhurst, Saylor, and Stuenkel (2005) perceptions of the environmental workplace by the staff nurse were associated with retention of experienced nurses. Reducing stress in the workplace included the following: fostering group cohesion, promoting autonomy in practice, having manageable workloads, and having skilled, nurturing and supportive management (Hayhurst et al., 2005). “Constructing and maintaining a work environment that is nurturing, supportive, and is less stressful and physically demanding is a daunting challenge” (Hayhurst et al., 2005, p. 288). Magnussen & Amundson (2003) stated that as a measure to retain staff nurses at the bedside of acute care facilities, staff nurses “need to be treated as valued professionals” (p. 261).

Studies about how nursing students affect the work environment of the staff nurse are limited. Investigation of the experiences that staff nurses have when working with student nurses may glean important insights for both nursing administrators and nursing educators. Increased understanding of the meaning of the staff nurse experience of working with student nurses may help nursing administrators and nursing educators improve the clinical environment where staff nurses work and students learn. The positive impact of improving the clinical environment is twofold: 1) increasing student nurse progression and retention in nursing schools, and 2) improving job satisfaction among staff nurses.

Problem Statement

The primary purpose of the study was to determine the lived experience of nurses working with student nurses in the acute care clinical environment.

Definitions of Terms

For purposes of this study the following terms will be operationally defined:

Nurse. A full-time or part-time staff nurse employed in an acute care hospital providing direct patient care, and works with students during their clinical placement (researcher's definition).

Student Nurse. A pre-registered student from an accredited baccalaureate nursing program enrolled in a clinical nursing course, and under the supervision of faculty has been assigned to provide direct patient care in an acute care facility (researcher's definition).

Acute Care Clinical Environment. A medical/surgical, obstetrical, pediatric, intensive care or emergency nursing unit within a private or public hospital that has a contract with a baccalaureate nursing program for clinical rotations of nursing students (researcher's definition).

Professional Socialization. "The norms, values, and behaviors deemed imperative for survival of the occupation" (Hardy & Conway, 1988, p. 263).

Limitations

1. Measurement of professional socialization attitudes toward student nurses at one particular moment in time may not be an accurate representation of the attitudes nurses have at all times during nursing practice.
2. Legal considerations when working with nursing students were limited to the rules and regulations for the practice of registered nurses in the state of Louisiana.

Significance of the Study

There is a health care crisis resulting from a shortage of nurses in the workforce and the shortage impacts upon nurses' workloads by creating increased responsibilities (Grindel,

Patsdaughter, Medici, & Babington, 2003). The increased responsibility of nursing students may add to the already existing stress in the work setting. As nursing educators recognize the need to prepare a competent, dedicated nursing workforce for the future, it is imperative that nursing schools retain students and facilitate a positive effective learning environment within the clinical practice setting. According to Chan (2002), "Clinical education is a vital component in the curricula of nursing programs because it provides student nurses with opportunities to develop competencies in nursing practice" (p. 69).

Castledine (2002) stated that nursing students encounter a wide range of support from being treated very badly to very good depending on the staffing and attitudes of the nurses. Furthermore, there is "much negativity and lack of respect for students when they enter clinical placements" (Castledine, 2002, p. 1222). Often the students feel that when there are staffing shortages, they are being exploited, as just a pair of hands to get the work done and their learning objective is not important. When nursing units are understaffed and nurses are not prepared or rewarded for educating nursing students, the learning environment may be compromised. If student nurses do not identify with the nursing profession they would eventually leave, (Li, 1997). Universities and healthcare organizations need to improve partnerships, links and communications in order to provide a quality learning environment for student nurses (Castledine, 2002).

Negative attitudes of nurses toward nursing students in the clinical practice setting has the potential of obstructing student learning and therefore threaten student progression and retention within the nursing program. Furthermore, the ultimate effect of a negative clinical experience by the nursing students can hinder nursing recruitment into the workforce. Many learning environment studies have been conducted within the traditional classroom settings;

"however, minimal studies have been conducted on clinical learning environments from the psychosocial education perspective" (Chan, 2002, p. 69). The purpose of the research study was to describe the lived experience of nurses working with student nurses in the acute care clinical environment using a phenomenological design. The study results has potential for helping nursing educators and nursing administrators understand clinical nursing education from the nurses' perspective and foster cooperation in the development of positive clinical learning environments for nurses and nursing students. The study answered the following questions:

1. What is the lived experience of nurses working with student nurses in the acute care clinical environment?
2. How does the lived experience of nurses working with student nurses affect the nurses' professional socialization attitudes toward student nurses?

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter will discuss the review of the literature pertaining to the study using the thematic method as described by Moustakas (1994). The search for relevant information began with identification of terms within the study topic experiences of nurses working with student nurses in the acute clinical environment. Computer searches using EBSCO, CINAL, MEDLINE, and UMI ProQuest Digital Dissertations were used to search and retrieve research and non-research articles. Information about the research topic also came from books. Themes that emerged from the literature review were used to formulate a conceptual model and provided rationale for the guiding questions used in the methodology for the study. Core themes are clinical environment as learning environment, professional socialization attitudes, nurses' motivation and incentives to work with students, and role theory and professional socialization. Additional themes are collaboration between nursing education and service, and legal considerations in nursing education.

Clinical Environment as a Learning Environment

Results from numerous studies concluded that the clinical environment is crucial for the educational experience of the nursing student (Callaghan & McLafferty, 1997; Chan, 2003; Cope, Cuthbertson, & Stoddart, 2000; Drennan, 2002; Foley, Kee, Minick, Harvey, & Jennings, 2002; Lo, 2002; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998). Because of studies from Project 2000 in the United Kingdom, there is increased publication about clinical learning environments. The Project 2000 was an institutional restructuring of nursing educational programs. This relocation of nursing education away from the hospital-operated system to institutions of higher learning has been a focus of concern for many educators, particularly in the

area of clinical placements of students. Studies on clinical placement of students and evaluation of clinical environments became the subject of research, particularly during the transition period (Cope et al., 2000).

Cope et al. (2000) conducted a study of the experiences of students in Scotland who had recently completed the last course from the traditional curriculum and students who were completing the first Project 2000 course. In this cohort qualitative study design, randomly selected subjects were asked to participate in semi-structured interviews about areas of the curriculum that had significantly changed. The published report focused on practice placement and the perceived theory-practice gap. Both groups expressed similarity of responses about clinical practice placements. The three significant themes that emerged from the analysis were joining the community of practice, the contextualization of learning, and the support of learning in practice. Students described being accepted as part of the team and suggested that social acceptance is clearly important to the students. Social acceptance was necessary before nursing students could demonstrate competence. Cope et al. (2000) asserted that “professional acceptance requires a basic familiarity with the context of the placement, confidence in one’s own capability within the context and acceptance by the professionals themselves” (p. 853). Findings from this study supported the belief that nurses socialize with students when they spend more time with the students; however, many clinical placements are too short for relationships to be established (Cope et al., 2000).

A conclusion from the study by Cope et al. (2000) was that it is important to recognize that clinical placements are areas for professional socialization and accomplishment of technical skills. Cope et al. (2000) stated “becoming a nurse is about joining the community of practice represented by qualified nurses as much as it is about learning the technicalities of nursing” (p.

854). Furthermore, “students require social support and reassurance when they start a new placement” (Cope et al., 2000, p. 854). Other conclusions were that mentors of nursing students should know how important it is to incorporate the students professionally into the community of practice. This study also emphasized the need for cognitive apprenticeship in clinical placement where novices (nursing students) should be guided by experts (staff nurses) through complex practice (Cope et al., 2000).

Benner (2001) described the student nurse as a novice practitioner who has no experience in dealing with situations where they are expected to make decisions and perform nursing care. Their practice is governed by rigid inflexible and limited rules and they have little understanding of the meanings in the textbooks. The student’s exposure to situational experiences helps them to incorporate and find meaning to the principles and theory learned in the classroom. Being in real situations helps the novice nurse to develop the context-dependent judgments and skills (Benner, 2001).

Papp, Markanen, and vonBonsdorff (2003) cited that clinical practice is a way to increase the professional competence of the student nurse. The learning environment is defined “as being the conditions, forces, and external stimuli, which affect the individual” (Bloom quoted by Papp et al., 2003, p. 263). “The clinical environment encompasses all that surrounds the student nurse, including the clinical settings, the equipment, the staff, the patients, the nurse mentor, and the nurse teacher” (Papp et al., 2003, p. 263). The clinical environment is a complex social and cognitive experience for the nursing student (Chan, 2002; Cope et al., 2000). The clinical environment offers situational learning where the student can participate in working situations (Chan, 2002; Cope et al., 2000; Papp et al., 2003).

Foley et al. (2002) identified a relationship between hospital environments and recruitment and retention of qualified nurses. Quality care is also linked to quality work environment (Foley et al., 2002). Callaghan and McLafferty (1997) concluded that improvement in the clinical environment as a learning environment can lead to “improved opportunities for the provision of excellence in patient care” (p.338). There is consensus in the literature that it is the responsibility of all nursing educators and practicing nurses to provide quality clinical experiences for nursing students. The clinical experience must adequately prepare nurses into the workforce (Callaghan & McLafferty, 1997; Chan, 2002; Cope et al., 2000; Drennan, 2002; Foley et al., 2002; Lo, 2002; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998). Callaghan and McLafferty (1997) stated that it is the right of every patient to have quality nursing care and it is the right of all nursing students to have quality nursing education.

In their studies to develop evaluation tools to evaluate the clinical environment as a learning environment for nursing students, Chan (2002), and Callaghan & McLafferty (1997) agreed that the student perception of the environment is an important component. Callaghan and McLafferty (1997) included the student’s perception as part of an audit tool for assessing the learning environment. The student perception questionnaire included items relating to orientation to the unit, availability of literature such as policy documents, textbooks or journals, relatedness of theory to practice, and relationship with a preceptor. Other components of the audit tool included an area profile and an educational profile. Each of these components was stratified to include items such as the physical environment, nursing establishment, staffing, clinical activity, availability and preparation of preceptors. The audit tool helped to differentiate clinical areas of excellence from those that were lacking. Nursing schools used the audit tool to

place students in clinical areas most conducive to nursing education (Callaghan & McLafferty, 1997).

Chan (2002) stated some clinical settings do not provide positive learning for student nurses. Chan (2002) furthermore asserted that there are minimal studies measuring the clinical environment from the psychosocial educational perspective. Identification of factors within the social climate of a clinical learning environment could promote teaching strategies that are most predictive of quality student learning (Moss, 1987 cited by Chan, 2002). Both studies concurred that it is necessary to evaluate and measure the educational quality of the clinical environment for human resource development of registered nurses. The quality of education is linked to cooperation and communication between the clinical site and nursing school (Callaghan & McLafferty, 1997; Chan, 2002). In development of the clinical learning environment inventory Chan (2002) recognized that the clinical experience is a classroom that produces anxiety for the nursing student, and creation of a supportive climate is crucial. Autonomy and recognition, role clarity, job satisfaction, quality of supervision, peer support, and opportunity for learning are variables that characterize the clinical learning environment (Chan, 2002).

Chan (2003) conducted a cross-sectional simple descriptive survey design of second-year bachelor's nursing students in South Australia. The purpose of the study was to estimate the discriminant validity of subscales of the Clinical Learning Environment Inventory (CLEI). Other purposes were to assess nursing student's perceptions of hospital learning environments, and to determine the differences between student nurses' perceptions of the actual clinical learning environment and their preferred clinical learning environment. Results indicated that the CLEI effectively measures students' perception of the clinical environment and students prefer a more positive and favorable clinical environment than their perception of what does

exist. Recognition and appreciation of nursing students' vulnerability in the clinical learning environment are important qualities for clients, clinicians, and clinical facilitators. In human resource development, having an open and direct communication between everyone is critical. For a complete evaluation of the clinical learning environment, inclusion of faculty, nursing staff, patients, and preceptor evaluation is necessary (Chan, 2003).

Evaluation of clinical environments for learning stressed the importance of having qualified staff, adequate staffing, guidelines for evidence-based nursing practice, effective communication between nursing educators and clinicians, and well-prepared preceptors. Preceptors should be willing to take on the responsibility for role modeling, teaching, and socializing student nurses into the profession (Callaghan & McLafferty, 1997; Chan, 2002). Because preceptors are so valuable and vital to creation of a quality clinical environment, several studies evaluated the effectiveness of preceptors or mentors for nursing students (Lo, 2002; Suen & Chow, 2001). Conclusions from these studies were similar to Cope et al. (2000), suggesting that socialization into the practice is a vital part of the learning process for student nurses and can only occur at the practice level of the clinical experience.

In light of the current nursing shortage, creating an ideal learning environment could be challenging, and nursing administration, education, and practice are called upon to make changes in the way nurses are recruited and prepared for the workforce. Foley et al. (2002) asserted that "increased work demands and adverse publicity have contributed to rising turnover rates and registered nurse (RN) shortages in acute care hospitals" (p. 273). Quality nursing care to patients depends on the availability of expert nurses. "By creating and sustaining environments that recognize and value the work that nurses do, it may be possible to reduce the exodus of nurses from the hospital setting" (Foley et al., 2002, p. 273).

Professional Socialization Attitudes

Studies of nursing students' perceptions of the clinical environment concluded that there is a need for nurses to welcome the nursing students into the profession. In order to promote a positive psychosocial learning environment nurses should offer support, be nurturing, and treat nursing students with dignity and respect (Atack, Comacu, Kenny, LaBelle, & Miller, 2000; Chan, 2002; Cope et al., 2000; Drennan, 2002; Li, 1997; Lo, 2002; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998; Suen & Chow, 2001). In Li's study (1997) the teaching behaviors between the student nurses and nurse educators were identified. Li asserted that clinical teaching enables the learners to integrate knowledge and skills into practice and gives the student the opportunity to internalize the role of the nurse as a caregiver (1997). Li (1997) furthermore cited that if the students do not identify with the nursing profession they will eventually leave. It is obvious that nursing educators have a high level of responsibility for teaching nursing students; however, Li's study brought out the importance of the clinical staff to be responsible for clinical teaching (1997).

In a study conducted by Lofmark and Wikblad (2001), facilitating and obstructing factors for learning in clinical practice were identified by students. Facilitating factors included being allowed to take responsibility, being allowed to work independently, having opportunities to practice tasks and receiving feedback, having collaboration with staff and supervision of others, gaining an overview of the setting and gaining a sense of control. Obstructing behaviors were identified as lack in the student-supervisor relationship, organizational shortcoming in the supervision, and experience of students' own shortcomings. The negative supervisor behaviors were described as taking over, condescending comments, irritated or not interested, and not giving feedback or opportunities to reflect. Other supervisor behaviors which negatively

impacted student learning were not knowing the educational objectives and abilities of the students, staff uneasiness from lack of guidelines for nursing care, stress on the ward and lack of time, and not allowing students to take part in care of patients (Lofmark & Wikblad, 2001).

In a study on student's perceptions of the effectiveness of mentors by Suen and Chow, (2001), results revealed that students agreed that the following roles were essential to that of a mentor: befriending, assisting, guiding, advising, and counseling. Scores of the effectiveness of mentors as perceived by students improved after the mentors attended workshops and were provided with materials to assist them with the mentoring roles. Also, the students were given the opportunity to meet with the academic staff to improve communication between the clinical setting and the university (Suen & Chow, 2001). Students felt that many mentors did not achieve the befriending role adequately, and most students prepared themselves to be part of the team but found that they were treated as guests. Because of the job stress, the students expected the mentors to have a counseling role but found this role to be weak. "It is difficult for the mentors to exercise their roles realistically" if the relationship between the mentor and mentee is minimal (Suen & Chow, 2001, p. 510).

In a study by Lo, (2002), the students acquired knowledge and integrated theory into practice in the clinical environment because of a working partnership between the mentors and mentees. Owen cited by Lo (2002) defined mentoring as "a supportive, nurturing relationship that can evolve from a formal teacher/learner or expert/novice relationship such as a preceptorship, or can be an assigned relationship as part of an institutional method used to link the mentee to the mentor" (p. 28). In Lo's study (2002) the evaluation of the mentor characteristics was categorized into four areas: personality traits, teaching ability, nursing competence, and interpersonal relationships. The mentors volunteered to provide additional

clinical experience for the nursing students and participated in training workshops for registered nurse (RN) mentors. Students were assigned to a RN and worked alongside that RN for all their shifts, but were not paid. The results demonstrated that 95% of the students rated their mentors as good and above. The positive outcomes for students were identified as gaining “continuity of practical experiences, developing nursing skills which enhance confidence, improving communication and reporting skills, working in a variety of shifts, working as a team member, and having excellent RNs as mentors” (Lo, 2002, p. 30). This study supported the need for recruitment and preparation of RN mentors in the clinical setting.

Studies on nurse’s perceptions of student nurses are limited. One study by Grindel et al. (2003) investigated the perceptions of adult-health/medical-surgical nurses of students’ contributions to clinical agencies by determining if students were perceived as an asset or liability to clinical agencies. Grindel et al. cited that the presence of student nurses on the nursing units would further increase the nurses’ responsibilities and cause more job-related stress. Grindel et al. (2003) cited previous studies revealed that “staff had particular difficulties working with students when students’ roles were unclear, leaving staff with a sense of responsibility and accountability for the care provided by students” (p. 119). In the study by Grindel et al. (2003) a 54-item questionnaire was used to measure nursing student’s contributions to clinical agencies (NSCCA). Items on the questionnaire emerged from interviews conducted with staff responsible for student placements. The NSCCA focused on perceived effects that undergraduate nursing students have on staff time, staff development, quality of care, staff’s personal satisfaction, and unit standards and practices. A 5-point Likert-type scale ranging from 0 (strongly disagree) to 5 (strongly agree) was developed by the researchers (Grindel et al., 2003).

Findings from this study revealed nurses perceive that student nurses make many valuable contributions to units and agencies during their clinical rotations. The nurses with less than 10 years experience perceived student contributions to be more favorable than nurses with 10 years or more experience. Both groups of nurses agreed that student participation in clinical is a source for recruiting nursing staff. Therefore, nursing administration should create an environment that promotes bonding and develops skills and abilities to move into the workforce of the institution, and staff nurses should display a positive attitude to support the learning experience of students. Offering incentives for preceptors as suggested by Stone and Rowles (2002) would support this concept.

Other findings from the study by Grindel et al. (2003) revealed that less experienced nurses agreed that student participation did not take up time and freed staff for other responsibilities. The more experienced nurses however, perceived nursing students as taking up too much time. Both groups of nurses agreed that nursing students enhance the clinical setting by stimulating staff intellectually, thus establishing collegial relationships. A recommendation was for studies to extend exploration of student contributions to different clinical agencies and populations including obstetrics. In addition, it was recommended that perceptions be clarified and confirmed by using a multi-method approach using questionnaires, interviews, and observations.

Matsumura, Callister, Palmer, Cox and Larsen (2004) conducted a replication and extension study of Grindel et al. (2003) and reported that nurses were ambivalent toward nursing students. The top ranked items on the nursing students' contributions to clinical agencies survey were in contrast to each other. One contrast was that students allow for opportunities for mentoring but they threaten professional role development. The participants were 165 staff

nurses from maternal-newborn, adult medical-surgical, pediatric, and psychiatric acute care units in three different facilities in which nursing students were assigned for clinical placement. Participants were also obtained from a community-based mental health agency. The years experience of the participants ranged from less than one year to 45 years ($M = 10.93$).

The study by Matsumura et al. (2004) had a qualitative component that revealed the following themes: student preparation, student qualities, and level of students on the unit, role of the instructor, and opportunities for staff nurse growth. These themes emerged from an open-ended question added to the survey tool that elicited a written narrative regarding staff nurses' experiences with students. Nurses expressed both positive and negative experiences with students. The nurses expressed frustration when working with problem students; but, students could also assist with patient care and allow the nurse to spend more time with high acuity patients. The students were viewed as increasing the workload or slowing them down and taking too much of their time depending on how prepared the student was, the student's attitude and willingness to participate and be engaged in patient care experiences, the patient acuity and staffing of the unit, and the availability and support from the instructor.

Matsumara et al. (2004) stated that the nursing shortage places increasing demands for clinical sites that are positive, nurturing learning environments. A recommendation was for nurse educators and administrators to collaborate in order to enhance the quality of the clinical experience for both the students and staff nurses. Specific strategies to increase collaboration between nursing education and service were presented. These strategies included sharing of information between academia and service, teaching staff nurses how to be mentors to the students, adjusting staff assignments, placement of a student with a nurse for three weeks after a front loading of content and clinical simulation, and providing rewards from the university to

staff nurses through recognition and participation in university events. Suggested principles for mentoring for staff nurses, students, and faculty were also presented. The principles for mentoring are related to having positive attitudes and behaviors to enhance collaborative relationships and to provide optimal experiences for staff nurses, students, and faculty (Matsumara et al., 2004).

A qualitative study was conducted by Attack et al. (2000) which described the student-staff relationship and the impact this relationship had on student learning among diploma nursing students. This phenomenological study was done to gain an understanding of the lived experience of staff and students within a clinical practice model. A focus group approach was used to elicit information. The same open-ended questions were asked of nurses and students which required the participants to use reflection and discuss their experiences they had with staff and/or students. They were asked to discuss what made the experience helpful and challenging. The participants were also asked to suggest changes in the relationship. The most important factor recognized by students in the student-staff relationship was open communication founded on mutual courtesy and respect. Open communication was defined as being direct and not by passing the student and going straight to the teacher or other nurse when a conflict or concern developed. It was also important for the students to receive regular feedback in constructive and positive forms. Other components of a beneficial relationship with staff included the sharing of knowledge and decision-making processes of the nurses with the students, and being viewed as part of the nursing team.

The staff nurses revealed that some students decreased their workload, while others students added to their burden (Attack et al., 2000). Students who required a lot of supervision were more time consuming to work with because the nurse spent more time with coaching and

stepping in to complete a task. When students left before the end of the shift, the nurses stated they had to catch up on the work missed by students. The nursing staff viewed their roles as educator and coaches and recognized that they needed patience and understanding when working with students. Nursing staff reported that it was helpful to spend time with each student to determine their competency level in order to establish a trust relationship. Both students and staff suggested that students work a full shift with the staff nurses so that positive relationships could be reinforced. Implications from the study were to emphasize socialization among students and staff, clarify and develop the teaching role of the staff RN, help nurses to adopt teaching strategies with students, and share with the staff their influence on students as a role model (Atack, et al., 2000).

Nurses' Motivation and Incentives to Work with Students

Stone & Rowles (2002) conducted a study to determine rewards for nursing preceptors or mentors because in the hospital setting the nursing preceptors or mentors are vital for orienting new nursing staff. The rewards that ranked highest were having an appreciation day with a meal and a free continuing education presentation. In this study most of the preceptors responded that they received no reward but would like one. This study suggested that incentives offered by nursing administration and nursing education to the preceptors or mentors could improve the clinical learning for nursing students.

When nursing units are understaffed and nurses are not prepared or rewarded for educating nursing students, the learning environment could be compromised. This was pointed out by Castledine (2002). He wrote that there is too much negativity and lack of respect for students when they are in the clinical setting, resulting from lack of support from nursing staff. Castledine (2002) furthermore stated that the nursing students encounter a wide range of support,

from being treated very badly to very good depending on the staffing and attitudes of the nurses. Often the students feel that they are being exploited as just a pair of hands to get the work done when there are staffing shortages and their learning objectives are not important. Castledine (2002) encouraged universities and healthcare organizations to improve partnerships, links and communications.

Role Theory and Professional Socialization

According to Hardy and Conway (1988) reference groups have a powerful psychological influence on an individual for whom one wishes to be a member. Socialization and reference groups are concepts that have major influence on role theory. “A reference group to which an individual does not yet belong can serve as a powerful influencing factor, provided the person perceives that group to be one from which to seek acceptance and approval” (Hardy & Conway, 1988, p. 258). Hardy & Conway (1988) furthermore stated “the goal of professional training institutions is to inculcate into their aspirants the norms, values, and behaviors deemed imperative for survival of the occupation” (p. 263). Faculty shape the perceptions of the nursing profession for the students by controlling the learning experiences. Multiple agents such as family members and friends who are nurses, clients, professional colleagues, and other health professionals also shape the students’ perceptions of the professional role. “Socialization into the professional role may therefore be either facilitated or hindered depending upon the degree of congruity between the role expectations of these multiple agents, those of faculty, and those held by the neophyte aspiring to the profession” (Hardy & Conway, 1988, p. 265). Nursing students develop a professional self-image from several sources, but early in their educational experience the staff nurse has the most influence. During the formative period of professional socialization, the role of the nurse is legitimized partly by acceptance from staff nurses and other hospital

personnel. This source of legitimization is withheld when faculty are so controlling of the students assignments and performance that nurses view the students as outsiders; therefore, the nurses do not fully accept the students (Hardy & Conway, 1988).

Mrayyan & Acorn (2004) reported the results of international collaborative teaching. Student nurses in a management course identified problems and solutions to professional practice environments that created job dissatisfaction, burnout, and low hospital retention of nurses. They concluded that unclear role expectations by nurses led to a negative professional practice environment. Having clear roles within the workplace should improve job satisfaction, reduce burnout and help to retain nurses which will improve quality patient care.

Collaboration between Nursing Education and Nursing Service

The literature pertaining to collaboration between nursing education and nursing service implored the two groups to communicate student learning objectives to staff nurses and to establish a working relationship to improve the learning environment for nursing students with the ultimate goals of reducing the cost of nursing education and to combat the nursing shortage (Rice, 2003; Schofer, Langenberg, Matheis-Kraft, Barid, & Bopp, 1996; Williams & Widman, 1998). The collaborative efforts described by Schofer et al. (1996) incorporated the Clinical Teaching Associate Model. This model incorporated baccalaureate prepared staff nurses from the acute care facilities as CTA's (clinical teaching associates) after in-service preparation into the role. The CTA's reported increased satisfaction in working with students because it legitimized and formalized their teaching role. The CTA's had more control of the student and were informed of the student's learning objectives. With this model the students developed self confidence because they had constant access to an expert practitioner and did not have to wait on an instructor. With this model the instructor guided the CTA, supervised the clinical experience,

taught the theoretical component, evaluated, and allocated grades for the student. The communication and relationships between the hospitals and educational facilities were enhanced (Schofer et al., 1996).

The collaborative project described by Williams & Widman (1998) used the Johnson Collaborative Service/Education Model and was prompted by a state budget crisis that impacted negatively on nursing education. The nursing school and hospital formed a partnership to educate nurses. The hospitals (service agency partner) provided additional funding for 10 nursing students and MSN prepared nurses from their own facility to have joint appointments between the hospital and university. The hospital found that by integrating the students into their system the students were more likely to select them as a place to work. Also, the nurses who participated in the project as students required less orientation time and therefore reduced the cost of orientation. In addition, the new graduates from the collaborative project had higher retention rates. Overall the project improved communication between university faculty and hospital staff, and they were more equipped to support each other to meet facility needs (Williams & Widman, 1998).

In the study by Matsumara et al. (2004), communication of students' daily learning objectives including skills development to staff nurses by faculty was listed as one of the principles of mentoring. Another principle related to communication was for the faculty to provide positive feedback and appreciation to the staff nurses for working with students and spend time with the staff nurses to discuss issues regarding student mentoring, and to keep up to date with clinical skills. Communication by students was suggested as an important aspect in developing a positive relationship with the staff nurses by being well-prepared for clinical and having an attitude of being ready to work. The students should be able to articulate their own

learning objectives to the staff nurses, and be willing to be engaged and connect with patient care activities rather than on written assignments. Another principle related to communication was for the student to share what they learn with the staff nurse, express a willingness to help whoever needs help, and express appreciation. Suggestions for staff nurses related to improving communication with nursing students were to have a positive attitude when working with students, getting to know them personally, and sharing critical thinking strategies, nursing care techniques, care planning, and decision making (Matsumara et al., 2004).

In 2003 the National League of Nursing published a position statement for nursing education (NLN, 2003). The statement called for a “dramatic reform and innovation in nursing education to create and shape the future of nursing practice” (NLN, 2003, paragraph 2). The NLN position urged educators to put aside the traditions of the past and design curricula that meet the current needs of students and health care delivery. This challenges faculty, students, consumers, and nursing personnel to develop partnerships for designing innovative nursing educational systems. The position furthermore stated “For too long nurse educators and nursing service personnel, although cordial and respectful of each other, have not been fully engaged in collaborating to prepare a workforce that can practice effectively in new healthcare environments” (NLN, 2003, paragraph 3). Since WWII the consequence of opening up more university and college-based nursing programs separated nursing education from nursing service. The NLN position statement suggested that the faculty and nursing service rejoin one another and collaborate and subscribe best practice for teaching in clinical. It also urged nursing educators to utilize evidenced-based teaching methods (NLN, 2003).

The NLN position statement of 2005 continued to proclaim the need for nursing education reform (NLN, 2005) and urged faculty to take the lead. The revised statement also

encouraged nurse education administrators to recognize scholarly productivity in teaching/learning strategies and for federal agencies to provide funding for such activity. The practice environment is complex and requires transformation of education and practice. A component of the driving force behind the transformation process is the need to be accountable for efficient and effective educational resources for nursing education and the need for research based teaching practices. The position statement recognized that the National Council of State Boards of Nursing and the American Association of Nurse Executives calls for planned, structured, and supervised clinical experiences of students. Other nursing organizations make demands on nursing education to include specific content. The NLN expressed concerns for multiple groups and organizations making mandates on nursing education because the mandates are not grounded in pedagogical research and do not encourage reform in teaching, program design, and collaboration for learning strategies. A warning was issued to refrain from making changes to nursing curriculum as a response to political pressure (NLN, 2005).

In a Heideggerian phenomenological study by Diekelmann (2001) over 200 nursing students, teachers, and clinicians representing all levels of nursing among 40 US states were interviewed in person or by phone to explore their lived experience of nursing education. They were asked to tell a story about a time that reminded them of what it meant to be student, teacher, or clinician in nursing education. Results of data analysis of the transcripts revealed that a collaborative community of sharing among students, teachers, and clinicians involved in nursing education create a new pedagogy for teaching/learning. When all three components of nursing education (students, teachers, clinicians) communicate with one another and share each others' needs, they have the opportunity to collaborate in an effort to reform instruction so that needs can be met. This 12-year study investigated the use of *Narrative Pedagogy* which “gathers and

explores contemporary successes and failures in nursing education into converging conversations that can guide substantive reform” (Diekelmann, 2001, p. 65). The pattern among the themes was identified as *The Concernful Practices of Schooling Learning Teaching* and described how teachers, students, and clinicians experience teaching and learning. The practices of concern are the common and shared experiences of what matters about education and were identified as gathering, creating places, assembling, staying, caring, interpreting, presencing, preserving, reading, writing, thinking, sharing dialogue, and questioning (Diekelmann, 2001).

An evaluation research on the use of a collaboration model between nursing practice and education study was conducted by nursing faculty in Norway (Halse & Hage, 2006). The clinical education model was used for nursing students in a three-year program and consisted of having 12-15 third-year students on the same nursing unit for 12 consecutive weeks. While the students were on the unit they worked all shifts and at the end of the 12 week course the students took full responsibility for the nursing care of one-half of the patients on the unit under the supervision of one staff nurse. The clinical model also required the staff nurses to take on the roles of clinical student counselors and student evaluators. At the end of one year of using the clinical model the students and nursing staff were asked to participate in a qualitative and quantitative evaluation. The results of the evaluation cannot be generalized because of the small sample size and lack of randomization; however, the evaluation revealed that from this sample the staff nurses and students were satisfied with the model. The students reported that they had increased their competency and staff nurses reported that the experience had a positive influence on the professional development of students and on the professionalism of the nursing unit. Use of this model also revealed that the need for the presence of the nurse lecturer from the school of nursing should be questioned. Use of this model helped the school of nursing to solve a problem

of finding a clinical placement for all the students by being able to place an increased number of students on a unit at the same time. Since the model was evaluated as being effective in organizing clinical studies for nursing students, the use of the model was continued (Halse & Hage, 2006).

Legal Considerations in Nursing Education

The legal aspects of collegiate nursing education have increased with the level of professionalism within the ranks of registered nurses (Regan, 1973). The nurse who cannot or will not perceive their patients as sensitive, troubled human beings will be prone to litigation. Patients who perceive that they have been inconvenienced by the nurses are more likely to sue. Because of the increase in available knowledge regarding hospital matters and of the responsibilities of nurses, there is no excuse for RNs to be ignorant about legal considerations in nursing education. Too little attention is given in nursing schools regarding the awareness of legal responsibilities of patient, nurse, and institution or agency. Hospital contractual agreements should not be executed casually. Serious consideration should be given regarding the continual legal responsibility by the collegiate nursing programs to provide quality nursing education to each student during their time of agency affiliation (Regan, 1973).

According to the LSBN (Louisiana State Board of Nursing, 1995), when a student nurse is taking courses that require a student to provide nursing care to individuals, families, and communities, the student is said to be in the clinical phase of nursing education, and during this phase of nursing education the student must be supervised by a faculty. The LSBN (Louisiana State Board of Nursing, 1995) also stated that a student nurse who fails to meet the standards of the nurse practice act can be disciplined by the board to include the disciplinary actions of limiting, restricting, delaying, or denying a student from entering the clinical phase of nursing

education. The board may also deny, suspend, probate, limit, or restrict any license to practice as a registered nurse or otherwise impose fines and assess costs to a licensee for failing to meet the standards of the nurse practice act (Louisiana State Board of Nursing, 1995).

The LSBN (Louisiana State Board of Nursing, 2005) document stated that a part of professional performance by registered nurses is to make assignments to others taking into consideration patient safety, and which are appropriate for the persons to whom the assignments are made. This performance standard requires that the nurse be knowledgeable of the competency level, and knowledge of the experience of the students for whom they allow to provide nursing care for their patients. This document furthermore asserted that faculty shall be present for student supervision while students are assigned to clinical areas and shall select, teach, guide, and evaluate all clinical learning experiences in the clinical facilities (LSBN, 2005).

According to the LSBN (Louisiana State Board of Nursing, 1995) selection and use of clinical facilities should meet specified criteria. The criteria includes but is not limited to the following: to have cooperation between faculty and the agency personnel in planning for the student's learning experiences, having registered nurses to ensure patient safety and to serve as role models for students, provision of an environment where students are recognized as learners, having criteria for assigning patient care, having a means of communication between nursing faculty and agency administrative personnel, and "evidence that the agency's personnel understand their relationship to faculty and students and that the responsibility for coordination is specifically identified" (Louisiana State Board of Nursing, 1995, §3529, E. 12).

Student nurses are given the authority to practice nursing without a license under a special exception by the regulatory board (LSBN, personal communication, 2006). However, this exception to practice as a student registered nurse is applicable only while the student is in the

clinical phase of nursing education from a board approved school of nursing, and does not have the authority to practice nursing outside of the student role. Furthermore, students do not practice nursing under someone else's license. The LSBN does not allow anyone to practice under another nurses' license. Theoretically speaking, if a nurse could allow a student to practice under their license, the nurse could allow anyone of their choosing to practice under their license. During the clinical phase of a student nurses' educational experience, the student is held accountable to the laws and regulations for practice as a registered nurse according to the Louisiana Nurse Practice Act. For this reason the LSBN requires nursing programs in the state of Louisiana to provide criminal background checks on all nursing students before they enter the clinical phase of their education. (E.Wade Shows, Attorney At Law, Legal Consultant LSBN; Thania Elliot, JD, MSH, RN, Compliance/Practice Director, LSBN; Dr.E.Tate, RN, Consultant for Education/Research, LSBN, personal communication, September 1, 2006).

The liability of nurses who work with students is the same as when working without students. Registered nurses are liable for actions of negligence and violation of the nurse practice act and are not held accountable for strict liability (W. Shows, Attorney At Law, Legal Consultant LSBN, personal communication September 1, 2006). As stated in the *Louisiana Nurse Practice Act for Registered Nurses*, nurses are given the authority to delegate nursing tasks to other competent nursing personnel in selected situations (Louisiana State Board of Nursing, 1995). The registered nurse (RN) is to follow the provisions for delegation as described in the *Louisiana Nurse Practice Act for Registered Nurses* and includes the following: the RN is accountable for the total nursing care of the patient; the RN is accountable to the patient for the quality of nursing care received regardless of who performs it. Before delegating a task the RN must assess the clinical situation and make a decision on which tasks to delegate according to the

acuity of the patient, the amount of supervision required, and whether the situation meets the LSBN criteria for delegation. Before an RN delegates a nursing task the following criteria must be met: adequate training for the task, demonstrated learning of the task, safe performance of the task in the nursing situation, the patient's status is safe for the person to perform the task, appropriate supervision is available during the task implementation, and the task is in accordance with the published policy and procedure of the facility (Louisiana State Board of Nursing, 1995).

CHAPTER 3

METHODOLOGY

This chapter describes qualitative research, phenomenological method, and the phenomenological processes used in the phenomenological research method. The data collection preparation is explained including the conceptual model, researcher role, guiding questions, reliability and validity, population and sample, selection process, confidentiality, informed consent, and pilot study. The data collection process using the interview method is described with additional discussion about potential ethical dilemmas. Organization, analysis, and synthesizing the data are explained according to the modified van Kaam method (Moustakas, 1994).

The purpose of the research study was to describe the lived experiences of nurses working with student nurses in the acute care clinical environment using a phenomenological design. The study results will help nursing educators and nursing administrators understand clinical nursing education from the nurses' perspective and foster cooperation in the development of positive clinical learning environments for nursing students. The study will attempt to answer the following questions:

1. What are the lived experiences of nurses working with student nurses in the acute care clinical environment?
2. How do the lived experiences of nurses working with student nurses affect the nurses' professional socialization attitudes toward student nurses?

Qualitative Research

This study is a qualitative research design and has an ultimate purpose of learning about phenomena that are of interest to the researcher in order to gain increased meaning or

interpretation (Rossman & Rallis, 2003). A feature of this design is that the research is conducted within a naturalistic setting to seek out some facet within the social world. Another feature explained by Rossman & Rallis (2003) is that “the researcher is the means through which the study is conducted” (p. 5). Phenomenology and hermeneutics are the philosophical roots of qualitative research, and it demands that the researcher use a well thought out but flexible conceptual framework. A formal hypothesis is not used, and knowledge about the subject emerges as the researcher conducts the study. A qualitative researcher uses the reasoning processes of induction, deduction, reflection, and inspiration to describe, analyze, or interpret (Rossman & Rallis, 2003).

The qualitative method has different genres such as ethnography, phenomenology, socio-communication, and case studies (Rossman & Rallis, 2003). Rather than using quantitative methods which measure and predict, the qualitative researcher uses contextual rich data to describe and interpret (Rossman & Rallis, 2003). According to Patton (1990), the qualitative researcher must identify the tradition used in the study and employ *triangulation* to ensure the integrity and accuracy of the findings. Triangulation is unique to qualitative research and is a method for looking at data in different ways or from different points of view. Multiple types of data can be triangulated to establish credibility and accuracy of findings. One of the methods for triangulation is for the researcher to use *triangulating analysts* and is described as having “two or more persons independently analyze the same qualitative data set and then compare their findings (Patton, 1990, p. 468).

Phenomenology and Phenomenological Method

Phenomenology is a research philosophy that focuses on the lived experiences and worldviews of a small number of people to obtain in-depth meaning of a particular aspect of an

experience (Rossman & Rallis, 2003). The true essence of experiencing the phenomenon comes from the “knowing subject to whom these phenomena appeared” and is a subjective process (Morse, 1994, p. 119). Husserl (cited by Morse, 1994) also described this process as the self, reflecting on itself and called it the transcendental subjective process. The most basic philosophical assumption is “that we can only know what we experience by attending to perceptions and meanings that awaken our conscious awareness” (Patton, 1990, p. 69).

Experience and perception are essential concepts within the philosophy of phenomenology. They are the “original modes of consciousness” (Munhall, 1994, p. 15). Through perception the body interprets and gathers meaning from experiences and is contextual. An individual’s perception of experience is what matters, not what reality is for someone else (Munhall, 1994). Patton (1990) cited that “there is no separate (or objective) reality for people” and “there is only what they know their experience is and means” (p. 69). The unique perspective from phenomenology is not what is happening but what is perceived by the individual to be happening (Munhall, 1994).

The interpretivism paradigm is used in this study as holding “status quo assumptions about the social world and subjectivist assumptions about epistemology” (Rossman & Rallis, 2003, p. 46). Within this view is the assumption that predictions in social science lead to social control; therefore, prediction is undesirable. Interpretive research is an attempt to understand the social world in the natural setting, without manipulation for the perspective of individual experiences. Another assumption is that humans create their own worlds and thick descriptions are necessary to describe, understand and derive meaning. Typical research methods used with this paradigm view are humanistic, face-to-face interaction (Rossman & Rallis, 2003).

Difficult as it may be, the reflection process is valuable to the phenomenological researcher for validation and correctness of the description or interpretation because it “awakens an inner moral impulse” (Morse, 1994, p. 130). This method requires the researcher to be able to use language to articulate their individual experience of the phenomenon. The lived experience is a self-understanding of the phenomenon through the subjective knowing of the researcher. The researcher obtains information about the phenomenon from descriptions of a small group of people who experienced the phenomenon. Since this study focused on the experiences of nurses, the implication for a phenomenological framework was evident. This genre of qualitative design is appropriate for this study because it is an attempt to understand the human experience in a context-specific setting (Patton, 1990). Through a method of dialogue and reflection, the phenomenon of the lived experiences of nurses working with student nurses in the acute care facility was described. As in the phenomenological tradition, truth is revealed through reflection of remembered experiences and in finding meaning to the experiences (Morse, 1994). "In accordance with phenomenological principles, scientific investigation is valid when the knowledge sought is arrived at through descriptions that make possible an understanding of the meanings and essences of experience" (Moustakas, 1994, p. 84).

Phenomenological methodology is an alternative to the positivist research paradigm. Munhall (1994) cited that the phenomenological paradigm for research is human science rather than natural science and is described as having a perspective of looking from the inside to the outside. The aims of natural and human sciences are different. Munhall (1994) furthermore stated that the “natural sciences seek causal explanation, prediction, and control” whereas “the human sciences seek understanding and interpretation” (p. 12). Patton (1990) described phenomenology as seeking meanings not measurements.

The phenomenological method as described by Moustakas (1994) was used for this study. According to Moustakas (1994) the first step in preparing to collect the data includes formulation of the study question, definition of terms, literature review, criteria for selection of participants, informed consent, establishment of confidentiality, and the development of guiding questions. The second step is collecting the data and includes the processes of Epoche, bracketing and conducting the interview. The final step is organizing, analyzing, and synthesizing the data. These steps were followed with some modification for increased explanation and clarity. The study is outlined and presented according to these steps (Moustakas, 1994).

Phenomenological Processes

The phenomenological processes utilized in the study were Epoche, phenomenological reduction, imaginative variation, and synthesis (Moustakas, 1994). According to Moustakas, (1994), understanding the phenomenological processes is necessary to conduct phenomenological research. These processes were used for understanding and deriving meaning from the experience of nurses working with student nurses in the acute care clinical environment.

Epoche

According to Moustakas (1994) Epoche is the ability of the researcher to set aside “prejudgments, biases, and preconceived ideas about things,” (p. 85). Epoche requires a conscious effort by the researcher to approach the data collection and analysis with a fresh new view as if seeing it for the first time. Moustakas (1994) stated “in the Epoche, no position whatsoever is taken; every quality has equal value.” The practice of Epoche is crucial to the phenomenological process because the researcher is an unbiased instrument for data collection and analysis.

Phenomenological Reduction

The process of phenomenological reduction begins with the formulation of the research question and ends with the final analysis of the data (Moustakas, 1994). Moustakas, (1994) stated “in phenomenological reduction we return to the self; we experience things that exist in the world from the vantage point of self-awareness, self-reflection, and knowledge,” (p. 95). This process has several steps which include bracketing, horizontalizing, identifying horizons (textural meanings and invariant constituents), clustering horizons into themes, and organizing the horizons and themes into a coherent textural description of the phenomenon. Phenomenological reduction essentially means reviewing the data repeatedly until a conscious self-evident understanding of the phenomenon is achieved. The researcher reduces the experience from a phenomenon in the world to self-awareness of its existence. In other words, the experience becomes lived through the researcher’s self consciousness. The lived experience becomes evident through inward reflection and continued looking and perceiving. Reflecting on “what other people say they see; we are encouraged to look again, from the perspective of another self” (Moustakas, 1994, p. 94). Reduction can originate from the descriptions of several participants. Through repeated reflection of the participants’ experiences, reduction of the data will enable the researcher to “uncover the nature and meaning of the experience, bringing the experiencing person to a self-knowledge and knowledge of the phenomenon” (Moustakas, 1994, p. 96).

Bracketing as described by Moustakas (1994), is a step in phenomenological reduction that maintains the focus of the study on the selected themes derived from the literature review and purpose of the research. Bracketing is used in the construction of the guiding questions. It also helps the researcher to collect data that is confined or bound to a particular point of interest.

During data collection the researcher brackets the research questions according to themes and prevents the researcher from straying away from the intended purpose of the study.

Another step in the process of phenomenological reduction is horizontalization and is described as treating all statements with equal value. For example, a description that is used one time is given equal significant to a description that is given several times. The researcher does not count the number of statements or descriptions but rather differentiates them from one another. After horizontalization meaning units known as horizons are formed. Horizons stand out as invariant qualities of the experience (Moustakas, 1994, p. 180). Horizons are also called invariant constituents of the phenomenon. Each horizon or meaning unit helps the researcher to understand the experience and can be given a label. In this study the meaning units were contextual descriptions that represented the answers to the guiding questions.

Imaginative Variation

The process of imaginative variation determines meanings and essences and requires intuition (Moustakas, 1994). The researcher imagines the experience from various viewpoints or varying frames of reference. The structural description of the experience is sought and helps the researcher to understand how the experience came to be what it is. Moustakas, (1994), stated “in this (imaginative variation) there is free play of fancy; any perspective is a possibility and is permitted to enter into consciousness” (p. 98). The structures of the experience are the conditions that must exist for something to appear (Moustakas, 1994).

Synthesis

The process of synthesis results in a “unified statement of the essences of the experience of the phenomenon as a whole” (Moustakas, 1994, p. 100). The process requires the researcher to synthesize the composite textural and composite structural descriptions through intuitive

integration. The essence is the condition or quality that makes something what it is and without it the phenomenon does not exist. Moustakas (1994) stated “the fundamental textural-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon” (p. 100).

Data Collection Preparation

The research questions were presented in Chapter 1, and the literature review was presented in Chapter 2. The conceptual model researcher role, guiding questions, reliability and validity, population and sample, selection criteria, informed consent, and the pilot study is discussed in the following text.

Conceptual Model

A conceptual model for the study was designed from the general assumptions in the literature review and the purpose of the study. The conceptual model was a tool that I used for the purpose of focusing and bounding the collection of data (Miles & Huberman, 1994). The model depicted the themes from what was known about nurses working with student nurses. The themes were the focus of the data collection and bounding of the data was accomplished by formulation of the guiding questions for the interviews. According to Moustakas (1994) this is the process of bracketing the research question. Since little is known about nurses working with student nurses the model also acted as a deterrent from collecting data that might have been useless in understanding the phenomenon.

The model was referred to frequently to remind me that the heart of the study was the nurses and their professional socialization attitudes toward nursing students. The themes related to the phenomenon, nurses working with student nurses, were job satisfaction, environmental

support, beliefs and philosophy about nursing education, incentives and motivational factors for working with students, and amount and type of contact with students. These themes were believed to be factors associated with the nurses' professional socialization attitudes toward student nurses and fluctuated on a continuum of positive to negative. Identifying the themes bracketed the research to provide a focus for the research questions. By bracketing the focus of the research the data obtained was related to the themes and topic of the study. The model served as a starting point for studying the phenomenon and established boundaries for the research process. Figure 1 is a graphic representation of the model.

Researcher Role

At the time of this writing I have been a registered for 29 years. For the first two years of my nursing experience I worked as a staff nurse on a medical surgical unit and on a post partal, nursery, and labor and delivery unit. During the time I worked as a labor and delivery nurse I helped student nurses who were assigned to my unit. The instructor was not available most of the time; so, the students came to me frequently for questions and I supervised them in patient care. During this time I was approached by a faculty member from a vocational technical institution for recruitment as a nursing instructor for students in a practical nursing program. While I was teaching in practical nursing I became interested in pursuing a masters' degree in nursing education in order to be qualified to teach in a baccalaureate nursing program.

During 15 years of experience as a nursing instructor I have met nurses with both pleasant and unpleasant attitudes toward nursing students. I have also witnessed positive and negative effects nurse attitudes have on students. My experience of working with students as a staff nurse allowed me to identify with the participants and helped to develop a trusting

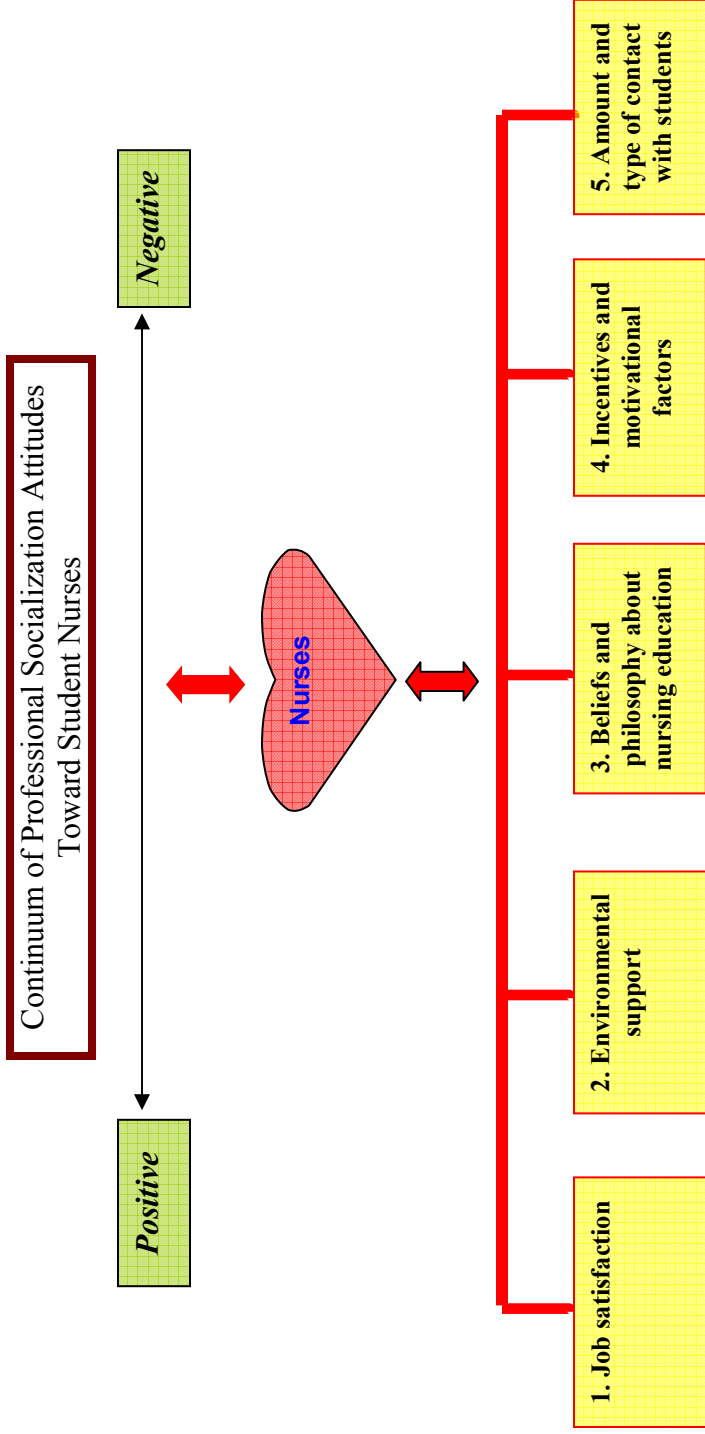


Figure 1. Conceptual Model of the Experiences of Nurses Working with Student Nurses

relationship with them. I was able to relate to the stress and demands of working with students while being responsible for quality care in a clinical environment. I wanted the participants to view me as a concerned, emphatic nurse researcher rather than an instructor or administrator; therefore, I did not include in the study nurses who worked on the clinical unit where I was currently teaching.

According to Moustakas "evidence from phenomenological research is derived from first-person reports of life experiences" (1994, p. 84). As the researcher I described the phenomenon as I understood it, or lived it through the nurses' descriptions and viewpoint. In order to experience the phenomenon I practiced "Epoche" as explained by Moustakas (1994). In the Epoche I avoided making suppositions from prejudgments, biases, and preconceived ideas that I had about the phenomenon. My relationships and observations from the past were consciously put aside in order to view the experience fresh and anew. I attempted to practice intersubjectivity, explained by Moustakas (1994) as experiencing what others experience. Their experience became my experience and I lived it with them and interpreted it from my own intersubjectivity. Moustakas (1994) stated "each can experience and know the other, not exactly as one experiences and knows oneself but in the sense of empathy and copresence" (p.57).

As I interviewed the nurses in the study I empathized with them and attempted to know the experience of working with students as they experienced it. I was careful to draw out their unique experience from the atmosphere I created during the interview process. The nurses were welcomed, respected, listened to, and guided to reflect freely and openly without being judgmental. My role was to discover what was really true for each nurse in the study. I validated statements and descriptions without leading the participant away from their personal perspective.

Guiding Questions

The guiding questions were constructed from the themes represented in the conceptual model. The themes in the conceptual model were formulated from what was known about the phenomenon through the literature review. Guiding questions were used to collect the data and was part of the research preparation process. The development of the guiding questions was carefully considered and well thought out before the interview process began. The guiding questions were as follows:

1. What does being a nurse mean to you?
 - a. What do you enjoy about your job?
 - b. What do you dislike about your job?
2. What kind of environment do you work in?
 - a. How would you describe the organization of the nursing unit where you work?
 - b. How would you describe the management style?
 - c. How did the nurses treat you when you were a student in the clinical setting?
 - d. How would you describe relationships with nurses, physicians, and other health care workers on your unit?
3. What are your beliefs and philosophy about nursing education?
 - a. How would you compare nursing education today with how you were educated?
 - b. What are your feelings about your nursing educational experiences?
 - c. How did the nurses treat you while you were in clinical?
 - d. What type of encounters have you had with the nursing students?

- e. What is your role in nursing education?
4. What motivates you to work with nursing students?
- a. What incentives if any, would you recommend for working with nursing students?
 - b. What are the benefits of having nursing students work with you?
 - c. What are the least desirable consequences of working with nursing students?
5. How do you describe your experiences of working with nursing students?
- a. What were the educational objectives of the nursing students while working with you?
 - b. What is your overall attitude towards nursing students?
 - c. What suggestions do you have to improve nurses' professional socialization attitude toward nursing students?
 - d. How would you describe your professional socialization attitude toward nursing students?
 - e. How would you describe others' professional socialization attitude toward nursing students in the clinical setting?

Credibility

Morse (1994) stated that “addressing reliability and validity in qualitative research is such a different process that quantitative labels should not be used” (p. 5). However, validity and reliability are not irrelevant; they are only achieved through different measures (Morse, 1994). Qualitative research uses the term credibility and dependability rather than reliability and validity. Leininger (cited by Morse, 1994) defined credibility as “the ‘truth,’ value, or

‘believability’ of the findings that have been established by the researcher” (p. 105). Credibility and dependability are achieved “through an extended, trusting, and confidential relationship between investigator and informants, rather than through the establishment of the psychometric properties of research instruments” (p. 286). Credibility of the researcher as the instrument was provided through a description of the researcher’s biography. Additional credibility was obtained through the use of triangulation, peer debriefing, and participant validation of the transcript (Morse, 1994).

Sampling Strategy

The sampling strategy used for this qualitative phenomenological research study was purposeful based on rationale for inclusion of specific participants, events, or processes (Rossman & Rallis, 2003). Appropriateness of the sample was more important than quantity or randomness. This means that the sample included participants who best articulated the needs of the study by being a “good” informant. A good informant is able to put into words the meaning or description of their experiences and is willing to reflect and share them with the researcher (Morse, 1991). Appropriateness was determined by asking a question “do the methods used to select a sample facilitate understanding?” (Morse, 1991, p.135). Since the data analysis was ongoing during the data collection, the participants were deliberately selected with particular knowledge or experience in order to fill a gap in developing theory or to confirm hunches. Morse (1991) stated that “an appropriate sample is guided by informant characteristics and by the type of information needed by the researcher” (Morse, 1991, p. 135).

In this study the rationale for selecting participants was based on their unique experiences as an RN working with student nurses. Large sample sizes were not required. The sample

required size for qualitative studies is usually small because the researcher controls who is selected to be interviewed by making sure of the appropriateness and adequacy of the sample. Eight to ten participants may be all that is necessary for saturation to occur in qualitative studies (Rossman & Rallis, 2003). Saturation occurs when the researcher is “not hearing anything new” during interviews (Morse, 1991, p. 135). The completeness and amount of information in the data determines when saturation is reached. In this study saturation occurred after six interviews.

Primary selection, a component of purposive sampling was used for this study. Morse (1991), stated that in primary selection

the researcher has a relationship with prospective informants and is aware of which members of the groups have the knowledge required, knows who would be “good to talk to,” and knows who would probably be willing to participate before inviting them to participate in the study (p. 136).

For purposes of this study, a nurse was defined as staff nurses who were full-time or part-time employees of an acute care hospital and who gave direct patient care and worked with students during their clinical placement. The nurses were selected on the basis of having a recent experience of working with a student nurse. The recent experience was determined by having at least two experiences in working with a student nurse within the semester that the interviews were conducted. The most recent experience allowed for more accurate recall by the participant.

I recruited and advertised for the participant by sending an announcement to selected nursing units where baccalaureate nursing students are placed and by word of mouth among the nursing community of practice. Since I am an instructor of nursing I had numerous contacts including other nursing instructors and former students who are now practicing RNs working with student nurses. This allowed me ample access to a sample group. I personally approached some of the nurses and invited them to participate.

Informed Consent, Confidentiality, and Selection Process

The internal review board of Louisiana State University and A&M College granted approval to conduct the study (IRB# 2573). Participation in the study was voluntary and the participants were able to discontinue the interview or request that their interview data be withdrawn from the study at any time. The names of the participants do not appear on the tape or transcriptions. Fictitious names replaced actual names of the participants in the study for labeling and referencing context. The audio tapes and the transcriptions were safely secured and kept from public access by the investigator.

A purposeful, primary selection sampling strategy was used (Rossman & Rallis, 2003). Nurses were invited to participate through posted announcements on selected acute care clinical sites where baccalaureate-nursing students from an accredited school of nursing were assigned for at least one semester. For purposes of this study, the nurses met the following criteria for selection to participate:

1. Staff nurse, part-time or full-time who provide acute care to patients in the selected clinical sites.
2. Having more than two shared patient care assignments with nursing students during the most recent semester.

The criteria for selection to participate in the study ensured that the nurses had recent experiences in order to obtain information-rich cases. During a clinical semester the investigator sent an announcement on selected nursing units directing interested nurses to contact the investigator by phone or e-mail. The investigator arranged to meet with the nurse at a pre-scheduled neutral environment that was convenient to the participant. The participant was asked to fill out a demographic questionnaire. The demographic data was used to describe the

participants and assisted the investigator in deriving meaning to the experiences from the participants' perspective. The demographic data collection included the following information: age, gender, ethnic background, marital status, experience as a nurse, type of basic nursing preparation, current level of nursing education, type of acute care unit currently employed, and length of employment on the unit. The participant submitted an address where the transcripts were sent for participant debriefing. The participant was also given the opportunity to select a fictitious name. This fictitious name was used in the transcripts to protect the participant's identity. Protection of anonymity and confidentiality was explained in the informed consent. After the interviewer obtained an informed consent the investigator turned the audio recorder on and began asking the guiding questions to solicit verbal responses. Immediately following the interview the interviewer recorded field notes to include observations about the setting, non-verbal behaviors of the participant, and other descriptions related to the interview. The investigator also recorded personal thoughts and feelings about the interview in a journal.

Transcriptions of the interviews were performed as soon as possible after the interview. Data analysis was ongoing, and the sample size was determined by saturation of emerging themes and categories from the interviews (Rossman & Rallis, 2003). Saturation is the "full immersion into phenomena in order to know it as fully, comprehensively, and thoroughly as possible" (Leininger cited by Munhall, 1994, p. 106). Saturation is an exhaustive exploration of the phenomenon being studied (Munhall, 1994).

Pilot Study

During the fall of 2005, dissertation committee members convened to determine approval for me to pursue the study in this area of interest. A pilot study of the guiding questions was conducted with the first interview (Kate). The guiding questions were tested during the interview

with Kate to determine if information pertinent to the study was addressed. As a result of the pilot study interview the guiding questions were enhanced. It was determined that a question regarding the nurses' own experiences in clinical as a nursing student needed to be incorporated with the third question "What are your beliefs and philosophy about nursing education?" A sub-question was added that stated "How did the nurses treat you while you were a student in the clinical setting?" This additional sub-question enhanced my understanding regarding the nurses' beliefs and philosophy about nursing education. Nurses' personal experiences of nursing school may have an influence on his/her beliefs and philosophy about nursing education.

Kate stated that she understood the questions. She furthermore stated that the order of the questions flowed well. Kate also stated she found the questions interesting, and they were easy to answer. It was determined that the questions elicited responses pertinent to the study and the pilot transcript contained context rich data that could be clustered into themes. As a result of the pilot study, the questionnaire was deemed appropriate and the interview data was used as part of the data analysis.

Data Collection

The steps taken in the data collection were: 1. engaging in the Epoche process; 2. bracketing the questions; 3. conducting an interview.

Interview Process

One-time in depth semi-structured informal audio taped interviews were conducted with six nurses who met the criteria for the study. Four of the six interviews were conducted in the researcher's office. Two interviews were conducted in the office of a colleague of the researcher. Each interview lasted approximately one and one-half hour. This prolonged contact with the participants gave the investigator time to become familiar with the personality and non-verbal

cues of the participant. During the interviews the processes of epoche and bracketing were utilized. Field notes and a researcher's journal were completed after each interview. The interviews were conducted intermittently over a period of six months. I transcribed the taped recordings in a private area to protect anonymity.

During the interviews I sensed that each participant shared their experiences freely and seemed grateful to be able to express themselves to a concerned, nonjudgmental listener. The experience was like witnessing a catharsis of feelings and opinions. All the participants verbalized that they enjoyed the interview. The practice of researcher Epoche' required a conscious effort that was energy draining especially during potentially emotional times when the participant spoke negatively about instructors or nursing education. Suppressing the need to be defensive or to explain curricula and nursing education issues required restraint. With practice the art of viewing and accepting the experiences as they existed through the descriptions of the participants became easier. I was amazed at how the nurses were able to work with nursing students in spite of the overwhelming workload and responsibility they have for patient safety and personal liability concerns. Each nurse truly enjoyed patient care and was dedicated to the nursing profession. It became evident that it takes extreme dedication to the nursing profession to work with nursing students and to support them in the acute care environment. Just from conducting the interview I gained insight into their experience and felt that the concerns of the nurses were often misunderstood and ignored.

Ethical Dilemmas

Measures were taken to decrease the potential for harm to participants of the study, although complete freedom from harm could not be guaranteed. Therefore, I was prudent and aware of possible causes for harm and made efforts to avoid them. I was honest with the

participants and informed them of the risks for participating in the study and shared with them the measures that I took to protect their anonymity and confidentiality. I shared with the participants how the tapes and transcripts were protected from public access. I made sure the participants were not coerced to participate, and I read the statement of informed consent and allowed the participant an opportunity to read it with ample time to ask questions. I did not rush the participant through this process. I was aware of the ethical dilemmas in having taped interviews such as copyright law violations, libel, and invasion of privacy. The tape recorder was not turned on until the participant felt comfortable and gave consent to have his or her words recorded. Once permission to be taped was verified the recording began. I taped the participants' permission to record at the beginning of the interview as suggested by (Wengraf, 2001).

I avoided violation of anonymity during transcribing the tape or in writing the results by carefully describing the participant in a way that could not uncover their identity. I warned the participants before the interview that describing the actions and descriptions of others can be incriminating or embarrassing. I asked the participants to refrain from using names of people or facilities in the interview. Wengraf (2001) asserted that "the participant should be warned about making assertions about others on tape that could result in a lawsuit from publishing or repeating information from a taped interview" and to "be aware of the possibility of defamation, a false statement that harms someone's reputation" (p. 185). Publishing personal and imitate details of a persons life should not be done unless absolutely necessary. I discussed how they could change the names to disguise persons.

The participant was told that they could discontinue the interview at any time and did not have to answer all the questions. None of the participants become emotionally upset after remembering an unpleasant experience from the questions asked by me. Such an incident is

unpredictable, but preparation for such a situation was warranted. If at anytime the participant became uncomfortable or I perceived there was emotional harm to the subject, I was prepared to discontinue the interview. According to Denzin and Lincoln (1994), if ethics were not considered there may be personal traumas for researchers, the researched and even damage to the discipline of study.

Denzin and Lincoln (1994) introduced five ethical and political positions for empirical inquiry. The five positions are, absolutist, consequentialist, feminist, relativist, and deceptive. Many times these stances overlap and intermingle with one another. Review of the benefits prompted me to adopt the following behaviors: I studied only behaviors and experiences that were in the public view, and I had an open and collegial relationship with subjects which involved mutual respect, noncoercion and nonmanipulation. I endorsed the ethical position that “stresses personal accountability, caring, the value of individual expressiveness, the capacity for empathy, and the sharing of emotionality” (Denzin & Lincoln, 1994, p. 22).

Organization, Analysis, and Synthesis of Data

Analysis and interpretation was a "process of deep immersion in the interview transcripts, field notes, and other collected materials" as specified in (Rossman & Rallis, 2003, p. 270). Triangulation of the data was achieved by using triangulating analysts which included the participants, a peer debriefer, and a colleague from the community of practice. Each participant was given a copy of their transcript with a request to review it and validate it as accurate or to make corrections or additions. A peer debriefer and a colleague from the community of practice read the transcripts and met regularly with the researcher to validate that saturation of the data had been reached and served to promote the credibility and rigor of the study. A “peer debriefer” is defined by Rossman and Rallis (2003) as an “intellectual watchdog” and was available for

design modification, and assistance with categorizing the data. The peer debriefer was Dr. Krisanna Machtmes, the chairperson of the dissertation committee. The peer debriefer validated the emerging findings, made corrections, and elicited additional information about the phenomenon. The colleague from the community of practice was an instructor of nursing who had experience with the phenomenological method of research.

I followed the steps for analyzing phenomenological data according to the modified van Manen method which are listed below.

1. Listing and Preliminary Grouping: list every expression relevant to the experience (Horizontalization)
2. Reduction and Elimination: determine the invariant constituents (the meaning units or horizons). Test each expression for two requirements:
 - a. Does it contain a moment of the experience that is a necessary and sufficient constituent (meaning unit or horizon) for understanding it?
 - b. Is it possible to abstract and label it? If so, it is a horizon of the experience.Expressions not meeting the above requirements are eliminated. Overlapping, repetitive, and vague expressions are also eliminated or presented in more exact descriptive terms. The horizons that remain are the invariant constituents of the experience.
3. Clustering and Thematizing the Invariant Constituents:
4. Final Identification of the Invariant Constituents and Themes by Application: Validation:
5. Using the relevant, validated invariant constituents and themes, construct for each participant Individual Textural-Structural description of the experience. Include verbatim examples from the transcribed interview.

6. Construct for each participant an Individual Structural Description of the experience based on the Individual textural description and imaginative variation.
7. Construct for each research participant a textural-structural description of the meanings and essences of the experience, incorporating the invariant constituents and themes. From the individual textural-structural descriptions, develop a composite description of the meanings and essences of the experience, representing the group as a whole. (Moustakas, 1994, p.120-121).

CHAPTER 4

ORGANIZING, ANALYZING, AND SYNTHESIZING DATA

This chapter explains how I organized, analyzed, and synthesized the data according to the modified van Kaam method (Moustakas, 1994). The data are reported in the following order: horizontalization, meaning units, themes, textural-structural descriptions, and composite textural-structural descriptions.

Horizontalization

The process of horizontalization of the data began with scrupulous review of the verbatim transcripts by the researcher, participant, peer debriefer, and the community of practice member (triangulating analysts). Since the participants did not make corrections or additions to the content, the transcripts were considered to be valid descriptions and representative of the true essence of their experiences. The triangulating analysts, excluding the participants, routinely met with the researcher to validate the data analysis process. Each transcript was read verbatim to gain insight into each participant's experiences. I read each transcript repeatedly between periods of reflection. I practiced the *Epoche* as I read each transcript and slowly over time, I understood more fully the experience of each participant. Each statement of the transcript had equal meaning. The process of reading the transcripts and reflecting on them helped me to organize the data and become familiar with every statement.

Meaning Units

The *meaning units* were identified from the responses to the guiding questions. First I organized the meaning units from each transcript, then I clustered all the meaning units according to each question. Each non-repetitive, nonoverlapping statement was organized according to verbatim descriptions. All relevant statements were weighted equally in importance

in order to establish the horizons or invariant constituents that I referred to as meaning units. The following section contains the clustered meaning units in the order of the guiding questions. The meaning units are verbatim responses from each participant with distracting phrases deleted so that they could be presented in exact descriptive terms. Great care was given in capturing only the parts of the transcript that answered the question and to not take any statement out of context.

1. What does being a nurse mean to you?

Kate: I enjoy taking care of people that are ill... I get a sense of satisfaction ... I think being a nurse means being able to help people.

Jenny: being able to help people that are hurting and that are sick and that need my help, care for people.

Sarah: caring, taking care of people, taking care of people who need my help.

Tommy: the ability to help others either maintain or re-achieve, help.

Natina: I think of it as caregiver, it means caring for other people and helping them through an illness or difficult time in their life.

Cindy: basically...just being able to care for people in a clinical environment

A. What do you enjoy about your job?

Kate: The people, the patients, the contact with the patients. There's not another job as far as I'm concerned that you have the kind of contact with the patients other than being in another medical field, is patient contact.

Jenny: the people I meet and bonding with the patients

Sara I love the people I work with. I love my fast paced environment... and on a good day I enjoy the interaction with all of the different people that I see.

Tommy: the interaction with my patients and being able to talk and spend time with them, seeing them get better progressively.

Natina: patient contact, being able to talk to my patients touch them feel them and just help them through the situation that they're going through

Cindy: I enjoy the outcomes, the good outcomes

B. What do you dislike about your job?

Kate: Working holidays, weekends, and long hours.

Jenny: not having enough time to give the attention to the patients I'd like to.

Sarah: I would have to say when people are rude to you and you just have to sit back and take it.

Tommy: probably the fact that paper work takes up more time than I have.

Natina: the workload, it's taxing and then you have to deal with a lot emotionally.

Cindy: when the outcome is not so good for some of the patients, and that's the hard part of it I think, is having to be there and witness whenever the doctor's telling bad news or the negative people that just have something bad to say about everything and aren't happy with anything that happens.

2. What kind of environment do you work in?

Kate: fast paced, somewhat stressful but an open environment.

Jenny: I think it's organized very well.

Sarah: I work in the emergency room

Tommy: It's a med surg floor so I have patients ranging from pneumonia to total hip repairs/replacements.

Natina: I work typically on just a medicine unit.

Cindy: surgical environment where patients come and stay post op for a couple of days after major surgeries,

A. How would you describe the organization of the nursing unit where you work?

Kate: We don't have somebody in our unit constantly as far as like a head nurse or charge nurse. We pretty much do our own thing and know what needs to be done and pretty independent of somebody...everybody takes turns being in charge.

Jenny: I think it's organized very well.

Sarah: Team oriented.

Tommy: There is definitely a hierarchy there is definitely an established way of doing things that's very organized.

Natina: they're doing a good job, they're trying to get better you know with the organization we, we have a 32-bed unit so, typically it takes five staff nurses on the floor to run the unit and uh a charge nurse and a desk nurse and a secretary. That's how our unit is supposed to run but it, it usually doesn't end up running that way but that's the set up of it. And when we do have enough people we all cover and our unit runs lovely. I think I for the most part yes it's organized, and our manager is, is very good about coming out on the floor and she'll take the place of whose ever missing

Cindy: For the most part I think it's organized, it's a very, very busy unit because when your getting patients, well you start with five or six patients and then, say you discharge one but your immediately getting another one back from surgery.

B. How would you describe the management style?

Kate: independent management style...just self management.

Jenny: The management is good.

Sarah: Right now it's going through a little rough time...we have two new managers.

Tommy: Authoritative, she (the unit manager) directs this is what's going to happen and she expects it to happen.

Natina: The style of it I think is kind of hands on.

Cindy: More like democratic I would say.

C. How would you describe relationships with nurses, physicians, and other health care workers on your unit?

Kate: we work real well together with the Doctors... I think we work real well together with nurses and have good relationships

Jenny: I personally have a good relationship with all the doctors.

Sarah: Excellent. Our physicians listen to the nurses what we have to say. We listen to each other...you might have your bickering every once in while; but for the most part we respect each other.

Tommy: Mixed, some of the people who are new that are other workers want it the way it was at their last job. So that creates issues with everybody and it's the same ones. It's the doctors and some of the new nurses; they want it the way it used to be at their other hospital. Some of them are going above and beyond to try to fit in.

Natina: As far as the nurse to nurse we are like a family. I think that is why that most people just hate to leave most of the time; because we are all so close and we do go out and we do things separate from just work.

Cindy: I get along pretty much with everybody, there's a few that I learned to just stay away from or just have a business relationship with; but for the most part pretty friendly. We call our self like a family, everybody's close, everybody knows everybody and their family, and we all

talk about it. We find that we're closer with the surgeons cause they're always on the floor I've never had problem or an issue with any of the physicians. For the most part I see everybody getting along pretty good. Some of the nurses and it might be assistants, sometimes they'll have issues with communicating and getting things done, and some of them take things personally.

3. What are your beliefs and philosophy about nursing education?

Kate: I think if I had to do it over again I would definitely go into a BSN program and then directly into a master's, some other level. I think the diploma programs and the two year associate programs were designed to help get nurses in and out real quick because there was a shortage. But I don't think it has really helped the nursing profession as a whole.

Jenny: (misunderstood the question, answered in terms of nursing educating patients)

Sarah: I believe that it could be better. I think that we need more skills. What I suggest to people that ask about nursing school is, if your gonna do nursing, go for your bachelor. Because, if you want to further your education it's a shorter time span.

Tommy: I firmly believe that if it were up to me we would not have anything less than a BSN program.

Natina: My belief is that, it's a good foundation, you should always educate yourself the best way you can. I get where my foundation came from and it did come from nursing school and it did help; education should always be your principle, it should always be your backbone.

Cindy: It was hard of course and it was a struggle but it made me stronger as a nurse, more respectful of what I was being prepared for.

A. How would you compare nursing education today with how you were educated?

Kate: now the nurses are required to broaden their education by taking more English's and arts and sciences and I think that is important... I felt like while we were in nursing school, that we were part of the staff

Jenny: They don't seem as strict, they don't seem as disciplined..... we didn't really work with the nurses. We would go on the unit and be with our instructor, and we would go to our instructor, and our instructor took full responsibility for what we did, and we worked under her license. We didn't work under the nurse on the floor's license. Our instructor would take report from the nurse and she would give us report and then we would work through her. ..When I would go on clinicals I would report to my instructor for anything that I did, in my charting, in my assessment, and my medications. But we would still talk with the nurses... I think we made more use of our time.

Sarah: I can still see the nervousness, the questions in their head and in their eyes

Tommy: What I experienced and what I see are sometimes different. (name of school) instructors come is and it is very obvious that they are in charge. They direct their students in front of the nurses that they, the students, are not to talk and have conversations with the nurses; because if they are doing that, then they have time to be doing other patient care, and their distracting the nurses from their patient care. Most of the other instructors seem to see interaction between the students and the nurses as a bonding-type thing and where we're talking most of the time we're talking about nursing care anyway. As far as the bachelors' with the bachelors' I don't really see any difference.

Natina: I think it's pretty much the same. The teacher and the nurses, the students working with them, I don't see anything different. You're drilling them on their drugs, that's the same thing I had to go through.

Cindy: It seems like there're getting more clinical time than whenever I was in school, in the beginning of it. But I think the more clinical experience is needed, more hands on.

B. What are your feelings about your educational experiences?

Kate: I think I had a real good opportunity...I had a good (nursing) education... I felt like I was lacking in other ways. In the English, the arts, and sciences, I just felt like I didn't get a well rounded education.

Jenny: I think I had an awesome one...from the time we got there till the time we left, we were learning.

Sarah: At the time I believed that I was learning a lot of information that I would actually use in the job setting. ...now not so much.

Tommy: I think I was well prepared... (In reference to feelings) confidence.(In reference to memories) Mostly fond.

Natina: Remembering everything I had to go through and studying and the papers and the, the math classes, the clinicals and all of that it was just so hard. To me it was worth it but, it was extremely hard. I do see how it did help me in my career but, to be honest it was very negative for me.

Cindy: Very stressful but at the same time it was rewarding you know, um, with the downfalls there was always something that helped.

C. How did the nurses treat you when you were a student in the clinical setting?

Kate: Good... I always felt like as a student my instructor and other nurses that I've worked with ...made an impression on me and their teachings were the things I remember.

Jenny: Ninety-nine point nine percent of the nurses were very nice to me. They had one, you know 1% that were rude, didn't want to help you....and only what you would be asking was where stuff is.

Sarah: It was different in different in areas....one area we did med surg I felt like we could do just about anything. The nurses basically let us take over their patients whenever patients were assigned to us. That was our patient and I never really saw the nurses for that patient. For my OB I didn't really do a whole lot of hands on or charting, and I think because the nurses are very protective of their patients or that's the way I felt at the time. In the ER, I did a lot there. I think that's where I got most of my experience.... they would watch me the first few times doing an IV to make sure I could do....I do remember one time in the emergency room where I didn't dilute a medicine before I pushed it. And she (the nurse) told my instructor, and the instructor told her to watch me closer, and it made me nervous, it made me feel a little more inadequate. She did treat me a little more like I didn't know what I was doing and that made me feel bad.

Tommy: I can't remember a time that was, that I was treated negatively. I think I was treated a little differently because I'm an older male. I certainly saw a difference in how the older nurses responded to me versus how they responded to the younger females. It was very obvious. I can't remember ever being, ever feeling like I was being intimidated, like someone was trying to intimidate me; but I certainly felt that way watching interactions between other older nurses and the new young female nursing students. I always observed from a distance. And I was not always close to hear, but when I was close enough to hear it was even more obvious that how their body language from a distance was obvious, their body language up close was so obvious and their tone of voice and the way they were saying things, the way they were directing the student nurse. And I never experienced that.

Natina: Most of them were helpful and then you could see those who were just not at all happy to see you because it mean extra work for them. Most of the facilities that I went to they were open and they would help you, teach you the ropes. But you could also see that some of them weren't too happy to have you and were kinda aggravated with you asking constant questions. But for the most part I think that they were happy to see us. I understood because it's taxing on them ...even though we were able to give meds, we weren't able to give all their meds...the pushes. I still had to come and say I can't give you've got to come and do this. It's kind of like extra stuff that your having to go back and do. I really didn't take it personal.

Cindy: I remember experiences where some of them were really nice, very helpful and then some of them tend to be a little aggravated maybe that I was there. Sometimes I remember feeling like I was in their way. For the most part they were all pretty nice and helpful. Different places we would go, different hospitals, you would see a change. Some of them loved it when you were there....looked forward to the help and everything; but some of them it was like, your in my way let me do it.

D. What type of encounters/experiences have you had with the nursing students?

Kate: They're working three or four days with me...towards the end of the week I let them take their own patients, with me watching them.... we usually(have) two patients in the ICU so we just take one and they (students) might help with the other one.

Jenny: probably 85% of them are educated and they know what they are doing and so it's been good. They're professional ... but like I said, they've had some that are not professional at all. No badge, don't even have a pen or paper to write down report...you ask them questions like, what are regular vital signs, they don't even know.

Sarah: pretty much what I do is watch them do basic skills.

Tommy: I always try to tell when they're first coming on the unit, because we're always busy and overwhelmed, ...if you need anything let me know, please ask questions, if you can't find something, let me know um and I'll try to comfort them in that sense.

Natina: Lots, I mean the LPNs as well as the RN programs and we've seen them all. I think if they could divide it to where you could get one student to a nurse and then that student helps the nurse with all of the patients the nurse has. It's kind of tough on the nurse when the nurse has 6 patients and each patient may have a different student nurse. Trying to keep up with who's who and where's your paper work going where's your Medication Administration Record (MARs) and your nurses' notes. Then when you have other disciplines coming in and asking for your paper work and you got go run down that student to get everything.

Cindy: The student nurses would come in and watch me do an assessment when they would first start. And once they were there and got on their feet then they would go in do the assessments and the vitals and bathing and would eventually hand out medications. You kind of learn working with them in the beginning certain things they can and can't do and you try to help them when they have questions. But then you see them grow ...whether you can trust them or not or what they can do as far as what the instructor lets them; but, by the end they're doing most of the nursing things except for the major that they can't do. The instructor, they'll come, in the mornings when we are listening to report and they'll tell us what patients they have say the student is going to be doing this, they cannot do this, and they'll tell us ahead of time and tell us what to watch for. They come in the day before and get their assignments.

Even if they have a different patient sometimes they will still come to you for questions and help, if they remember,. Say they had me last week but this week there was a different nurse and that

nurse might be busy but they will still come to you for guidance if they have questions or anything like that, I've noticed that.

D. What is your role in nursing education?

Kate: To teach, to take time and not have an attitude with the students or frustrated.

Jenny: We're there to help them answer questions, but we shouldn't have the responsibility of teaching and instructing and doing.... To show how a professional nurse acts and how a professional nurse should be working on the unit, and just show real life. . . just to be a mentor an example.

Sarah: giving them confidence, verbally praising them. try to give them the experience. I like to teach them ...to give them pointers.... watching to make sure everything's done properly. I'm not there to give them a grade or to pass or fail them.

Tommy: Answering questions, uh being an example of what to do versus what not to do um.. Picking them up and getting back on their way. Being a role model and assisting in their education

Natina: To be the educator. I think that's my little issue to show them that there's just more than just that book that you have to deal with.

Cindy: Be a mentor.

4. What motivates you to work with nursing students?

Kate: Just for something different, just so I don't have the same monotonous day at work.... I enjoy the students and they are a lot of fun....

Jenny: I was there and I remember how scared I was. I remember how nervous, I remember how much in awe I was of the real nurses. ... Payback... personal satisfaction...it makes you feel good.

Sarah: I want them to feel better whenever they go into the job.... I hope they're not going into their job feeling, oh my gosh, I'm scared to do this like I did.... where they don't feel insecure and inadequate like I did.

Tommy: Actually I have no say on it, I'm sure if I wanted to not to work with the students I could arrange that; but otherwise we find out usually by the end of report that students x,y and z has one, two, and three. So it's not whether or not I want to, it's that they are assigned to my patients.

Natina: Having been in that situation and I know that they're nervous when they come. I know that they have all this anxiety because this is their grade and they could flunk out if they don't go a good job of helping. I think that's my motivation, of trying to ease their anxiety a little bit.

Cindy: I was there where they were and trying to help them get through it without getting sad about it, discouraged. Cause it seems like a lot of them might be a little bit discouraged after seeing certain things or dealing with certain things. You try to help them and encourage them that they can do it and it will get better stick with it.

A. What incentives if any would you recommend for working with nursing students?

Kate: We don't have incentives. Maybe some incentive would be not to give you the two worst patients in the unit just because you have somebody working with you...Somebody to lighten the load.

Jenny: I don't think you should have incentives. I just think that that's something that, it's a right of passage. You went through it, somebody helped you, so you help them.I think money would entice somebody who really doesn't want to do that because I really don't think anything

else is going to persuade em. I've worked with those types of nurses, and if they don't want to do precepting then, that's just the type of person they are and nothing's really going to change it.

Sarah: No, not really...yes and no. Yes because of the fact that we get incentives whenever we precept new employees. But then again I could say no because of the fact that really I'm not the one overseeing them it's the clinical instructor.... (Suggestion for incentive) Pay...

recognition would be one way, I remember in nursing school one way that we at the end of the semester we would always throw a little party for all of the nurses. We would bring food and stuff like that just as thanks. And I think that is very nice. It shows that they're considerate and that means a lot when they do that.

Tommy: I think it behooves us to work with student nurses and to do a good job and making sure their gonna be good nurses because they're going to be our co-workers, and we need more of them . I don't think we need to get paid more for that, I don't think we need incentives for that.

Natina: Incentives are that they do help, I mean the little stuff. They take a little pressure off the aides because they go in and they bathe the patient and they change linens and they're constantly in and out of there and telling them can I help you with something, do you need anything. And that fact they do come in and give meds, so when you have a nursing student at the higher level they come in and they're able to do everything; so it does take a lot off you. They're using their facility as a teaching instrument so I think the nurse should definitely get something; because they are educating ...even though the teacher is there with them...the nurse is the one who they use to come to. . I don't know what type they should give you know whether it should be a pay raise.

Cindy: Your volunteering you help ...I don't need any money for that.

B. What are the benefits of having nursing students work with you?

Kate: I think it's good for the unit, you gain knowledge from them too.... I enjoy doing stuff with teaching I always have. I used to teach parts of the critical care course and the balloon pump course and stuff. I enjoy working with people...And it makes my day, changes what I'm doing after 20 years...Any change would be nice (Chuckle) Every now and then.

Jenny: If done correctly, they take some of the patient load away from you so you can spend more time with your patients not only are you spending more time with the people you have left, hopefully their spending time too....I've learned when their in clinical they do special stuff that we probably overlooked...they help with the patients too.

Sarah: Sometimes because we give them little jobs to do... and I can concentrate on something a little bit harder that might be more time consuming....giving the students the knowledge that they need to work in the real world. ...it might help me in the long run ,they might becoming an employee.

Tommy: Some of the benefits would include things such as the fact that they will be passing most of the meds so therefore I can focus on more time on other patients um they will be spending time with the patients x, y, or z so I can spend more time on other patients. They may be doing the dressing changes...the students are very excited about the possibility of getting to start an IV; so I don't have to spend that time. They generally don't need my time as far as being new students are being uneducated or not being able to figure out the answer so therefore I do have more time with the other patients and they are doing what they need to do, I'm looking over their shoulder, I'm asking them questions that I know they should be considering for each

patient, but for the most part it's wonderful because they're doing what they're supposed to be doing their doing what I would be doing.

Natina: They do take a little bit of the work load off. I think it's also a reward for the patient as well; because they get a little bit of extra attention.

Cindy: It helps the patient to get more hands on care receiving it from two different people cause sometimes your so busy as a nurse and if your starting with 6 patients, you try to provide as much for your patients; but sometimes your just so busy where that helps a lot when the students are able to do things that you are not able to help them with at that time. It helps as far as your workload.

C. What are the least desirable consequences of working with nursing students?

Kate: You get a more heavy load...but you're still responsible...that doesn't leave you a lot of time to teach or help the students... They've tried to change that but it doesn't always work because the night shift makes all the assignments...So they really don't understand, they think of it as an extra set of hands ...if you have students in the very beginning...it slows you down... because I'm talking and showing and stopping.... they're not given the kind of attention they should get, and the patient. Even if you do have a regular assignment ...I find myself behind. It's a strain.... I'm more worried about them doing something that might hurt the patient...of course there would be repercussions; but, I don't feel threatened, really. I guess I probably should. (chuckle) I feel more, just responsible. Sometimes your scared that they may make a mistake and give them (patients) the wrong medicine ...it might harm the patient...it might drop the blood pressure, depending on what kind of medicine it is. As long as I feel comfortable with that particular student and we have at least one run through together...I like to check up on them

and make sure I don't just go sit down and let them do. I like to make sure if there are drips that need to be changed out or titrated or whatever I make them come get me and we do it together.

Jenny: Being responsible for em on your license. Your doing your work twice because they're doing it and then your having to check on em and then, if it's done wrong then your having to redo it... Someone has to sign behind them. They have to operate under somebody's license, so what it means to me is when I put my initial that means I'm saying I saw them do this or I know they did this and they did it correctly. They leave and you see that they haven't charted anything....(In reference to how this makes her feel) Angry, and then I feel unprofessional, and I feel like this isn't my responsibility, it shouldn't be done. It's the instructor's responsibility, to have her students. We're not their clinical instructor. We've had them come along where they leave the unit without giving report.

Sara: They just don't have the experience. And a lot of time they don't have the knowledge which can kind of go hand in hand. Trying to be in an educator role I have to sit down and take even more time to teach them what they need to know; so it's taking up more time.... sometimes all the beds are full ...I don't have the time to sit here and give you five minutes,.... I haven't personally had any bad experiences; but there can, there is potential for it. There could be errors in procedures, errors in medication that's being given, if things aren't checked properly. A patient could die, that's the worst consequence. (In response to a student error) ...If I'm over the student, I should have been watching. If the student has never given a certain medication before, I should have quizzed her. You always have to take responsibility yourself. I wouldn't let anything happen to let my license become threatened. Because if I'm going over something with that student, I'm going over it as if I was her doing it.... and if I feel as if she is doing it to my level, then, I'm OK with that.

Tommy: The students will come ask me about certain meds about procedures other things and I'm answering more questions instead of giving the meds. Because they don't stay the entire day it gives me a chance in a sense to relax in the morning; but when they leave I've got all six patients and if I learned to follow everybody thoroughly; when they leave I don't know what's been done or what hasn't been done or what's been going on. If I have to go through report with one nurse and then turn around and give report to three different students, it's time consuming and irritating, because I've lost another twenty minutes or thirty minutes and it's now after seven and I haven't even begun to do anything,

Natina: It's a little bit extra work because you have to go back and chart, even though the nursing student did her little note or whatever about what's going on with the patient you still have to go back and start your stuff and go back and make sure everything was done and make sure that your meds were given at the correct time. You know they have to wait on their teacher before they give meds. Well I've got insulin that's due at 7:30 and well I can't find my teacher and my breakfast trays are about to be passed out and I have to give insulin before he starts to eat all that breakfast because it's gonna shoot his blood sugar up and then I'm gonna have to be dealing with that all day and trying to get his blood sugar back down so you really need to go find your teacher. If the doctor writes something stat, well I've got to go find my teacher and I've got to look up what this medicine before I can give it. But the doctor wants me to give it now and I understand that this is your patient but I got to take care of this now and so you do have to go behind them and you have to check your chart and check you patient as well and make sure that everything was done when it was supposed to be done and how it was supposed to be done. Even though the student had that patient, at the end of the day it's gonna be on me whether something didn't get done right, it's still gonna be back on me because I was that patient's nurse,

I was responsible for the care of that patient. If something didn't get done they're not gonna blame the nursing student cause I was supposed to oversee that and ... make sure that my patient got taken care of. As far as license, we're held accountable for whatever goes on and if something happens with that patient that patient can sue my hospital, they can sue me! I'm still accountable for that, that's still on my license. That's the only bad thing about it because you constantly go in and check; but, there's still that moment where you're not in there and the student may be in there, she may be helping them up to the bathroom and if the patient falls then....yeah, then who's that on, is that still on me? Because you know I was the patient's nurse. So, that patient may choose to sue the hospital and of course you know it's still gonna fall back on me because I was the patient's nurse.

Cindy: Worrying about a med error or something like that. When you're really busy and stressed, and you have the students coming to you for questions, you can't get to them all the time. If there is a med error there's an incident report filed and you have to call the physician they are under your license too, so you're on the incident report. The patient's under my care too so I feel just as much responsible if something were to happen. You don't constantly have that feeling of on you like something's gonna happen or go wrong; but, at the same time you feel like, well I feel like, it's my patient too. I don't think I would loose my license, but I didn't mean to make it sound like that. But, as a nurse that's the part of, you have that responsibility and I guess you could loose your license if it were something major. I mean I've never known anything major happening with a student; but it's just the thought of having them care for your patient and helping you with them if something were to let's say, a patient were to fall or something, I would feel just as much responsible for it. If something happened but the nurse

helped the student nurse resolve the issue, and take care of it, I don't think you'd be held as much responsibility.

5. How do you describe your experiences of working with nursing students?

A. What were the educational objectives of nursing students while working with you?

Kate: To learn parts of recovering open heart surgery patients, to work in a ICU setting, the different drips, machines that they've never seen before. I think its just to be exposed to different ICU settings. (In response to how they know) I'm guessing..... and from talking to some of the instructors..... and the students.

Jenny: to practice their skills, assessments, practice what they've learned. Doing what they've read about and learned about in class. (Response to how she knows) They don't tell us anything. the one (instructor) that comes, she doesn't even talk with us, fool with us, she has her students and she's running the show, so it's her and her students on our unit using some of our patients and she has full responsibility; so, we're not even watching what they're doing. At the end of the day, she turns her chart in, you open it up, it's done, everything's done according to our policy, she (instructor) knows our policy she knows how to tell them how to chart. She's teaching em, we're not, we're not doing anything with em except you know talking to em, answering questions.

Sarah: I didn't really discuss it with any of them but I, would think to get experience.

Tommy: Primarily I would have to say time management um and then secondarily being the um how to deal with patients and, and the assortment of things that we have on our floor um and just underneath that is how to deal with the family members. (Response how he knows the

objectives) The visual clues, they are asking me questions about when do you do this and when do you do that and I can see them trying to figure out what they have to do and when they can do it. But they actually don't tell you that this is what I'm working on today.

Natina: I think the teacher wants them to learn medications, and the disease process. I think that they are focusing on and how it's effecting the patient and how it's effecting their life, and their life style, and their family. I think those are the things they focus on because that's of the questions that they are asking. That's three big things that I notice they focus on is medications, disease process, and observations of the patient. (Response to how she knows) Based on what I remember from nursing school.

Cindy: You know what they are trying to, and the instructor tells you too, that this is their first time clinical or they're trying to get to this point, sometimes the instructors will tell you that, but just know from my experience.

B. What is your overall attitude toward nursing students?

Kate: I think I have a positive attitude.

Jenny: I welcome em, I mean if you come on the unit prepared like your supposed to be and excited, I think it's great, we need more nurses. My attitude towards them is that if your prepared we're gonna work ya.

Sarah: Aggravation. Not necessarily the student personally. But, just aggravated that they can't do it all. Why can't you get this IV? A certain nursing student may walk into the door and I've been with her before and I'm like, oh she's good, oh I like her, come on over, you can be mine today, come on. But, then there might be this one student who is just like, oh gosh, this person has a thick skull and you can't get anything through to um. (In reference to her response to a student she doesn't want to work with) I'm more abrupt and sharp with the student. I don't

explain things as thoroughly. I try to shorten my time with them as much as I can. Some hold a grudge and they'll like I'm not gonna work with anymore students and just, that's just too much aggravation for me I don't want to do it, I don't have the time to sit here and talk to em. So I'm just not gonna do it anymore....(In reference to behaviors of nurses when aggravated) Talking in a rude tone, making them feel stupid, like "Why aren't your getting this?", "Is that hard to understand?" Ignore em., out of site out of mind thing. If I don't see that student then I don't have to deal with em, and I'll just veer away from em.

Tommy: I like them.

Natina: I like them, I like being able to teach them and helping them and educating them about what really goes on in our in the nursing field, I enjoy having them.

Cindy: My experiences that I've had have all been pretty you know, good. I haven't had any, bad experiences that I can say right off hand. I try to have a positive attitude towards them, I try not to seem superior to them or that type of thing, but I try to keep a positive attitude. I try not to be negative or discouraging in any way.

C. What suggestions do you have to improve nurses' professional socialization attitude toward nursing students?

Kate: I think some incentives might start the ball rolling, and maybe they would enjoy, if they did work with them one time. But sometimes they re not going, there's people that have attitudes and you'll never change (them)...and you'll know after you've been in the unit for a couple of years who's willing to work them and not work with them.

Jenny: Again it's a time element, if they come on the unit and we're dead, we're gonna be more so friendly. But when we're busy my attitude is great, you look as though here's more stuff for me to do. I got a heavy load; I don't have time for this right now. If they would take the

responsibility off of us and put back on the instructor ...they come on the unit we can look up and go “ Oh, hey how are ya’ll doing?” and think in our mind this isn’t going to be extra work on me. They are going to take some work load off of me. Instructor’s going to be responsible, now I can enjoy em being here. Even though we’re busy, they’re helping me so it’s a positive thing that they’re here.

Sarah: I don’t know. I think it’s just gonna take a lot of the nurses being willing to just let the students do. Seeing adequacy, confidence, knowledge from the students. If I see my fellow nurse, my coworker is competent, then I socialize with them more because I like to work with them. They work hard like I do. I had this problem the other day with one of my co-workers, I didn’t feel like she is as competent as she needs to be and I felt like I had to back track over her and look at her work and make sure everything was getting done. And that’s another time aspect; I don’t have time to be doing that whenever you should be competent enough. .

Tommy: Well just with the intimidation that I’ve seen, I unfortunately don’t know if there would be a way to, to stop that. Encourage the students to talk to the nurses about professional nursing as a whole.

Natina: One way would be to like I said to just give one student to one nurse and I don’t want to say phase the teacher out of it, because I know the teacher has to be there; but I think if the nurse could just take that just one student and say you explain meds to me. I think if they will allow us to just have that, just give us that student and say OK she’s with you and you have her with you and of course she’s gonna take my patient. I think it would be a better experience for the student. I think they would get a more well-rounded education than just what goes on in that book.

Cindy: It would help, I think, if the students were allowed to work more with the nurses. Like when they come, there're just having to hurry and do their assessment and then they're having to hurry and do their meds and I feel if they had the chance to come one day with the nurse and just follow her. They don't get the chance to really go in and see all the different things that you are doing with that patient and all the responsibilities that you have as a nurse. When they come they are just with that one patient. I mean maybe being able to just stay with that one nurse all day and follow her and work with her and go to all her patients' rooms and just, not necessarily do meds and do anything but just maybe kind a watching. And then like maybe the day before they take care of that patient (pre-clinical), just kind a come in cause that way they would get to know the patient the day before and it would help them, to follow a day to be able to make them feel more relaxed and more comfortable with it. I remember, coming in that day and not seeing the patient before and just knowing what's about them in their chart. For the most part what I've noticed is they come in and they get the chart the day before and they go through the chart and they get all the information that they need. I think that would help with pre-clinical maybe just spending, I mean not the whole day, but just a little while... just to get to know the patient. I know it would have helped me as a student and it would probable make them feel more comfortable coming in the next day and that patient's knowing that their coming. Just going in and just being in the room and say when the nurse is changing a dressing on the patient ... doing something, or going in to see the nurse assess the patient head to toe. You kind of go home and remember those things that the nurse did and when you come back the next day it will help.

D. How would you describe your professional socialization attitude toward nursing students in the clinical setting?

Kate: I don't treat them like a student, I think. I ask them what their opinion is sometimes about certain things. I would just be willing to hear them out and listen to what scares them, and some of their experiences, and just being open ,and then wanting, having the willingness to teach them.

Jenny: I like having students when we're not busy. ..we still don't know what they've been checked off to do, what year they're in or anything. I don't want to be responsible for em on my license. When we're busy they come on ... my attitude is...you look as though here's more stuff for me to do. I got a heavy load, I don't have time for this right now. I think if they (instructors) would take the responsibility off of us ...to take some work load off of me...even though we're busy, they're helping me; so it's a positive thing that they're here. If they're slower than you are and your busy, that's when you get shafted. ...And then you feel ...the guilt thing, the anger thing, and then you're behind and then you feel like I let my patient down,I can't swear that I was never ugly to a nurse...I will be very condescending. You don't have a pencil. OK, maybe you need to go talk to your instructor and get what you need to get. I mean that makes me livid...the students are as good as their clinical instructor and as professional as their clinical instructor apparently... how did you even get into nursing school? How did you get this far?

Sarah: I think I'm very professional and I try to stay conscious of that because I know they're a student. I don't think it's appropriate that I should act a certain way that I do with my co-workers that you know I shouldn't act that way with my students.

Tommy: I address the student professionally, talk to them about professional nursing

Natina: I always have a smile on my face, and I will say can you come help me with this,I know it's not your patient, just come see this.

Cindy: You try not to make them afraid of you. I try to tell them if you have any question about anything if you don't feel comfortable with doing something, make sure you come and get me,

E. How do you describe others' professional socialization attitude towards nursing students in the clinical setting?

Kate: I think for the most part that they (nurses on the unit) are pretty nice... They seek out the students sometimes when they have something going on that they think they ought to see or hear. When we are really busy what embarrasses me is when they come up and say "Here's such and such she's going to be working with you" and they are like (sigh) Oh, I can't have a student today ... I just think it's rude! First of all they should have known about the student before that day, that's poor planning on maybe our head nurses. I have seen that happen before, in front of the students. It was a while back we had a nurse for some reason they kept putting nursing students with her and she just didn't have the personality for it... she would get frustrated with them and I think they dreaded coming to clinical... a lot of times she would embarrass them and if they said something about a medicine that she didn't think was right she would say "I can't believe your not even, they didn't teach you that at school" it was a put down on the school not per se the student...and said, they just don't teach those nursing students the way they used to. She never yelled at them, but that was humiliating. It was embarrassing...very condescending, but she was like that anyway. She would go and sit down when the nursing students did a lot of the work. Did not really guide them.

Jenny: I think it's the same thing as me because I've heard them talk and I've seen um when we're busy. How we treat them depends on how busy we are, how prepared they are, and how competent their instructor is. How much responsibility their instructor takes, and I'm not saying their instructor comes and does it all and we don't say a word, cause we will. When you have a competent group with a competent instructor you don't mind going, stepping over that line and going, hey I'll step in here and help ya'll. Because so what if they're on your license for

something, they're competent and they know what they're doing.... You're more trusting of them. We need more time too, if we're gonna be expected to train them, we need more time because I can go in and do a catheter in 2 minutes. To show a student or work with a student, you're talking about 20 minutes. I will help you but I'm not taking the responsibility or the pay. I mean you are getting paid to put people under your license and you're experienced at having people working under your license, I'm not.

Sarah: With the students it's very good. I think that we pretty much take the time with them. There are instances where we don't. That's usually when everything gets faster paced. But I think everybody is pretty much the same; we tell them stuff they need to know. I think everybody's open communication with them.

Tommy: At this point the nurses I work with address the student professionally, talk to them about professional nursing and I think we do it well. (In describing nurses who didn't socialize well) It was almost as if they're reaction to students was "Oh goody, I have slaves for the day" and it's like you know and they would assign task after task even if it wasn't the student's patient, even if it wasn't the students level of responsibility,

Natina: I think that the majority of the people that I work with have been out of school less than five or six years; so, they're kind of happy and are very helpful, more helpful than I think others. Cause we are short and they are the future they are coming out of school and so we want them to come to our facility. We are going to do whatever it takes to show them there is a benefit to working for this facility. So, we definitely want them.

Cindy: I've witnessed some other nurses working with some students who have had some issues and stuff like that. From witnessing my unit, the other nurses working, a lot of them don't mind and they love it when they come, and they are friendly to them. Some of them, very few,

I've noticed that get kind a bothered and feel like they are in their way. They want to be taking care of their patients completely and nobody else. The ones I know who would rather not deal with them they just, I don't know, you know how some people are, they are set in their ways of doing things and it kind of bothers them to be out of that. And I've noticed it makes the students feel nervous, and afraid to ask the nurse anything. They just say if the student comes to them for something "go get your instructor!" "I don't have time for that" or "I don't feel comfortable doing that, go find your instructor she can do that with you." It's pretty much (chuckled) the same ones. Sometimes the instructors know who that nurse is and won't assign them any (students). There are some nurses who try to be their instructor.... And I feel sorry for them, cause the nurse is over there drilling them and asking them these questions and well did you do this? I think they are trying to help the students but....(In reference to nurses who don't socialize with students) ...it may be some younger who just cant' handle it, because my unit is very stressful and very busy and a lot of them just may feel like they don't have time, they don't feel like they should have to help the student and I feel like a lot of them think that's what their instructor is there for. That it's their instructors' responsibility to do this and that, leave me alone I got my other things to do. I don't know if that's exactly what they are feeling but that's the the impression I get from some of them. But for the most part we, we love it when they come, we try to help them.

Themes

The triangulating analyst read the meaning units that I clustered. Through reflective-mediation and imaginative variation, we consensually agreed on the themes (invariant horizons) of the experience that became self evident. I validated the meaning units and their accompanying theme against the complete record of the transcripts. I checked each meaning unit to determine if

it could be categorized into one of the themes by either being expressed explicitly or by being compatible with the theme. In other words, the themes were supported by the meaning units. According to Moustakas (1994), these themes represented the core elements of the experience. The themes were labeled and are listed in the table below:

Table 1: Themes and descriptions of the lived experience of nurses working with student nurses.

Theme	Description
Beliefs about nursing education	Experiences as a student. Experiences as a nurse
Role Expectations	Personal Students Faculty
Communication Structure	Learning objectives Clinical schedule Student patient assignments Unit organization and management
Motivational factors	Intrinsic motivators Extrinsic motivators
Deterrent factors	Increased workload Liability concerns Not enough time Threat to quality care
Professional Socialization attitudes	Feelings when students are on the unit Attitudes about students

Thematic Textural-Structural Descriptions

The transcripts were reviewed again individually to capture the meanings and essences of the experience by incorporating the meaning units into the identified themes. First, I constructed textural and structural descriptions then I completed the process of phenomenological reflection, imaginative variation, and analysis of the textural and structural components of the experience. I then reanalyzed the data according to the emerging themes. As I analyzed the data I considered the study questions and I constructed thematic portrayals of the experience through narrative

descriptions of each participant The study questions were: what are the lived experiences of nurses working with student nurses in the acute care clinical environment?, and how does the lived experiences of nurses working with student nurses affect the nurses' professional socialization attitudes toward student nurses? A textural-structural diagram was constructed to represent each experience thematically. The following text is the presentation of the thematic textural-structural descriptions with a representative diagram of each participant.

Kate

Kate, a Caucasian married woman, was the first nurse that was interviewed. The interview was conducted in the researcher's office on November 8, 2005 at 1:15 pm. Kate's basic nursing education was from a diploma program and she had more than 20 years nursing experience. At the time of the interview Kate had been employed on a cardiac surgical unit for more than 10 years and she was between 41 and 45 years of age.

Kate's beliefs about nursing education are based on her own experiences as a nursing student. Kate said that she did not have as much of the "humanities or the arts and sciences" that is necessary to "broaden one's education." Kate stated that as a student she had more clinical experience but does not think it was "necessary" because some of the time the students spent on the unit was not quality. The nursing staff delegated students to perform menial tasks and often left the unit when students arrived. She thinks that nurses should be professional and this can be established by the type of basic preparation required to enter the field. Because Kate did not acquire a bachelor's degree she believes that she has missed out on a component of her education that would have validated her as a professional nurse. Kate stated "I think if I had to do it over again I would definitely go into a BSN program and then directly into a master's, some other level." She also stated "I think the diploma programs and the two-year associate programs were

designed to help get nurses in and out real quick because there was a shortage; but, I don't think it has really helped the nursing profession as a whole." Kate thinks that having baccalaureate-prepared nurses has the advantage of having a more "professional profession" and stated "if you can't go through college and finish college with a nursing degree, I don't think you should be really taking care of people." She also thinks that physicians and other health care professions would respect nursing more if nurses were baccalaureate prepared.

Kate's role expectations for herself is to teach, to "show them around" and to "let them help me with the patients and towards the end of the week, let them take their own patients with me watching them." Kate feels like she is selected to work with students because she is willing to teach, "to take time, and not have an attitude with the students or get, you know, frustrated." Kate did not express her expectations of the instructors and seemed to be comfortable with having limited contact with the instructor.

The communication structure between the nursing faculty and Kate is partly open but mostly closed. The nursing instructors assign the students to rotate through the unit, but they have limited contact with Kate and they do not communicate the learning objectives or specific competencies of the students. The instructor does not remain on the nursing unit with the students. Kate makes assumptions about the learning objectives based on what the students or instructor verbalizes to her. Kate said she guessed what the student objectives were by talking to some of the instructors and the students, but she has never seen any written objectives.

The communication structure between the night shift and the day shift is closed in regards to student assignments to patients and nurses. Kate does not have input with the assignment of students because the night shift makes the assignments for the day shift nurses. Sometimes the night shift is not aware that students are coming the next day and says they do not consider that

into the daily assignments. Kate sees this as poor planning. Even when the night shift is aware that students are coming, the assignments are unfair. Kate stated that the night shift doesn't work with students and they don't understand the impact on the workload of the nurses who work with students. Kate said that some nurses refuse students because they do not know about students coming and the work assignment is not equitable.

Kate said that usually each nurse is assigned one difficult patient and one easy patient. On the days she works with nursing students she might be assigned two difficult patients and describes it as "a bad assignment." Kate stated that the night shift sees nursing students as being "an extra set of hands" and concluded that their rationale for a bad assignment is "I think sometimes it's hard to divide patients up evenly between the five nurses and somebody's got to take the heavy load; so, why not give it to somebody whose got help." Kate's response to this situation is "but you're still responsible for both these patients and that doesn't leave you a lot of time to teach or help the students."

The motivational factors that influence Kate's willingness to work with nursing students are all intrinsic. She enjoys working with them and stated "they are a lot of fun." Kate believes that having students in the unit is a benefit. She stated "I think it's good for the unit, you gain knowledge from them too." Kate said she enjoys teaching and having students, "and it makes my day, changes what I'm doing after 20 years."

Kate doesn't have any extrinsic motivators to work with students and stated "We don't have incentives; in fact ...it can be really be hard and difficult because it does slow you down." She stated this is because she is "talking, and showing, and stopping." Kate thinks that having incentives for nurses who work with nursing students will improve professional socialization among nurses who usually do not enjoy working with students. She believes an incentive of

having a reduced work load, rather than a heavier work load, would encourage nurses to work with students. She also believes that when nurses who usually do not want to work with students begin to work with them, they will enjoy it. Kate believes that forcing nurses to work with nursing students causes a bad experience for the nurse and the student. She also believes that there are some nurses who have bad attitudes and incentives will never change them.

Deterrent factors that influence Kate's experience of working with students are discussed in the following text. When working with nursing students Kate said even when having a regular assignment she finds herself running behind schedule and this is a strain. She said this is stressful and she struggles to get out of her shift on time. Kate said that sometimes working with students is "a little scary" because the students trust in her and she doesn't "want them to make a mistake and hurt the patient or anything." Kate feels responsible for a medication error that a student might make and said she "usually checks them just to go through it with them." Kate said she rarely has a feeling that she may lose her license because of an error made by a nursing student and stated "I'm more worried about them doing something that might hurt the patient than the repercussions." She furthermore said that she does not feel threatened, just responsible.

Protecting her patients to ensure quality care is a deterrent because it requires more time to review procedures and observe student activities. She does not have a problem with a student administering medications to her patients as long as she feels comfortable with the student and she reviews the procedure with the student. "I like to check up on them and make sure I don't just go sit down and let them do." She instructs the students to come get her so they can do procedures together. Kate said that if a medication error was made by a student she would feel that she wasn't directly responsible, but would think that maybe she wasn't doing what she needed to be doing. She stated that she would feel responsible because she was not watching

them closer. Kate also stated that she can't always watch everything nursing students do and stated that it was more difficult when she was working on a regular floor rather than in ICU because "they are scattered out your unit in different rooms and whatever, and uh, you know, it's just kind of nerve wracking sometimes."

Kate's professional socialization attitude is described as positive and her socialization pattern is to always work with students and listen to them. She stated she has never refused to work with a student and likes them. She has guilt feelings when she is too busy to teach or show

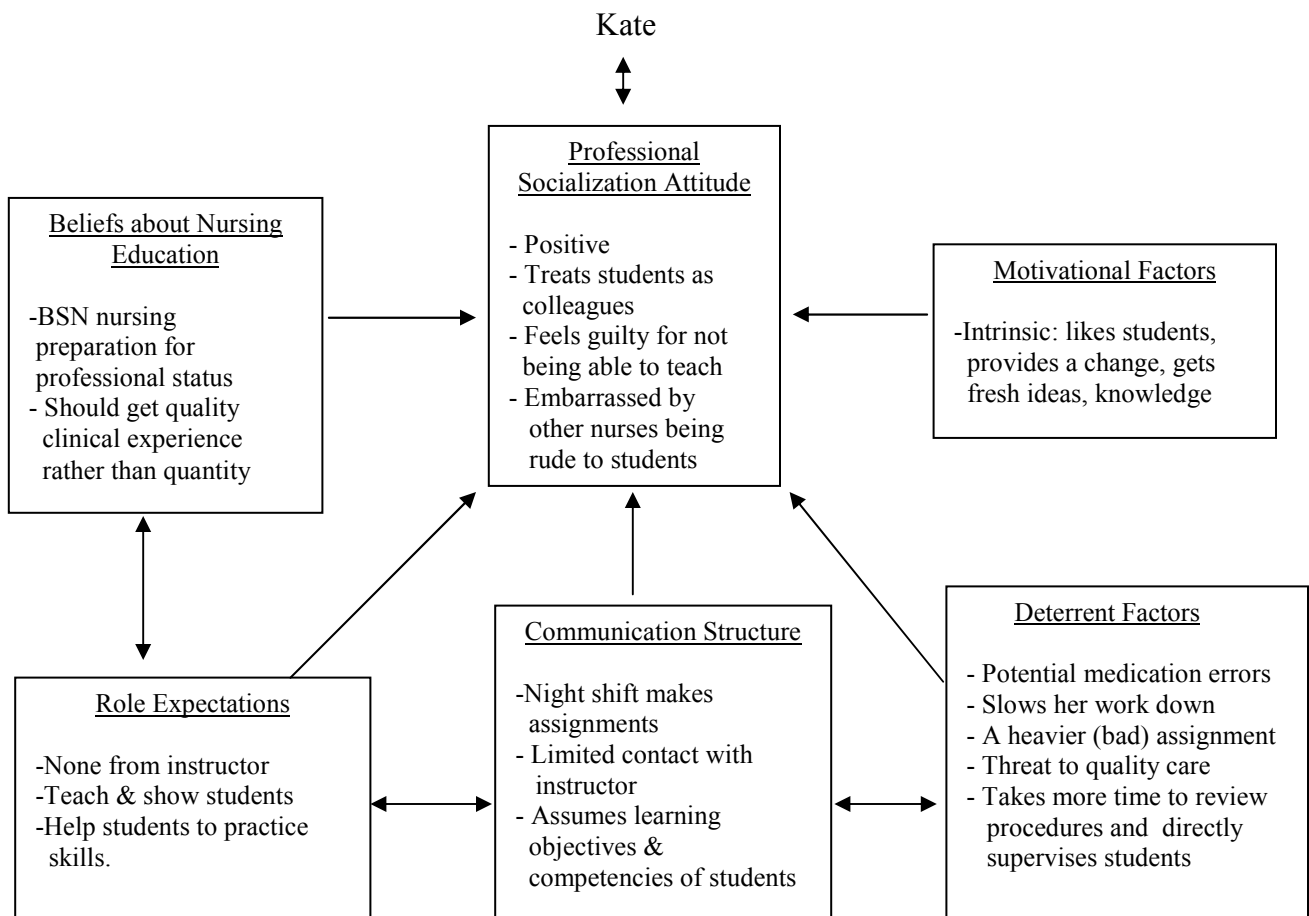


Figure 2. Thematic textural-structural representation of Kate's experience of working with nursing students in the acute care clinical environment.

them what she thinks will be beneficial for their education. Kate says she treats them as a colleague and considers their opinions. She expects others to respect them and feels embarrassed when other nurses are rude to students. The diagram in Figure 2 depicts how the themes of her experience are related to her professional socialization attitude.

Jenny

Jenny, a married Caucasian woman between the ages of 46-50, was the second nurse that was interviewed. The interview was conducted in the researcher's office on January 10, 2006 at 10:30 a.m. Jenny's basic nursing education was from an associate degree program and she also had received certification in nursing care for labor and delivery patients. Jenny had 6-10 years of nursing experience and was working in an obstetrical unit where Jenny had a rotating schedule between the labor and delivery area to the post partum area that included care for both the mothers and the infants until discharge from the hospital. The post partum unit had a 14-bed capacity.

Jenny's beliefs about nursing education are strongly influenced by her nursing educational experience. Jenny compares current educational practices and clinical methods of teaching to the way she was taught. Jenny said that her own nursing student experience was stricter than that of students she works with and thinks the faculty is more permissive and tolerant of what would be unacceptable behaviors when she was a student. For instance, when Jenny was in school students would be sent home if they did not have their name badge or did not know about medication administration. Jenny further described a difference in the way nursing students are supervised while in clinical. When she was a student the instructors had more control by taking patient report and then relaying the information to the students, going with the students to administer medications, and signing off on all the students' charting. She stated "our instructor was

approving everything and doing everything.” At the end of the clinical time, the students gave a patient report to the instructor and the instructor checked and signed off all students’ charting before they could leave.

The clinical instructor and the nursing students cared for selected patients on the unit and the nurses who worked on the unit did not care for the patients assigned to the students. She said “we would help out where as we would take two or three patients away from the staff and then the staff would do their own thing and we would be over here with those three patients, they didn’t have to worry about em, they didn’t have to check up on us, because our instructor was checking on us.” Jenny calls this method of clinical teaching as “old school.” Jenny stated “we didn’t bother the nurses” and “we went straight to our instructor and our instructor checked off everything we did and our instructor took full responsibility for that patient.” She said that as a student she did not work with the nurses but with her instructor. She stated that the students worked under the instructors’ license.

Jenny said her instructors expected her to learn before arriving to clinical rather than learning it while she was there. She said the instructor would ask her questions during clinical and if she did not know the answers, she would be sent home. Saying they haven’t covered the content in class yet was not an excuse for lack of knowledge about patient care. As a student Jenny said she was too busy to “just sit around and talk” and she “made more use” of the time during clinical. Jenny describes her experiences in nursing school as awesome and she was constantly learning while in clinical. She said that “ninety-nine point nine percent of the nurses were very nice to me and the rest were rude and didn’t want to help.” She remembers that while in clinical she would learn from the stories the nurses told about real experiences with patients

Jenny's role expectations encompass the role of instructors, students, and nurses. Jenny thinks the nursing students should practice what they've learned in school. She expects BSN students to have more education and clinical experience and to be better prepared than students from other nursing programs. Jenny's role expectation of the students and the instructors is for them to provide complete care for the patients they are assigned. The nurses should not be involved in the care of the student's assigned patients. She believes the instructor is responsible for helping the students to care for the patients. Jenny has definite boundaries where she interacts with students and will be friendly and helpful within the limitations of the boundaries. Jenny believes the role of the instructor is to sign behind the students when they document on the patients' chart. She stated "I just think their instructor needs to take responsibility for their students, not us." Jenny stated "I think we're allowing them (the students) on our unit for the instructor to show them things and teach them things

Jenny expects the instructors to practice the "old school" method of clinical instruction. She described a BSN instructor who does this. She said the instructor who teaches "old school" does not talk with the nurses, "she has her students and she's running the show, so it's her and her students." Jenny explained that the nurses on the unit do not even watch what the students are doing because the instructor is responsible for them. Jenny is very concerned about who is responsible for the students and believes that the students are practicing under someone's license. If the clinical instructor is not available she believes that the students that are assigned to take care of her patients are practicing under her license. Jenny resents being forced to take this responsibility. Jenny believes that her role she should be limited to being an example of a professional nurse to the students, to be a mentor, and to show them "real life."

The communication structure between Jenny and the nursing instructors is closed and prevents socialization with the students. The instructors do not communicate the learning objectives or competency abilities of the students. Jenny stated “they don’t tell us anything.” Jenny did state that she is aware that from time to time the BSN program will change the curriculum; but, she has never been informed about student expectations as a result of curriculum changes. When the instructors leave the unit it is difficult, especially during busy times because she doesn’t know the student’s level of experience or what they can and cannot do.

The motivational factors for Jenny are both intrinsic and extrinsic. Jenny said she gets personal satisfaction from helping students and it makes her feel good, especially when former students see her in public and acknowledge her in front of her children. She said this is “payback” to all the nurses that helped her and it’s what she owes to the “next generation of students.” Jenny thinks that nurses should not be offered incentives to work with students and it’s just “something that you do for your little nurses,” a “rite of passage.”

Extrinsic factors such as special recognition or monetary incentives are not offered by her employer. Jenny specified that if clinical were “done correctly” there would be benefits for having nursing students on the unit. She explained that some of the benefits would be to “take some of the patient load away.” Jenny has noticed that when nursing students have patients “they do special stuff that we probably overlooked” and this is also beneficial for the patients.

The deterrent factors associated with Jenny’s experience of working with nursing students are related to increased workload and liability concerns. These concerns are repeatedly expressed throughout her transcript. Jenny fears that a student may not know enough to report a dangerously high blood pressure and the physician is not notified in time to treat it. As a result the patient may be harmed, the physician will fuss at her, and she may lose her license. Jenny

stated that when clinical is not done correctly the consequence is that the nursing students are practicing off of her license. She furthermore explains “I mean, it’s just that’s a lot more on ya, and going behind them because that’s like, like doing it twice.” Jenny said that it takes more time for her to check the students’ work and if it is done wrong, she may have to redo it. She expects all charting and patient care to be followed according to the policy and procedures of the facility. Jenny feels that she is responsible for quality care and when the students do not chart properly she has to make corrections.

Jenny said that students work slower than she does and on busy days working with them gets her behind. When she is unable to check behind the students with their charting and patient care she feels like she lets the patient down. She said “that’s when you get shafted” because she is ultimately responsible for the quality of care. Jenny said that when she has to sign behind a student’s charting it means that she saw the student nurse perform correctly, whether it is an assessment or medication administration. Jenny has discovered charting mistakes after the students have been dismissed for the day. Some of her discoveries included seeing abnormal vital signs that were charted but not reported to her, or no vital signs charted at all. These events occurred because she assumed that the instructor would sign behind the students’ charting, like when she was in school. Jenny is uncomfortable with the idea that she may lose her license because of something a student nurse would do and feels especially vulnerable when the unit is busy. She said she cannot watch the students during busy times.

Jenny gets angry and it makes her “livid” when she finds student mistakes that were made on her patient after the student has left the unit. She said it also makes her feel unprofessional. She said her anger is projected to the nursing students and to the patients. She said that sometimes after the students leave she has to “straighten everything out” and realizes

that “nobody with a license has taken report on this patient.” She feels guilty that she did not follow behind the student and thinks that “she shouldn’t have trusted them” even after the student told her they knew what they were doing. Jenny resents doing the work of the instructor while the instructor is there getting paid for the job. Jenny expressed that even if she were paid extra to instruct the students she would not want to because she has not been educated in how to teach nursing students and in having people work under her license.

Jenny’s s professional socialization attitude is strongly related to how busy they are, how prepared the students are, and how competent the instructor is. Jenny said that when the staff nurses know there is a competent group, and the students are working under the instructors’ license, the nurses will offer to help the students. If the student is unprepared and not ready to learn, Jenny admitted to being rude, condescending, and not helpful. Jenny said she will send the unprepared student to the instructor. When the unit is not busy it can be fun working with students because she has time to talk with the students and determine their ability to take care of patients.

Jenny described her overall attitude toward nursing students as “if your prepared, we’re gonna work.” She said that she converses with the students to determine if they know what she is talking about “as opposed to talking to someone off the street that has no idea.” Also, if the students act excited, very interested, and follow the nurses, they are welcomed to the nursing unit. She stated that when clinical is done correctly, having students would reduce the workload and would be seen as helpers. On the other hand, if the nurses are stressed with heavy workloads, her reaction is “great, you look as though here’s more stuff for me to do” and “I’m slammed; now I’ve got this on top of my shoulders.” Jenny said that on busy days there is not enough time to be sociable with the students by saying hello or asking them their names.

Jenny's thematic representation of her experience of working with nursing students is shown in Figure 3. There is a strong relationship between Jenny's personal educational experiences and her role expectations. Jenny is unconcerned about the communication between herself and the instructor because she believes a competent instructor does not need to share the learning objectives of the students with her.

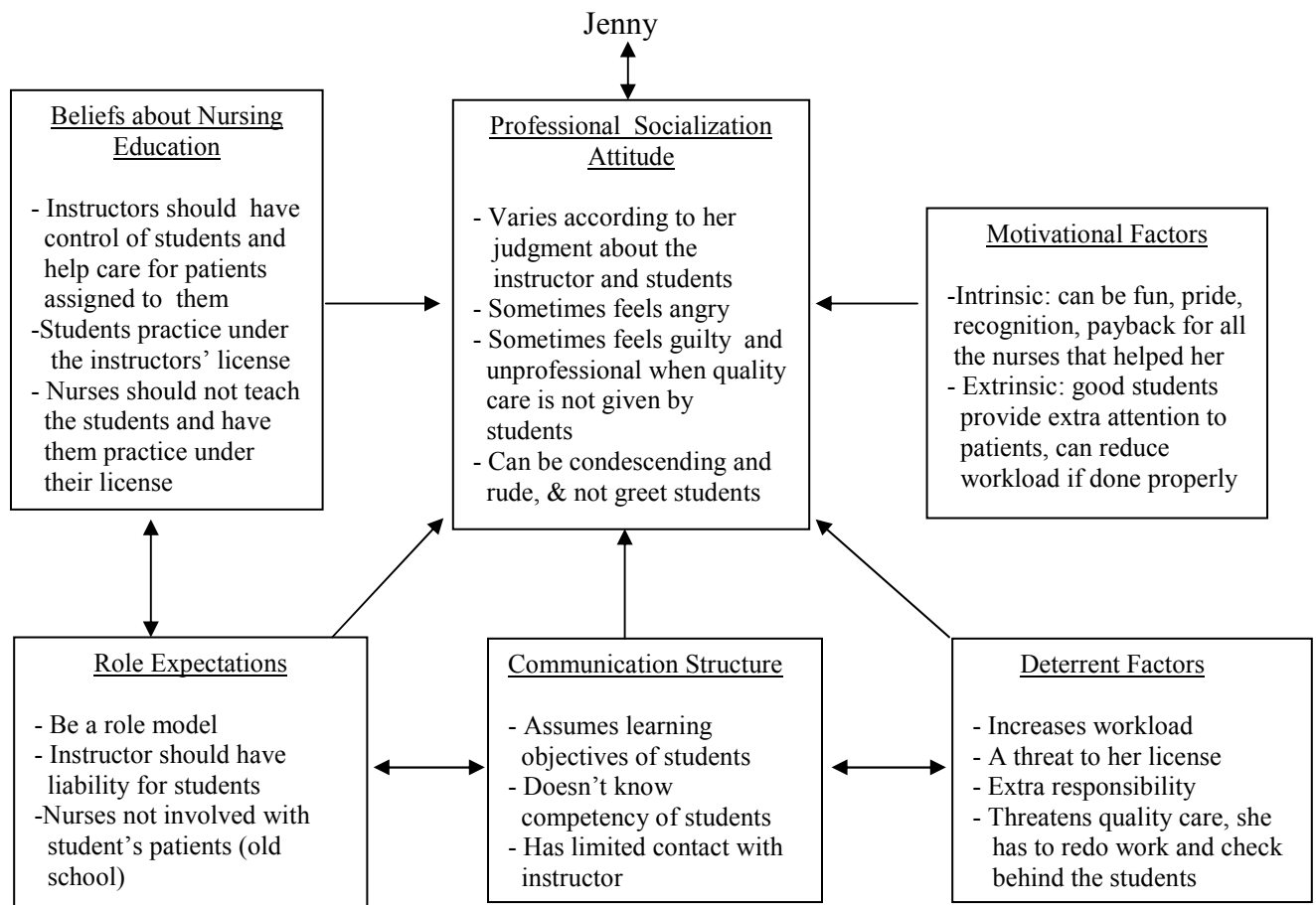


Figure 3. Thematic representation of Jenny's experience of working with student nurses in the acute care clinical environment.

Sarah

Sarah, the third interviewee, was a married Caucasian female between the ages of 25-30 years. Sarah's basic nursing preparation was a bachelor's degree and she had been working on

the night shift in an emergency unit since graduation from nursing school 1-5 years ago. The interview was conducted on January 24, 2006 at 7:30 a.m. in the researcher's office.

Sarah's beliefs about nursing education are that it should focus more on teaching nursing skills and building the confidence of students. This belief is based on her personal disappointment in her ability to perform skills when she began working. She stated she realized how inadequate she was and felt "dumb" when she first started to work. She missed having an instructor acting as a support person for her and to reassure her that she was functioning correctly. Sarah said that she thinks it is important for students to gain confidence and to receive verbal praise for doing something good. Sarah believes that if anyone desires to become a nurse they should get a bachelors' degree in nursing because it is easier to get a master's degree later.

In considering role expectations, Sarah views her role with the nursing students primarily as a patient advocate, someone to protect the patients by making sure the students perform safely. She said she never really thought about herself as being an educator but realized that is part of what she does. Her role "is to teach them so that the patient doesn't fall into harms way." Sarah expects them to learn what she learned as a student and tries to remember what she focused on at different levels. She also likes to give students opportunities to practice the skill of starting an IV and gives them "pointers" that she wished she had as a student. Sarah also describes her role while working with students as to help the students gain experience. Sarah did not describe a role expectation of the instructor.

The communication structure between Sarah and the nursing instructor is limited. Sarah does not routinely communicate with the nursing instructor about the student's performance and said that if a student repeatedly performed inadequately she would inform the instructor. Sarah said the instructor places the students in the emergency area and "they kind of place them where

they want to go.” Sarah is not included in the process of student placement and is not given the choice to work with a student; however, she stated “if I don’t want to work with somebody, then I’ll talk to the instructor.” Sarah has never refused to work with a student and said she doesn’t know what would happen if she did. She hopes that the instructor would reassign the student. Sarah said she always knows when students are coming to the unit.

Sarah shared that she has never been informed about what the student’s learning objectives were and assumed it was to gain clinical experience by practicing skills. Sarah does not know the competency level of the students and only knows their level by asking them. Sarah said it would be helpful for her to know about the objectives and about their competency level.

The motivational factors that influence Sarah’s willingness to work with students are mostly intrinsic. Sarah wants to work with nursing students because she doesn’t want them to feel scared, insecure, and inadequate like she did when she started to work. She has empathy for the nursing students and said she can see herself in them. Sarah said there were no employer incentives for working with nursing students and she is ambivalent about whether or not they should be offered. After some discussion comparing being a new employee preceptor to working with students, Sarah determined that she does not think she should get a monetary reward for working with nursing students. Being a preceptor is different than working with BSN students. A clinical instructor is “overseeing” the students and they evaluate and give them grades. Sarah said she does not feel in charge of a student and stated “with a nursing student I’m just watching to make sure everything’s done properly” and that no harm comes to the patient. She does not evaluate the students. If a monetary incentive was given, she questioned if the source should be the hospital or the university. Sarah’s final conclusion regarding incentives is that it will not

make a difference for nurses who just do not like to work with nursing students. Some nurses she knows will not be a preceptor even when a monetary incentive is offered.

An extrinsic motivator for working with nursing students is to have them perform “little jobs” so she can “concentrate on something a little bit harder that might be more time consuming.” Another motivation is recruitment and preparation of a future employee. A student may become her co-worker and she wants to help them gain the “knowledge they need to work in the real world.”

Sarah discussed the deterrent factors associated with working with nursing students. She gets frustrated with students because of the fast pace required in the emergency unit and if a patient has a life threatening condition such as a cardiac arrest she stated “that’s the time when I don’t have the time to sit and teach the student how to start an IV, the patient’s life depends on me getting that in quick.” Sarah said she has to use discretion in when to allow a student to perform certain procedures, and it depends on the patient’s situation. Sarah stated she does not sacrifice quality patient care for the nursing student’s chance to practice a skill.

What Sarah doesn’t like about having a nursing student is “that they just don’t have the experience” and the knowledge. Because of this she has to “sit down and take even more time to teach them what they need to know, so it’s taking up more time.” Sarah said she cannot be in an educator role or share information with a student when her patient load is high. Sarah has not had any incidents with students but realizes there is a potential for students to make errors in procedures. If there is an incident Sarah stated she would feel responsible because she is supposed to be watching the student. It is added responsibility to protect her patient from potential harm. For instance, if she knows a student has proven competency in a certain skill, she will assign a student to perform it and not be as worried that the student will harm her patient.

Proven student competency will also save Sarah time in having to validate it herself or teach the student about it.

To ensure quality care Sarah likes for the students to verbalize their knowledge about a procedure before performance of it. She furthermore stated “if things aren’t checked properly” there can be an incident which can cause a patient to die. Sarah said that if a student has never given a medication, she feels responsible for quizzing the student and if she does not have time for this, she just allows the student to observe. When she makes the decision to let the student observe it is because she thinks it is for the patient’s safety, and she is also protecting herself from liability. She said if a student harmed a patient she could be punished or possibly lose her license.

Sarah’s professional socialization attitude depends on the workload and the students’ ability or personality. During the interview Sarah’s tone changed dramatically when she was asked to describe her overall attitude towards nursing students. Her mood changed from being somewhat guarded in her speech to much more open and animated. Her immediate and unhesitating response was expressed in one word, “aggravation.” She added that sometimes the situation causes it; but, sometimes it is the student. Some students are more difficult to work with because they may be less competent or they don’t learn as fast. Sarah said this is the source of her feelings of aggravation. Sarah tries to exchange students who tend to aggravate her with students assigned to other nurses. When an exchange does not occur, Sarah admits to being more “abrupt and sharp” with the student and stated she doesn’t explain things as thoroughly and “I try to shorten my time with them as much as I can.” Sarah said that having a student who takes up too much of the nurses time has caused some of them to refuse to work with students. She stated “some hold a grudge and they’ll like, I’m not gonna work with anymore students and just, that’s

just too much aggravation for me, I don't want to do it, I don't have the time to sit here and talk to em; so, I'm just not gonna do it anymore." Sarah described the behaviors of some nurses who hold grudges against students as "talking in a rude tone, making them feel stupid" and they make comments such as "why aren't you getting this?" and "is it that hard to understand?" Some nurses ignore the students and described it as "kind of out of sight out of mind thing. If I don't see that student then I don't have to deal with em and I'll just veer away from em."

Sarah stated that when the workload is less and the students are competent the socialization behaviors toward students are "very good." Sarah said she calls the student by name if she can remember it. Sarah stated that for the most part "we tell them stuff they need to know" and "I think everybody's, you know, open communication with them." Sometimes the students are not welcomed because she's had a bad shift and the only ones welcomed in are nurses to relieve her. When she is having a bad shift, Sarah's response to nursing students coming in is, "Oh God, we got students here today" because it is more stress for her to work with a nursing student. Sarah believes that if the nurses realized the competency level of the students, the nurses would interact with the students more and this would improve professional socialization. Not knowing what the student's competencies are is a source of stress for Sarah.

The diagram shown in Figure 4 is a thematic representation of Sarah's experience of working with nursing students. The themes are diagrammed to show how they impact on her professional socialization attitude toward nursing students. Sarah struggles with her desire to help students acquire skills she thinks they need to be successful on their first job and her responsibility for providing quality patient care. This struggle causes Sarah to have guilt feelings. In spite of her feelings of guilt and aggravation, Sarah continues to work with students and has never refused to work with them.

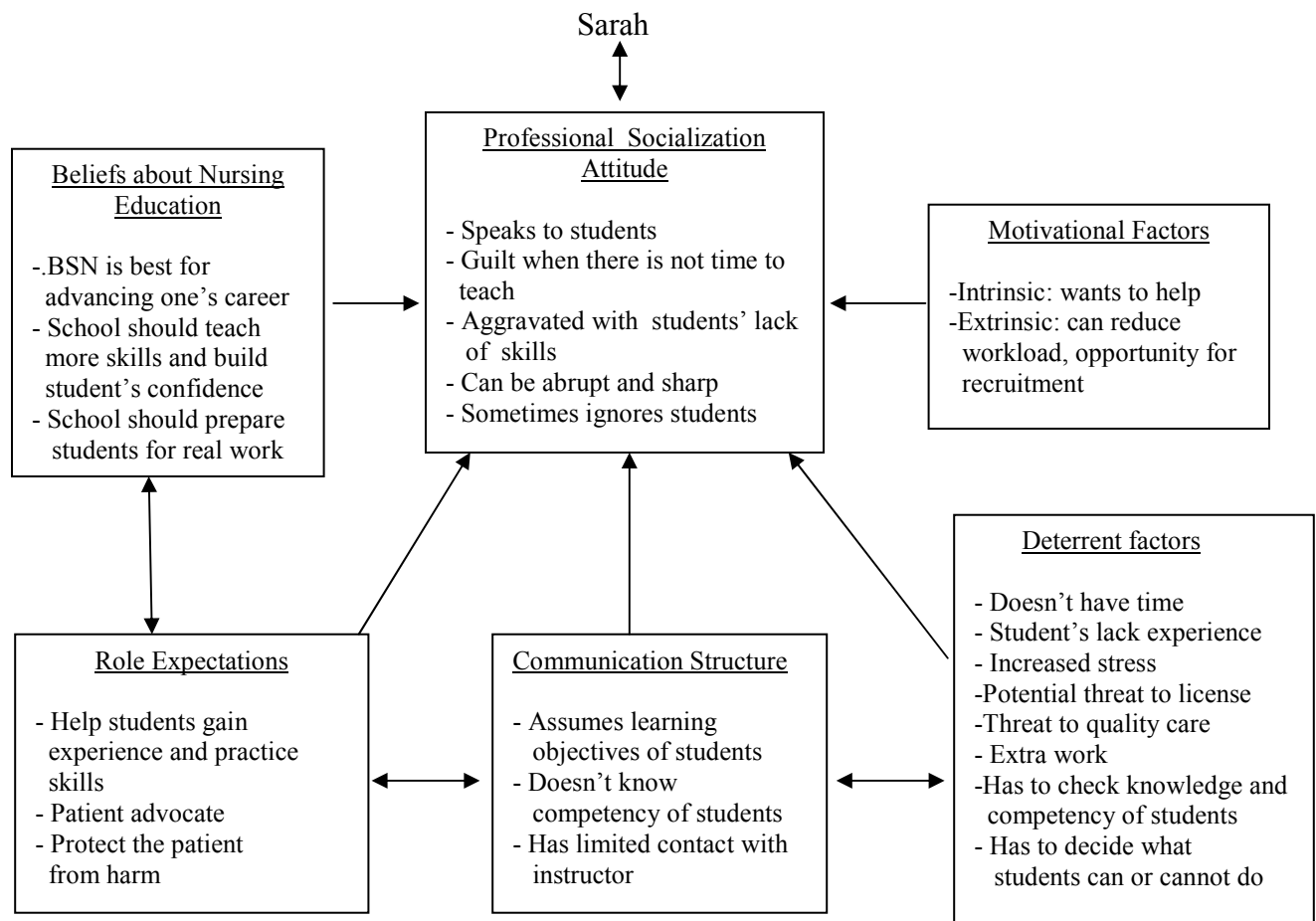


Figure 4. Representation of Sarah's experience of working with student nurses in the acute care clinical environment.

Tommy

The fourth interviewee was Tommy, a married Caucasian male between the ages of 36-40 years. Tommy had less than one year nursing experience and held a Bachelor's degree in nursing. He was presently employed on a 21-30 bed medical-surgical unit. The interview was conducted on March 15, 2006 at 1:00 p.m. in the researcher's office. Tommy was dressed casually for the interview and appeared relaxed and eager to participate.

Tommy's beliefs about nursing education are partly influenced by his experiences in nursing school. Tommy believes that nursing school should give the student confidence to care

for patients and to learn how to socialize with other nurses and health workers. While in nursing school Tommy witnessed older nurses intimidate the younger female nursing students. He said there was at least one nurse on every unit who was rude and intimidating to the younger female nursing students. He described how some staff nurses “would stand up close to and look down on” the student nurses. He also described their tone of voice as rude. Tommy stated that the nurses did not try to intimidate him but he felt intimidation by observing his fellow students being intimidated. As a student Tommy would talk about what he was witnessing and offered support and encouragement to the students. He said the students never complained to the faculty about how they were treated.

Tommy also stated that he witnessed the confidence level of previously confident students decline as the semesters progressed. This experience affected him greatly and it impacted on his role in nursing education and his beliefs that students should be supported and nurtured by faculty and nurses on the units where they work. Tommy said he doesn't remember being treated negatively by nurses and it was very “obvious” that the older nurses responded differently to him. Tommy adheres to the belief that the minimal level of entry into nursing practice should require a BSN preparation.

The role expectations that Tommy has of himself is that of a role model for the students. Tommy seems to be sensitive to the feelings of the student nurses he works with and tries to comfort them and offer help by answering questions or locating supplies. Tommy said he still remembers the way he felt as a nursing student and tries to instill in them confidence. For instance, if he sees a physician “tear down the student nurse” and the instructor is not there to see it, he talks to the student to help them feel better about themselves. He advises the student to develop a “thick skin” in order to deal with the way some physicians act. Tommy also

encourages other nurses on the unit to comfort the students when they know a student had a bad experience. Tommy said he would not tolerate a nurse intimidating a student nurse and he “would certainly step in and just, you know, stop it.” He said an additional role in working with the students is to assist them with their education. Tommy acts a protector and described an incident where he witnessed a nurse exploiting a student by having her perform menial tasks that were not even for the student’s assigned patient. He reported the nurse to the unit manager. Tommy said that he didn’t care that the nurse he reported was upset with him. He does not like to work with people who treat students in an unacceptable way.

The communication structure between the nursing instructors and Tommy is mostly closed. This is evidenced by the way in which Tommy described how he knew about the student’s learning objectives and competencies. Tommy said that an instructor or student has never informed him of the student’s learning objectives and he only knows what level they are on because he asks the students. Tommy said he thinks he knows what the objectives are from “the visual clues” and by the questions they ask him. He thinks the biggest clue that they’re working on time management is that the students are always running behind. He also determines what their objectives are by the type of patients they are assigned and assumes they are to learn how to care for a particular type of patient problem or family situation.

Tommy said that he is not given a choice to work with the students and finds out in report at the beginning of the shift that students are assigned to some of his patients. He said that he feels that he can refuse to have a student if he wanted to. Tommy said most of the time a student will approach him at the end of report to inform him that they have been assigned one of his patients. The instructors do not come to him directly and ask him if it’s ok with him that they assign a student to his patient.

The communication structure between Tommy and the nursing students is somewhat closed, depending upon the nursing instructor. He said that some instructors in a BSN program tell their students not to talk to the nursing staff and not to interfere with their work. Tommy described this as a conflict because the staff want to talk to the students but are hindered by the instructor. He said to avoid getting the student in trouble, if the nurses wanted to talk with a student, they waited until the instructor was off the unit. Tommy thinks that professional socialization between nurses and student nurses would improve if instructors encourage communication and interaction with staff nurses. He said that “if you have my patient you certainly better be associating with me because if something’s wrong, I better know about it, um, and if you don’t tell me, I’m gonna be upset.”

The motivational factors for Tommy to work with students Tommy are intrinsic and extrinsic. Tommy likes working with the students and does not believe nurses should be offered incentives for working with them. He stated “I think it behooves us to work with student nurses and to do a good job and making sure they’re gonna be good nurses; because they’re going to be our co-workers, and we need more of them. An extrinsic factor is that when a student is competent, it reduces his patient load and he can spend more time with the remainder of his patients. Tommy described most of the BSN students as being educated enough to “figure out the answer; so, therefore I do have more time with the other patients and they are doing what they need to do. He said that when the students are good, it’s a wonderful experience “because they’re doing what they’re supposed to be doing, they’re doing what I would be doing.” He said most of the time it’s like he has fewer patients. He also believes that having the students on the unit can be used as recruitment, and if they are treated with respect and professionalism they will consider working there.

The deterrent factors of working with nursing students are mostly related to the type of students he is assigned and the number of students assigned to him in one shift. One instructor intentionally assigns the weak students to work with him because he is willing to help them. However, it takes more time to work with a weak student. Tommy said that typically he will be assigned six patients and the BSN students are assigned two patients. Two of his patients may be assigned to one nursing student or two of his patients may be assigned to different students. He usually works with two nursing students during one shift. Sometimes three of his patients have been assigned to nursing students and he has had as many as five of his six patients assigned to students. On occasion he has had three student nurses assigned to his patients.

With several students being assigned to his patients Tommy said it would seem that he would have more time. However, the time he spends answering questions and validating competency is the same as if he were taking care of his full load of patients. He said there are typically six to ten BSN students on the unit with one instructor and “too many questions.” He said he realizes how difficult it must be for an instructor to answer all the questions and understands why they would ask him instead of the instructor. He stated “so, it’s not quite like I’m gaining that much time unless they’re very good students.”

It can be problematic for him when the students leave before his shift ends because he takes over where they leave off. He stated if he has been lazy and has not checked up on the patients, and what the students have done, he has to spend time catching up. He stated he learned he needs to follow the students’ work very closely so that “when they leave I’m able to just pick up and go with the patients cause otherwise, I don’t know what’s been done or what’s going on.” When a student is taking care of his patient, Tommy said he will still go into the patient’s room and assess the patient for himself and check the student’s charting to “make sure

it's matching what I'm seeing with the patient." He says he also validates that the patient is comfortable having a student nurse and offers additional help for the patient.

Tommy has learned by experience that he needs to ensure quality care for his patients when the students are on the unit. "I'm, looking over their shoulder, I'm asking questions that I know they should be considering for each patient." He periodically checks on the patients and looks over the paper work to make sure it's ok.

Tommy also said he gets frustrated with the way students come into the unit for report on their assigned patient. Some instructors do not require the students to arrive on the unit in time to receive patient report with the staff nurses. He stated "we start report at 6:30, and if I have to go through report with one nurse and then turn around and give report to three different students, it's time consuming and irritating." He stated that he loses twenty to thirty minutes, and this delays his work. If a student is caring for the same patient, after one day they only need a quick five minute update about the patient; but, when they are caring for a patient for the first time, it is more time consuming. Tommy suggests that instructors require the students to arrive early and get report with the staff.

Professional socialization attitude as described by Tommy is that he likes students and is willing to help them. He said "there's been very rare times when, um, the student took more time than what I was willing to give." He and the other nurses on his unit treat students with respect and interact with them in a professional manner. He described how in the past there were nurses who thought students were a bother but those nurses were no longer working there.

The diagram shown in Figure 5 is a thematic representation of Tommy's experience of working with student nurses. Tommy's role in working with students is strongly connected to his experiences in nursing school.

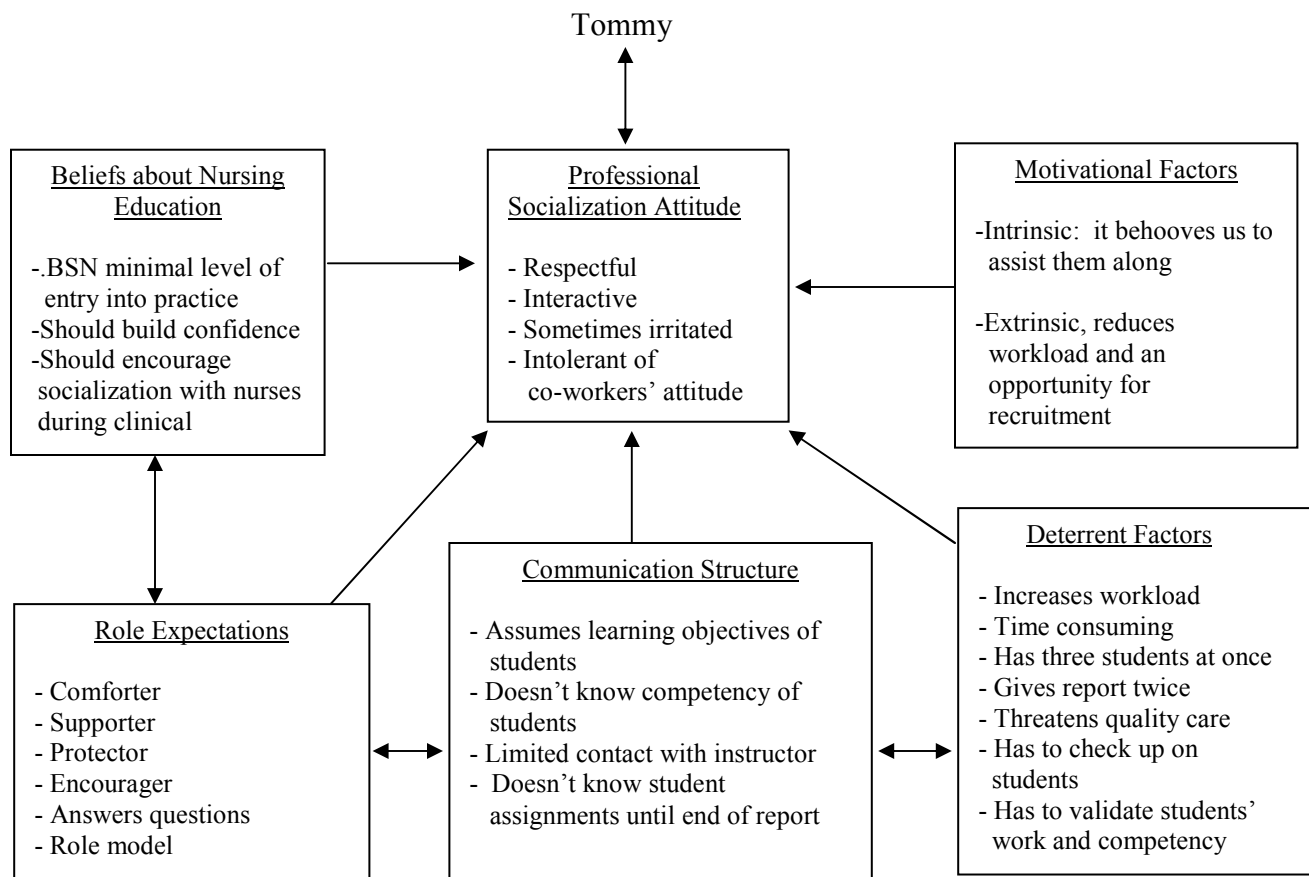


Figure 5. Representation of Tommy's experience of working with student nurses in the acute care clinical environment.

Natina

Natina, a married African/American female between the ages of 25-35 years, was the fifth interviewee. Natina held a bachelor's degree in nursing and had 1-5 years experience as a nurse. Since graduation from nursing school Natina has been employed on a Medical-Surgical unit with a 32-bed capacity. The interview was conducted in the office of the researcher's colleague on April 24, 2006 at 10:00 a.m.

Natina's beliefs about nursing education are influenced by her work experiences. Natina's philosophy of nursing education is that it is necessary as a foundation for on the job. Natina said nursing school did not teach her how to be a nurse, she learned on the job. She believes that

nursing school should prepare a student to think critically and realistically about patient care situations rather than focusing entirely on theoretical concepts.

As a student, Natina described the nurses as mostly helpful to her. She said there were nurses who were not happy to see students because it meant extra work for them. Some nurses seemed to be aggravated to see students and would be constantly asking her questions about patient care; but, for the most part she thinks the students were welcomed to the units and were given good support. As a student Natina did not take it personally when nurses seemed aggravated, and the way nurses treated her as a student did not impact negatively on her learning experience. The way Natina was treated in school by other nurses did not have a negative influence on the way she treats students.

The role expectations that Natina has for herself includes: being a educator, facilitator of student learning, support person, and encourager. She desires to have more involvement than she has presently because she does not like to wait for the instructor to be available before the student can perform certain tasks. She said she likes to help students to “see the whole picture” and not be limited to the text book. She also helps the students to be less anxious because she sees how difficult it is for them to explain what they have learned to an instructor. She hears students state how they have stayed up all night studying something and when the instructor asks questions they become too anxious to answer. Natina stated she will go with the students and say “so you just tell me why, why do you think this patient is on this and why this patient is, you know, having this trouble, and they’re able to explain because they know it.” Natina says she tries to show the students how to think critically and practice in the real world. She stated she also likes for them to compare what she does with the way they are taught in school or what is in the text book.

The communication structure associated with Natina and the instructors is closed. There is little communication regarding student objectives and competencies. Natina stated that she has not been told what the student's learning objectives are but remembers what she was supposed to learn as a student. She said their unit has different levels of nursing students from the BSN program and knows what each level is focusing on in clinical because she graduated for the same program. Natina does not relate the performance of the students with the instructor and collaboration with the instructor is mostly absent. Natina initiates communication with the student and takes opportunities to teach one-on-one teaching with the students when the instructor is not present. Natina says it would be best if the student did not depend so much on the instructor. She said she knows the teacher should be present; but she would like to supervise the student more, and eliminate having to wait on the instructor before a student can perform a procedure for her patients.

The motivational factors associated with Natina's decision to work with nursing students are mostly intrinsic. She has compassion for the students because she remembers how anxious she was as a student and desires to alleviate their anxiety. Extrinsic motivation is having the students help with the work on the unit and stated "I mean the little stuff, you know, they take a little pressure off the aides because they go in and they bathe the patient and they change linens and they're constantly in and out of there and telling them can I help you with something." When the nurses do not have time, Natina stated she can send a nursing student in the room to spend time with a lonely patient who needs someone to talk to.

When a nursing student is at a higher level they can give meds and "start the opening notes" on the chart, and this motivates her to want to work with students because they can reduce the workload. Natina believes that incentives should be offered to nurses for working

with nursing students because “even though the teacher is there with them ...the nurse is the one who they use to come to,” so the nurses educate the students. Natina did not have any suggestions for what the incentive should be. She said it should be something like a pay raise or some form of monetary reward. Natina explained that having students is also an opportunity for recruitment because they need nurses and stated “we are going to do whatever it takes, you know, we’re going to show them there is a benefit to working for this facility” and “they are the future.”

The deterrent factors for working with students are described by Natina as over-assigning or having too many students at once, having to check behind the students for quality care, delayed medication administration because of waiting on an instructor, and liability concerns. Natina explained that when the nurse has six patients she may also have six different nursing students taking care of each patient. She stated “it’s kind of hard your trying to keep up with who’s who and where’s your paper work going, where’s your MAR’s (medication administration records) and, you know, where are your, um, nurses’ notes.” Natina said when other disciplines come in the unit to get the chart it is time consuming to find out which student nurse has the chart and “run her down” to get it. Natina said that if a nurse could have just one student to work with at a time this would help.

Natina listed another problem as having to check behind the nursing students to make sure everything was done and that the medications were given on time. Natina said that when students have to find their teacher and wait for them to come before the student can give a medication it can cause delays in medication administration. Natina stated that this can be a risk to the patient when the medication is insulin or the physician orders a stat medicine. Also, if the student does not know a drug and has to look it up and report about it before giving it, it causes

delays. Natina said she has to check her patient to make sure that the student did everything that was supposed to be done and make sure it was done properly. Natina described that students may not understand the importance of giving insulin before the patient receives breakfast, and she has to prompt the student to call the instructor. This seemed to cause stress for Natina because she worries about patient safety when stat meds and meds such as insulin are not given on time.

Another concern Natina has in working with students is being responsible for what the student does to her patient and stated “even though you know the student had that patient, at the end of the day it’s gonna be on me whether something, you know, if something didn’t get done right, it’s still gonna be back on me because I was that patient’s nurse, you know, I was responsible for the care of that patient and if something didn’t get done they’re not gonna blame the nursing student, cause I was supposed to oversee that and I was supposed to, even though that teacher was there, I was supposed to oversee that and make sure that my patient got taken care of.” Natina has a concern that the patient could sue the hospital and sue her and her license would be threatened. Natina continued by stating even though the student was with the teacher “I’m still accountable for that, that’s still on my license.”

Natina seemed unsure about exactly what she is liable for when working with students and had difficulty explaining it. For example, when asked to explain how students work off of her license Natina replied “Well, just not, not really working on your license, but just, you know, they’re just, and I don’t think that’s even how it goes but just you know, knowing that, you know, it’s still your license that’s on the line.” Because of the threat of potential harm to patients, and as a consequence affecting her license or being sued, Natina is cautious and conscientious when working with students. She follows behind them and checks up on her patients. One time a student forgot to sign on the MAR that a medication was given and she had to call the instructor

after the student left to confirm that it was done. Natina also prefers to perform procedures with students to ensure quality care of her patients.

Natina's professional socialization attitude is described as positive. Natina enjoys working with the student nurses and said she has not had a negative experience with them. Natina said that she has never refused to work with a student as long as she is sure the instructor is available. Natina said that she thinks the staff at her facility likes the nursing students more than other at other facilities because the students help them in their work. She stated she has never seen the nurses react negatively about the students coming. She did admit that the nurses who have been out of school longer may not have as much empathy for the nursing students and stated "they don't remember how tough it was in nursing school, you know, and how the anxiety level is through the roof." Natina thinks the nurses on her unit are more tolerant of the students because most of them have been out of school less than five or six years. She said they are happy and more helpful and they welcome the students to the unit.

Natina said that even though students tend to "clutter" the unit and "they are all over the place, you know, and they can't find stuff," and they can be in the way on busy days, the benefits of having the students outweigh the problems they create. Natina said on busy days she finds a way to incorporate the students in the work so that they will be helpful to her. Natina compared having the students to having agency nurses and said when agency nurses are on the unit they ask questions about where to find things.

Natina also said that if a nurse is not having a good day and they know they will not be able to "stay on top of what is going on," they should not have a student. Natina thinks it is an increased responsibility to have a student nurse and if the nurse is uncomfortable working with a

student they should have the right to refuse to work with them. Figure 6 is a thematic representation of Natina’s experience of working with student nurses.

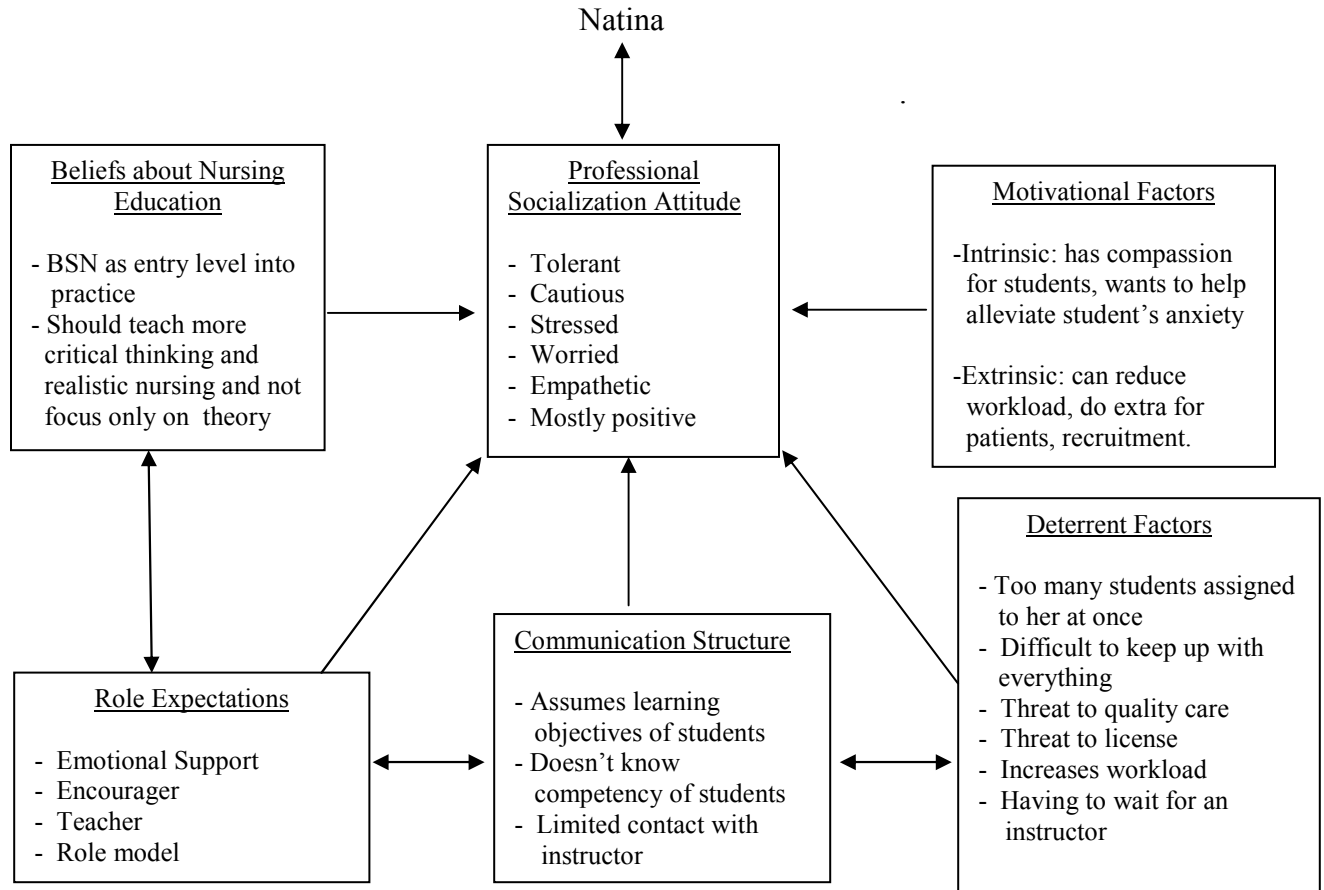


Figure 6. Representation of Natina’s experience of working with student nurses in the acute care clinical environment.

Cindy

Cindy, a married Caucasian female between the ages of 31-35 years was the sixth interviewee. Cindy held a bachelors’ degree in nursing and had 1-5 years experience as a nurse on a surgical unit. The interview was conducted in the office of the researcher’s colleague on May 18, 2006 at 3:00 p.m.

Cindy's beliefs about nursing education are influenced from her experiences as a student and as a nurse. Cindy said it's good to have more clinical and to get clinical experience while in school. She believes that nursing school made her stronger as a nurse and she learned to respect her profession.

Cindy views her role with students as a mentor and stated she sees the students looking to her to see what a nurse is like, and she wants to "set a good example and give the best advice" that she has. Cindy does not like to tell the students that the way she does things is the way it should be done because each nurse develops their own way of doing things. Cindy takes on this type of role because this was the role the nurses took when she was a student. She said she knows that the students look to her for advice on certain things; so, she tries to help them.

The communication structure between Cindy and the instructor is open but not consistent and appear to be one way communication. The instructor verbalizes the student's learning objectives, there is no written or formal communication, and the verbal objectives are all task-oriented. Cindy said this is how she knows what the students are allowed to do. Cindy said the instructor comes to morning report at the beginning of the shift to inform the nurses about the competencies of the students and tells them what to watch for in the students. Cindy also said that most of the time the instructor tells her what the students are trying to learn, but not all the time. Cindy thinks the learning objectives are the same as when she was in school and said that is how she knows what the objectives are, from being a student herself, and from the experience of working with the students. Cindy said the BSN students who come to her unit are at different levels in the curriculum. She has learned by observing them what their objectives are. Some students just perform assessments on the patients and just stay long enough to do that while some of the higher level students do more and stay on the unit longer.

Cindy is motivated to help students because she sees some of them being discouraged after “seeing certain things or dealing with certain things” and she has compassion for them. She remembers how it felt as a student to need someone to help and offer encouragement. Cindy does not believe she should have an incentive or receive extra pay for working with students because she volunteers to help the students and stated “I don’t need any money for that.” Cindy said that if she were working as a preceptor, she would consider it more appropriate to receive monetary compensation.

Cindy identified a benefit for having a student share her patients as reducing her workload. Cindy explained that it also helps the patient to have two people giving hands-on care and when she is so busy it “helps a lot when the students are able to do things that you are not able to help them (the patients) with at that time.” She elaborated that “when your swamped and they are there to help, even if it’s just for bringing a patient a glass of water, something where you can’t go do, or the assistants are busy.” Cindy said the nursing assistants get help with bathing and feeding the patients. Cindy also said a student has more time to give special attention to the patients such as to “go in and talk to them more” and “learn more about them.”

The biggest deterrent cited by Cindy is “worrying about a med error or something like that happening.” Cindy said that on her unit the patients receive narcotics and she thinks a medication error could occur if a student was afraid to ask her a question and did something wrong. To reduce this treat Cindy is careful to not make the students afraid of her and stated “I try to tell them if you have any question about anything, if you don’t feel comfortable with doing something, make sure you come and get me.” However, Cindy said when she is really busy and stressed she does not have time to answer all the students’ questions. Cindy could not recall when she has had a bad experience with a student.

Cindy said that if a student made an error, an incident report would be filed, the physician would be notified, and because the student is under her license she would be on the incident report too. When asked to clarify her statement about students working under her license, Cindy seemed unsure about it and said “I feel that way sometimes because I’m the patient’s nurse, and I feel like I should know exactly at all times what’s being done and what’s being given.” Cindy furthermore stated “so, as, maybe not as under my license; but, under my care,” and added, “I feel just as much responsible if something were to happen.” Cindy said she feels better knowing the instructor is on the unit watching the students and she doesn’t dwell on the possibility of the students making an error, but she is always aware of her responsibility to protect the patient. Cindy admitted she doesn’t really know how her license would be affected as a result of a student error and didn’t mean to make it sound like she would lose her license.

Further in the interview Cindy said she thinks she may lose her license if something major happened, but did not define what this meant. She stated, I’ve never known anything major happening with a student, but it’s just the thought of having them care for your patient, and helping with them, if something were to let’s say a patient were to fall or something, I would feel just as much responsibility for it.” Cindy said that she allows the student to work with the patient; so, she has the responsibility for everything the student does with the patient. Cindy also stated that if an incident happened and the nurse helped the student resolve it, she doesn’t think she would be held with as much responsibility.

Cindy’s professional socialization attitude is positive. Cindy tries not to be negative or discouraging in any way. Cindy said that she usually works with the same group of students for a semester and she sees the students grow. She learns to trust them and their abilities within the limits of what the instructor allows them to do. By the end of clinical time on her unit the

students are “doing most of the nursing things.” Cindy said that sometimes a student will continue to come to her for help even if the student is assigned to be with another nurse.

Overall Cindy said the experiences with students have been good, but she has witnessed other “nurses working with some students who have had some issues.” Some nurses who do not like to work with students are older nurses who are “set in their ways” and don’t want to be bothered with students. Some nurses who don’t like to work with students are younger and just out of school themselves, and are overwhelmed with their job. She feels that nurses like this think the instructor should be with the students and not the nurses. Some nurses “want to be taking care of their patients completely and nobody else.” Cindy also notices that the student senses the negative attitudes and it makes them nervous and afraid to ask the nurses anything. The nurses who do not want to work with students usually say to the students “go get your instructor” and “I don’t have time for that” or “I don’t feel comfortable doing that.” Cindy stated it is always the same ones who “get into different moods” and it’s pretty much the same ones that do not like working with students. Sometimes the instructor learns which nurses do like working with students and avoids making assignments with them. Cindy described some nurses as trying to be the student’s instructor and she feels sorry for the student when that happens because the student gets “drilled” by the instructor and the nurse. Cindy thinks that the nurses who drill the students are just trying to be helpful and are not intending to be unkind to the student. Cindy said she feels free to refuse to work with a student, but she has always agreed to work with them.

When asked for suggestions about improving professional socialization among nurses and nursing students Cindy described allowing the students a chance to shadow a nurse before being assigned to care for a patient. She explained that this would be good for the students to do early in their clinical experience. Cindy believes this would give the nurses an opportunity to get

to know the students and help the students feel less anxious. She said when students come they are assigned one patient and they are “having to hurry and do their assessment and then they’re having to hurry to do their meds, and I feel like if they had the chance to, um, come one day with the nurse and just kind of follow her” the nurse would get to know the student better. Cindy said if the students were able to go into every room with a nurse to see how she takes care of all her patients, and just have an opportunity to watch, they would understand what it’s like. Cindy stressed that this method can be a way to introduce the students to clinical practice and give the nurses an opportunity to practice professional socialization skills.

Cindy also discussed how professional socialization can be enhanced during preclinical time. She suggested that during preclinical when students are gathering data from the chart to study about the diagnosis and medications that they use this as an opportunity to associate with the nurse who is taking care of the patient. The nurse can introduce the student to the patient and spend some time with the nurse to “feel more relaxed and more comfortable.” Cindy says she sees the students come in on preclinical day and get information from the chart without talking to the nurse about the patient or even going into the patients’ room to introduce themselves. Cindy believes that if the student just spends a little time with the nurse on preclinical day, it would help. She said it would probably help the patient also to be introduced to the student nurse who will be involved in their care the next day. She went on to say that the type of patients in her unit makes this activity in preclinical possible because they know the patient will be there the next day. Figure 7 is a thematic representation of Cindy’s experience of working with student nurses.

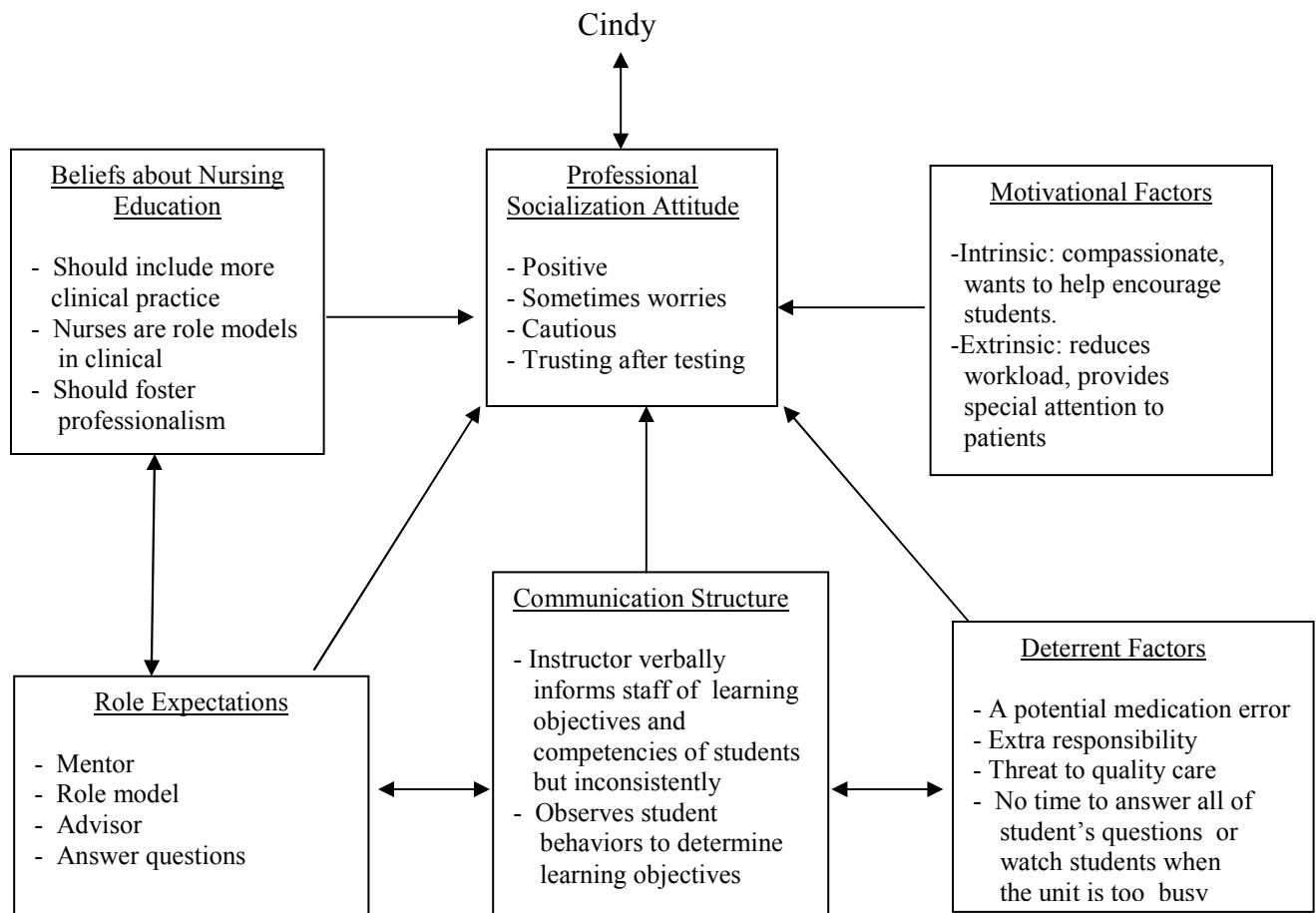


Figure 7. Representation of Cindy’s experience of working with student nurses in the acute care clinical environment.

Composite Thematic Textural-Structural Descriptions

The groups’ beliefs about nursing were varied and the participants described their beliefs differently. Several participants believed that a BSN should be the basic preparation for entering nursing. One participant expressed that a BSN degree preparation gains respect among other health care professionals. Although not all participants shared this belief, it was the only type of preparation mentioned for basic RN preparation. Other participants did not give an opinion in this matter. Nursing education should focus more on clinical nursing courses where students practice clinical skills and learn in the “real world” of nursing. Instructors should praise students

and help build the student's confidence for practicing nursing. The educational experience should provide a foundation for being able to learn on the job and to gain respect for nursing.

The role expectations focused mainly on the nurses working with student nurses. However, some participants described role expectations of students and instructors. The expectations of nurses who work with students included the following: be a role model, be a facilitator, to help students practice skills and gain experience, be an educator, a guide, and a patient advocate protecting patients from harm. Other roles included comforting the students when they experience something that could shatter their confidence, support and encourage them to succeed, protect them from emotional harm and to be a resource for answering student questions.

An expectation of the instructor was to remain on the nursing unit with the students. This expectation was prevalent in the group. When the instructor is on the unit with the students the nurses felt more comfortable being with the students. Some nurses perceived that they were not as responsible for the student with the instructor on the unit and this lowered the stress of working with them. Other expectations of the instructor included taking patient report and helping the students care for the patients, to be strict with the students, accept full liability for student actions, not place the nurse at risk for loss of licensure, and to monitor and check behind all student work. Expectations of students were to come to the unit prepared by being knowledgeable, and to act interested in learning about patient care.

The communication structure described by the group was similar for each member of the group. Communication was one-way meaning that the instructors disseminated limited information among the nurses regarding the clinical instruction process. The instructors or students usually informed the nurses about student assignments. Nurses' input in the clinical

process was absent, but all felt as if they could refuse to work with a student if necessary. The most prevalent problem with communication was the nurses' complete unawareness of a formal notification about the students' learning objectives and competencies. The nurses made assumptions about what the students were to achieve by observing the students or from memories of being a student. One participant mentioned that the instructor verbally informed the nurses of the students' objectives and competencies; but, was inconsistent and incomplete. The nurses discovered that a student was assigned to their patients at the beginning of the shift. Some instructors asked them permission to have a student take care of their patient, and some nurses were not approached by the instructor at all. Some of the nurses were approached by the students who introduced themselves and stated that they had been assigned one or two of their patients. Some nurses were assigned two to three nursing students per shift.

Most of the nurses were approached after the change of shift report by either an instructor or a student to ask for a patient report on the student assigned patients. In the intensive care unit there was conflict between the night shift nurses and the day shift nurses regarding student assignments because the night nurses made the assignments for the day shift nurses. Since the night shift viewed students as "helpers" they made unfair assignments to the day shift nurses who worked with students. Sometimes the night shift nurses were not aware that students were coming and this caused confusion when the students arrived.

The group was motivated to work with nursing students in various ways. The motivational factors identified were: to gain knowledge and fresh ideas, provide a change in the work routine, personal satisfaction and pride in helping, it can be fun, and fulfilling a professional responsibility. These factors were defined as intrinsic because they are intangible and create inner feelings of personal satisfaction. Extrinsic or tangible incentives that motivated

nurses to work with students were reduced workload for the nursing assistants, more help when the unit was short staffed, more time to spend with patients, special benefits for patients, and an opportunity for recruitment. If the students were functioning at a higher level and trust was established between the nurse and the student, having a competent trustworthy student would reduce the nurse's workload.

All but one participant agreed that a monetary incentive would be inappropriate and should not be offered. One nurse stated that she volunteers to work with students and does not expect to be paid for a volunteer job. However, one nurse thought getting monetary rewards for working with students was appropriate because she spends time with the students and helps to educate them. The group believes that offering monetary incentives would not influence nurses who truly did not like working with students. One nurse believed that monetary incentives would help recruit nurses that have never worked with students and may discover that it is enjoyable.

As a group the most outstanding deterrent factor when working with students was being responsible and liable for the student's actions. The awareness of this risk was heightened when the instructor was not on the nursing unit. The nurses believe that the students were "working off" of someone's license and if the instructor is not present, the nurse becomes liable for what the student does. Even when the instructor was on the unit and with the student, the nurses felt responsible for everything that was done to their assigned patient. There was a tremendous sense of responsibility in assuring quality care that was not only associated with patient safety but also included adhering to the institutional policy and practice for patient documentation and treatments. An additional responsibility was ensuring that the patient was satisfied with nursing care. When the students were taking care of their patients the nurses spend extra time and effort to act as patient advocates. This was an added burden when having students. and the

unfamiliarity with students' learning objectives and competencies made it more difficult for the nurse to relinquish certain tasks to the students.

A trust relationship began to form with repeated contact between the nurse and the student over time. The nurse evaluated the competency of the student and judged how much responsibility they allowed the student to have. This also took more energy and time for the nurse. Once the competency level of the student was determined the nurse was more comfortable with allowing the student to participate in selected patient care activities. Being assigned to a student over a more extended time period helped the nurse to evaluate the competency level of the student. The higher-level students who remained on the unit for a longer time period become more efficient and the nurse began to trust the student more.

The professional socialization attitudes were defined as the nurses' feelings when the students were working with them and the attitudes they had toward the students. The feelings and attitudes of the group varied and changed according to the circumstances or structure of the situation. Some of the feelings and attitudes affected the nurses in a negative way and altered their perceived performance. The group expressed concern about quality care when the unit was very busy and they did not have enough time to check behind the students. When students made mistakes or errors in charting the nurses took personal accountability for it and thought that management and patients would see it as a reflection of their nursing care.

The nurses viewed working with students as negative because of the extra strain and stress on the job. Some nurses had a fear or worry about patient harm or loss of their nursing license as a result of student actions. One nurse was assigned a heavier workload just because she had a student working with her. Since the workload of most nurses is highly demanding even without students, the nurses felt they had more responsibility when a nursing student cared for

their patients; this added stress was difficult to cope with. The nurses coped with the increased stress in different ways. Some nurses became impatient with the students and felt aggravated by how much slower they performed nursing tasks. Other nurses felt angry or irritated that they were placed in the stressful situation. One nurse stated she gave very limited information about the patient to the student if she felt pressure from time constraints or she was aggravated with the student.

Another negative impact of working with nursing students was time management. The group stated that working with nursing students was time consuming. The nurses said they get behind in their work, and some stated they struggled to get out on time at the end of their shift. When the students did not listen to the full report at the beginning of the shift it took away the nurses' time to give a separate patient report to each student. It also took extra time during the shift for the nurses to stop and explain procedures or answer questions. The nurses said it also took more time to validate the student's competency level by having the students review knowledge about medications and other nursing skills, and checking behind their work to make sure it was accurate. The nurses stated that students work slower and this causes them to get behind. They had to wait for a student to perform certain tasks. It also took more time for the nurses to redo the student's work or to perform something that was left undone by them. It was especially time consuming if it an error in charting was determined after the students were dismissed for the day. Because the students do not care for a patient the entire shift, the nurse spent more time in readjusting the work schedule and re-evaluating the patients after the students left. Sometimes it was difficult for the nurses to resume care when the students did not report off thoroughly or did not chart accurately. Knowing that incidences have happened in the past or that there is always a potential for error related to nursing students caused the nurses to be more

guarded and to spend more time checking behind the students to ensure patient safety and quality care.

When the nurses did not have time to teach the students they reacted in various ways such as ignoring the students and completing the patient care themselves, or being rude and condescending to the students. Some of the nurses felt guilty from not being able to help the student or not allowing the students to participate in patient care. There were nurses who felt embarrassed and angered about the rude behavior of co-workers toward nursing students. One nurse took on the role of protector because he did not tolerate bad treatment from his co-workers.

One nurse reported that having students can cause confusion because they clutter up the nursing unit and they get in the way. Also, some nurses said that having several nursing students assigned to them was confusing because it was difficult to remember the students and their assignments. One nurse said when a health care worker wanted a patient chart or wanted information about a particular patient, it took time to sort out which nursing student was assigned to the patient. Locating the student and the chart was confusing as well as time consuming.

Some of the nurses accepted the responsibility of having a nursing student and some resented that they have been assigned to work with a student and believed that this should have been the full responsibility of the instructor. All the nurses agreed that having a nursing student is more stressful on busy days when patient census is high and there are more high acuity patients on the unit. Also, just having a heavy workload as a result of staffing issues and the shortage of nurses makes the added responsibilities of having a student more stressful. The nurses were always aware that there was a potential for harm to their patients and taking the extra energy to monitor what the student did just added to their heavy workload.

Generally speaking, the group enjoyed working with the nursing students, and they did not dwell on the negative aspects. In spite of the negative impacts of working with students there were benefits of having students. Some of the participants suggested ways to reduce the causes of the negative aspects of working with students and to improve professional socialization attitudes nurses have toward the student nurses. One suggestion was to require the nursing students to listen to the change of shift report. This would prevent the nurse from spending extra time repeating the report to individual nursing students. Another suggestion was to have instructors encourage communication and socialization among the nurses. One nurse suggested that the nursing students discuss the patient assignment with the nurse during preclinical time and have the nurse introduce them to the patient. Shadowing a nurse at the beginning of the foundations course was suggested to allow the beginning student to see a nurse in action and formulate a realistic expectation of the professional role and responsibility. In order to reduce confusion, stress, and workload, some nurses suggested to only be assigned one student at a time to work with or to have no more than two. The students could be assigned to work with a nurse rather than by patient diagnosis or condition. Another nurse thought that having more control of student's activities would be helpful in reducing the stress of having to wait on an instructor for a medication administration or treatment that needs to be done in a timely manner. Finally, a suggestion was to have equal or reduced workloads when they are working with students.

The theme professional socialization attitude toward student nurses was the core of the experience and demonstrated the structural description of the experience. The attitudes were influenced by the interrelationships of the outer core themes. Beliefs about nursing education, and role expectations of nurses, faculty, and students influenced the professional socialization attitude. The nurses' beliefs about nursing education also had an influence on the communication

structure. The communication structure between the nurses, faculty, and students also had a direct influence on the nurses' attitudes as well as an influence on deterrent factors. The theme of deterrent factors was influenced by the communication structure and possibly enhanced the deterrent factors' influence on attitudes. The motivational factors were influenced by beliefs about nursing education. Motivational factors and deterrent factors had an influence on the nurses' professional socialization attitudes.

An example of the interrelatedness of the themes is presented in the following text. Professional socialization attitudes of the nurses varied from negative or positive according to the circumstances surrounding the student's being on the unit. When the students were on the unit the timing of their presence influenced the nurses' attitudes. The nurses were aggravated with students when the unit was busy and they did not have time to wait on a student to perform a procedure that the nurse could do in much less time. The nurses felt angry when the instructors left the unit or did not function in a way the nurses deemed as competent or when they thought the students were unprepared and lacking skills. When the nurses did not have communication about the objectives or competencies of the students, the nurses would be angry with the students. The nurses would also be condescending or they ignored the students when they felt at risk for losing their license.

The diagram shown in Figure 8 is a composite thematic textural structural representation of the experience of nurses working with student nurses. The thematic representation of the experience describes the lived experience of nurses' working with student nurses and how these experiences affect the nurses' professional socialization attitude toward student nurses. The themes are interrelated and there is potential influence of all the themes on each other. The experience of the nurse working with students had a direct impact on their attitudes toward

student nurses. The nurses' beliefs about nursing education had influence on communication between nurses, instructors, and nursing students. The limited to absent communication between the nurses and instructors and between the nurses and the students impacted on the deterrent factors. Examples of deterrent factors were: the nurses' frustration with how students were assigned to patients, and the time constraints and liability concerns when working with students. The nurses' beliefs about nursing education also had an influence on the expected roles that nurses have for themselves, instructors, and students. The role expectations influenced the nurses' motivational factors in that they worked with students as a professional obligation. This in turn became an influence on the deterrent factors because even though the nurses felt obligated to work with students, they felt guilty for not helping the students when they were too busy.

In this chapter I explained the process of data organization, analysis, and synthesis according to the modified van Kamm method for phenomenological data. I discussed horizontalization, and identified meaning units and the emerging themes. I also provided narration of the individual thematic textural-structural descriptions with a depiction of the individual experiences in the form of diagrams. Finally, a composite thematic textural-structural description was presented with a diagrammatic representation of the lived experience of the nurse working with the student nurses and how it affects the nurses' professional socialization attitude toward students.

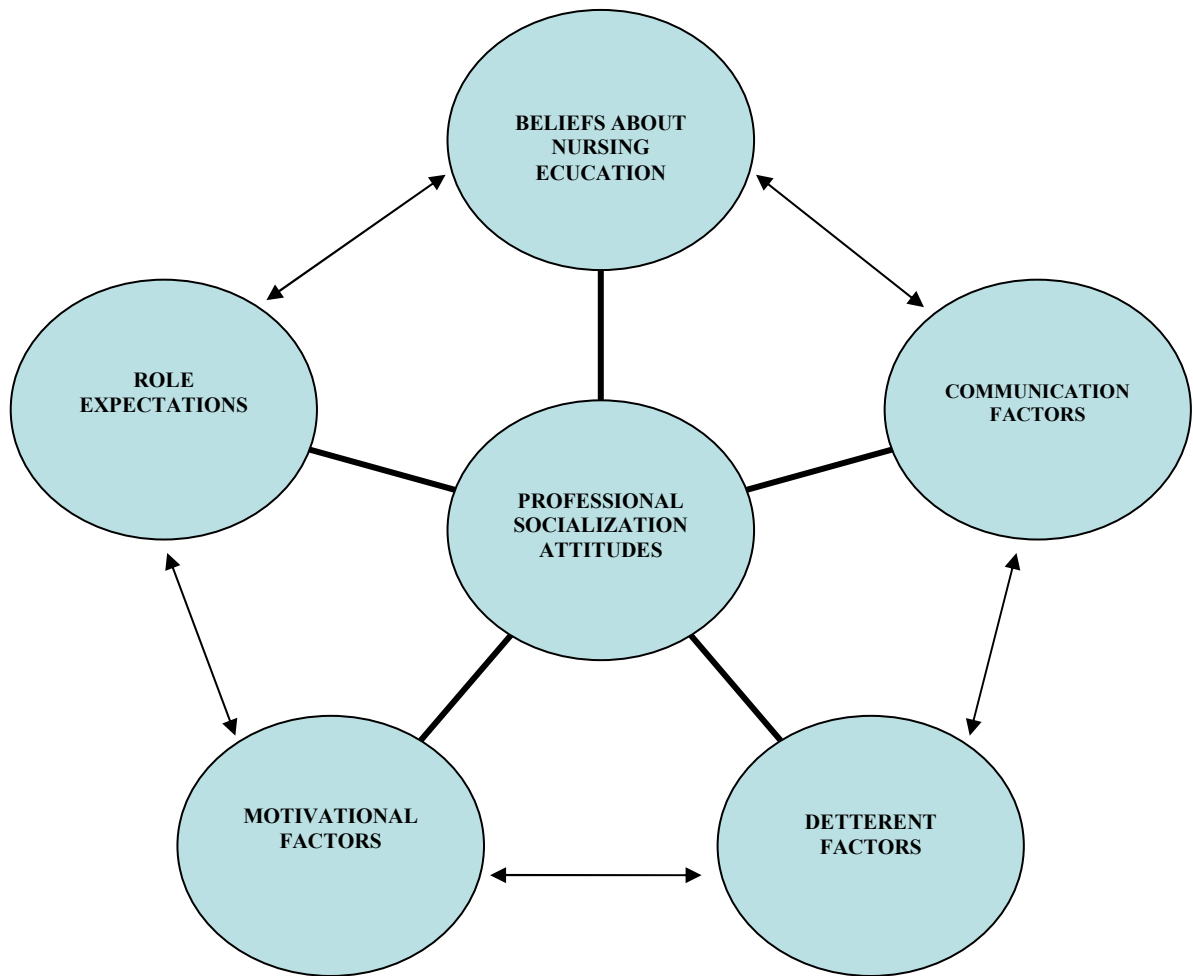


Figure 8. Composite representation of the lived experience of nurses working with student nurses in the acute care clinical environment.

CHAPTER 5

SUMMARY, OUTCOMES, AND IMPLICATIONS

This chapter presents a summary of the research and contains a review of content from each of the preceding chapters. The outcomes of the study were compared to relevant research findings from the review of the literature in chapter two. This chapter concludes with a discussion of the implications of the findings from this study to nursing education, practice, and future research.

Summary

This was a phenomenological study conducted according to the phenomenological model outlined in Moustakas (1994). In chapter one I described the need for the study, and explained that because of the nursing shortage nursing education is challenged with equipping a safe qualified workforce while preventing or reducing student attrition. I furthermore explained how the clinical environment is a learning and working environment and is a vital component of nursing preparation. Yet, because of the stress related to the clinical environment, students may choose to leave the profession or receive less than optimal learning experiences. Students are strongly influenced by professional socialization behaviors of the nurses who work in the clinical environment. If the students are exposed to negative socialization they are more likely to resign from nursing school or leave the profession later on during their career. This study explored the nurses' experiences in order to obtain insight into their socialization attitudes toward student nurses. The purpose of this phenomenological study was to explore the lived experiences of nurse's working with student nurses in the acute care clinical environment. I also operationally defined the terms of the study and described the study limitations.

In chapter one I also described the significance of the study as having the potential for assisting nursing educators and nursing administrators to understand clinical nursing education from the nurses' perspective and foster cooperation in the development of positive clinical learning environments for nurses and nursing students. The study questions were: 1.) What is the lived experience of nurses working with student nurses in the acute care clinical environment?, and 2.) How does the lived experience of nurses working with student nurses affect the nurses' professional socialization attitudes toward student nurses?

In chapter two I conducted a literature review according to a thematic method. The themes of the literature review were clinical environment as learning environment, professional socialization attitudes, work environment and job satisfaction, nurses' motivation and incentives to work with students, role theory and professional socialization, collaboration between nursing education and nursing service, and legal considerations in nursing education. In phenomenological methodology data analysis is ongoing and the literature review may not be completed until after the data analysis. The literature related to collaboration between nursing education and nursing service, and legal considerations in nursing education were added because these themes emerged from the data analysis.

In chapter three I discussed the methodology and explained the phenomenological processes. The method for preparing data collection was discussed, including the development of a conceptual model that I used as a guide for the data collection process, and formulation of guiding questions that were used for bracketing the data. I described my role as a researcher throughout the research process and gave personal biographical information to describe my qualitative lens for data analysis. I discussed the establishment of credibility and the sampling strategy for participant selection. I described how confidentiality was guarded and explained the

process of informed consent. A description of the pilot study and results were presented. I also discussed the interview method and the awareness of potential ethical dilemmas associated with interviewing. The chapter concluded with a description of the van Kaam method of organizing, analyzing, and synthesizing phenomenological data.

In chapter four I explained how I organized, analyzed, and synthesized the data. I explained horizontalization, and presented the meaning units of the data from each participant's verbatim transcripts. I then described the emerging themes from the meaning units. The triangulating analyst agreed that the themes were common or compatible with each participant's description, and were appropriately identified. The emerging themes were beliefs about nursing education, role expectations, communication structure, motivational factors, deterrent factors, and socialization attitudes. Thematic textural and structural descriptions were combined for each participant and described in detail using verbatim excerpts from the transcripts. I also portrayed each participant's experience in the form of a diagram to depict the thematic textural-structural relationships that had an influence on the nurses' attitudes toward students. I also presented a composite thematic textural-structural description of the experience and composed a diagram to represent the lived experience of nurses working with student nurses in the acute care clinical environment.

Findings from the data analysis revealed that the theme professional socialization attitude of nurses toward student nurses were influenced by their beliefs about nursing education, the role expectations of nurses, instructors, and students, and the communication structure between instructors, nurses, and students. The nurses' professional socialization attitude was also influenced by intrinsic and extrinsic motivational factors, and deterrent factors. Each of the

themes surrounding the core theme of professional socialization attitude also had influences on each other and had the potential for further influence on nurses' attitudes.

Outcomes

The outcomes are presented in terms of a detailed description of the relationship of the research findings to the literature review discussed in chapter two. My approach was to compare the six emerging themes and their descriptions to what was relevant in the literature.

Professional socialization attitudes of the nurses in this study varied from negative or positive according to the circumstances surrounding the student's being on the unit. The circumstances related to negative socialization attitudes were having students on busy days, not knowing the competency level of the students, and being slowed down in their work by students. Some of the negative attitudes were described as being angry, frustrated, and aggravated. The negative socialization behaviors were making condescending remarks to the students, ignoring the students, taking over the patient care and not allowing the students to be involved, not giving a thorough report or withholding information, or being rude to the students.

On the other hand, nurses had a positive attitude toward students when they had time to teach and when the students could perform tasks that helped lighten the workload, and when nurses could assign a student to a patient that needed special attention. Another finding was that nurses had positive attitudes when the student acted in a competent manner and was enthusiastic about learning. These findings are consistent with previous studies (Atack et al., 2000; Lofmark & Wikblad, 2001; Matsumara et al., 2004). In a study conducted by Lofmark and Wikblad (2001) students reported obstructing behaviors by the nurses and described them as taking over, making condescending comments, being irritated or not interested, and not giving feedback or opportunities to reflect, and not allowing students to take part in the care of patients.

In the study by Matsumara et al. (2004), a qualitative component of the survey methodology revealed that nurses expressed both positive and negative experiences with students depending on what type of student they worked with and the circumstances on the unit. The nurses were frustrated when they had to work with a problem student or when the unit was too busy. Nurses reported they enjoyed students when they could assist with patient care. Other findings that were similar to this study are that students were viewed as increasing the workload and/or slowing the nurse down. Also the negative experience by the nurse working with students was dependent on how prepared the student was, the student's attitude toward learning and being on the unit, the student's willingness to participate and be engaged in patient care, the patient acuity and unit staffing, and the availability and support from the instructor. Another study by Attack et al. (2000) reported that some staff stated students decreased their workload while others indicated that students added to their workload.

The nurses in this study reported that their negative attitudes toward student nurses were related to the additional stress and responsibility when working with students. This increased stress led to nursing socialization behaviors that obstructed student learning. This is consistent with previous data reported in the literature by Chan (2002), Grindel et al. (2003), and Castledine (2002).

The nurses in this study had beliefs about nursing education that influenced their socialization attitudes. They had various views regarding the purpose and focus of nursing education which strongly influenced their role expectations and consequently the communication structure. Some nurses expressed a belief that the basic nursing preparation should be a baccalaureate degree. However, there was no relationship between the preparation level of the staff nurse and their socialization attitude or role expectations. The literature review does not

contain studies that compare the staff nurses' basic nursing preparation to their attitudes toward working with BSN students, role expectations, or communication structure.

Role expectations of nurses working with student nurses in this study were assumed and were influenced by their beliefs about nursing education. The nurse's role in education was similar to what they experienced as a student. None of the nurses expressed dissatisfaction with their jobs and stated they had a good relationship with co-workers. However, none of the nurses in this study reported they had a written job description or expectations for working with student nurses. In a publication by Mrayyan and Acorn (2004) it was reported that the lack of written job descriptions and role expectations has a negative impact on nursing practice. The nurses who have unclear role expectations are more likely to develop job related burnout and become dissatisfied with their job. Having clear role expectations leads to higher retention rates in hospitals and increased quality care for patients. Having clearly written job descriptions for all nursing personnel is also a requirement of the LSBN (Louisiana State Board of Nursing, 2005).

Findings of this study reveal that the communication structure between staff nurses, nursing students, and faculty is weak. Some of the communication problems were caused by lack of information that was given to the staff nurses regarding student learning objectives and student competency while some of the problems were caused by the method of communication within the nursing unit. The method of communication between staff nurses and nursing education was described as predominately one way in which the instructors or students, the senders, sent messages to the staff nurses, the receivers. An example of the one way communication pattern is that one staff nurse reported they were approached by the student or an instructor after the shift began to be informed as to which of their patients would be assigned to students. According to previous studies (Atack et al., 2000; Chan, 2002; Cope et al., 2000;

Drennan, 2002; Li, 1997; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998; Suen & Chow, 2001) the communication between the nurses and students is crucial to the socialization and learning of the students. Poor communication between nursing education and nursing service is also contrary with the NLN position statement (National League of Nursing, 2003) that urges the two entities to be fully engaged in collaboration to prepare a workforce for the future. The LSBN (Louisiana State Board of Nursing, 1995) also requires that the clinical agencies meet specific selection criteria for nursing education programs. Lack of communication between nursing faculty and staff for planning student activities and promotion of an environment for learning is in violation of the selection criteria; furthermore, lack of evidence that the agency's personnel understand their relationship to faculty and students and the responsibility for coordination is also a violation of the selection criteria (Louisiana State Board of Nursing, 1995). Although none of the staff nurses refused to work with students, they reported they knew of nurses who have. Refusing to work with a student can be viewed as a violation of the contractual agreement between the nursing school and clinical agency. This is possibly due the lack of communication between the facility administration and nursing personnel regarding their understanding about the relationship with faculty and students.

The motivational factors of the staff nurses were influenced by their professional responsibility and viewed working with students as a professional courtesy. None of the participants in this study were offered rewards for working with students; although, the possibility of receiving monetary rewards was thought of as both positive and negative. Some nurses thought that monetary rewards would not influence nurses to make a decision to work with students while some thought that it would. One of the nurses believed that a monetary reward was deserved; but, the others thought working with students was a courtesy and part of

being professional. Both Stone & Rowles (2002) and Castledine (2002) suggested that having incentives would improve the clinical learning environment for the students. However; in the study by Stone & Rowles (2002), the nurses did not favor monetary incentives and suggested special recognition or free educational offerings from the university instead. This is consistent with this study in that the monetary rewards was not the major motivator for working with students.

The deterrent factors from this study were numerous and included the following: increased stress and strain, increased workload, getting behind in the work schedule, and having guilt feelings for not being able to help the students. The increased stress and strain on the job was influenced by the responsibility the nurses felt from being legally liable for what the student nurse did, and thinking that the students were working off of their license when the instructor was not present. The increased stress and strain also came from not knowing the learning objectives or competency level of the students which caused the nurses to spend more time checking behind the students and acting as a patient advocate ensuring quality care. The nurses also stated it also took extra effort to learn the competency level of the students and did not trust the students to perform patient care until competency was determined over time. Working with students was time consuming for several reasons. One time consuming task was in giving report or informing the student about the patient care. Another time consuming task was created by the student nurses leaving before the shift ended causing the nurses to reassess the patient and determine what needed to be done before the end of the shift. The nurses also reported that students work slower and this caused them to get behind in their work schedule. Finally, the nurses stated they had guilt feelings when they could not help the students because of the heavy workload and lack of time they had to teach them.

The ways in which the nurses reacted to the deterrent factors associated with working with nursing students is very consistent with the negative behaviors of nurses reported in the literature (Lofmark & Wikblad, 2001; Suen & Chow, 2001). Having an increased stress from having a sense of responsibility and accountability for how the student performs, the increased workload from working with students, and getting behind in the work schedule is consistent with what the nurses experienced in the studies by Attack et al. (2000), Grindel et al. (2003), and Matsumura et al. (2004).

The nurses' belief that students work off of someone's license is a false assumption and is inconsistent with the rules and regulations for the practice of registered nurses in the state of Louisiana. A student nurse is granted an exception to practice nursing while they are in the clinical phase of their education and is restricted to the role of a student (LSBN, 1995; E. Wade Shows, Attorney At Law, Legal Consultant LSBN; Thania Elliot, JD, MSH, RN, Compliance/Practice Director, LSBN; Dr. E. Tate, RN, Consultant for Education/Research, LSBN, personal communication, September 1, 2006). The increased responsibility for ensuring the safety and quality of patient care while working with nursing students is a legitimate concern and is consistent with the registered nurses' scope of practice for delegation of nursing tasks (Louisiana State Board of Nursing, 1995). The registered nurses are ultimately responsible for the care a patient receives; however, they are not held accountable for strict liability (W. Shows, Attorney At Law, Legal Consultant LSBN, personal communication September 1, 2006). Nurses are to supervise care of their patients and follow the criteria for delegation of nursing care. If a registered nurse supervises a student, a certified nursing assistant, or LPN and they do so in a reasonable and prudent manner, they are not held accountable for the actions of others.

Supervision of other nursing personnel according to the *Louisiana Nurse Practice Act* is time consuming and requires extra effort.

Implications

An implication for nursing education is to take the lead in improving communication and collaboration with nursing service as suggested by the NLN position statement of 2005 (National League of Nursing, 2005). The establishment of optimal communication should begin with nursing education administrators informing faculty of their responsibilities as stated in the contractual agreements with clinical agencies where they conduct clinical instruction. Nursing education administrators should keep the faculty informed of the laws and regulations pertaining to nursing education and practice. Nursing educators should also clearly and accurately inform the students of their accountability and responsibility for patient care in the clinical setting according to the laws that regulate their practice before initiation of their clinical experience. Nursing educators should spend more time teaching students about their legal liability when practicing in the clinical phase of nursing education. Nursing educators should offer to conduct or develop educational training courses for nurses who work with students within the agencies. The educational training courses should include role expectations, mentorship, and professional socialization skills. The nursing educators should ensure that the staff nurses are informed of the student's learning objectives in a language that is clear and understandable to the staff rather than in general vague higher education jargon within a course syllabus. Nursing educators must also clearly communicate the nursing students' level of competency to the staff nurses. The nurses' knowledge of the learning objectives and competency level of the students will assist the staff nurse who works with students to safely assign students patient care tasks.

Nursing educators can also foster professional socialization between students and staff nurses by initiating socialization activities before working with the nurses and encouraging students and nurses to collaborate with one another about patient care. Nursing educators should invite and encourage staff nurse to participate in making student assignments. Developing a two- way communication pattern with the staff nurses and showing support and appreciation for them would improve relationships between staff nurses, instructors, and students. Having a more effective communication structure between faculty, students, and nurses would also foster a more favorable working environment for the staff nurses and a quality teaching/learning environment for the students. Nursing education could improve relationships between nurses who work with students by offering incentives and/or rewards through recognition, invitation to university events, or awarding gratis attendance to educational workshops. Most importantly it is imperative that nursing education follow the NLN position statement on nursing education reform and be willing to change the way students are taught in the clinical setting (National League of Nursing, 2005).

Implications for nursing practice affect nurses in all areas of nursing. Increased awareness among nurses about the impact they have on recruitment and retention of nursing students may ultimately help alleviate the shortage of professional nurses in the workforce. Nurses need to know how important they are as role models for future nurses and the impact they have on the student's professional socialization. Nurses need to be informed of how their professional socialization attitudes affect nursing students and they must take an active role to change situations that create negative socialization attitudes. Nursing service administration should allow staff nurses to voice concerns and participate in problem solving activities that are identified when working with student nurses. They should also have clearly identified and

written job descriptions to include the nurses' responsibility for working with nursing students. Nursing administration must be willing to offer workload reductions or incentives for nurses who work with students and be open to collaborative efforts with nursing education that would be mutually beneficial. As suggested for nursing education, nursing administration must be willing to change the way students are managed and include faculty and students as an important and integral part of the institution rather than treating them as guests in the facility.

Nursing education departments within the nursing practice facilities should be actively involved with the schools for nursing and develop in-service training for nurses to inform them of their roles and responsibilities when working with students. Nurses need to be informed of the contractual agreement that the facility has with the schools of nursing and their legal liability according to their *Nurse Practice Act*. The nursing education departments should inform the nurses that they are responsible for delegation and supervision of nursing care provided by student nurses. Nursing education within the clinical facility should inform the nurses of their legal liability when working with students. They could also conduct training in communication techniques and conflict resolution for working with faculty and students to empower nurses to solve problems and improve the work environment. Identification of nursing roles and responsibilities may lead to increased job satisfaction and improve nurse' attitudes toward nursing students.

Implications for research include the following: increase qualitative and quantitative studies on staff nurses who work with baccalaureate student nurses in all areas of clinical practice. Descriptive studies related to the nurses' educational preparation are needed to determine if this variable has an influence on the nurses' professional socialization attitude toward students. Studies pertaining to faculty perceptions of staff nurses working with students

are needed. Also, studies conducted on clinical education should include staff nurses' perceptions of nursing faculty. Quasi experimental studies need to be conducted on the use of experimental clinical practice models for baccalaureate nursing education. In conclusion, future research is needed on the effects that collaborative educational reforms have on nurses, students, and faculty.

REFERENCES

- Atack, L., Comacu, R.K., Kenny, R., LaBelle, N., Miller, D. (2000). Student and staff relationships in a clinical practice model: Impact on learning. *Journal of Nursing Educaiton*. 39(9), 387-392.
- Benner, P. (2001). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice, Commemorative Edition*. Upper Saddle River, New Jersey: Prentice Hall Health.
- Diekelmann, N. (2001). Narrative pedagogy: Heideggerian hermeneutical analysis of lived experience of students, teachers, and clinicians. *Advances in Nursing Science*. 23(3), 53-71.
- Callaghan, I., & McLafferty, I. (1997). An audit tool for assessing the learning environment for project 2000. *Nurse Education Today*, 17 (4), 338-342.
- Castledine, G. (2002). Castledine column: Students must be treated better in clinical areas. *British Journal of Nursing*, 11(18), 1222.
- Chan, D. (2002). Development of the clinical learning environment inventory; using the theoretical framework of learning environment studies to assess nursing students' perceptions of the hospital as a learning environment. *Journal of Nursing Education*, 41(2), 69-75.
- Chan, D. (2003). Validation of the clinical learning environment inventory. *Western Journal of Nursing Research*, 25(5), 519-532.
- Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of Advanced Nursing*, 31(4), 850-856.
- Denzin, N.K., & Lincoln, Y. (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publication, Inc.
- Drennan, J. (2002). An evaluation of the role of the clinical placement coordinator in student nurse support in the clinical area.. *Journal of Advanced Nursing*, 40 (4), 475-483.
- Foley, B., Kee, C., Minick, P., Harvey, S., & Jennings, B. (2002). Characteristics of nurses and hospital work environments that foster satisfaction and clinical expertise. *Journal of Nursing Administration*, 32 (5), 273-282.
- Grindel, C., Patsdaughter, C., Medici, G., & Babington, L. (2003). Research for Practice: Adult-health/medical-surgical nurses' perceptions of students' contributions to clinical agencies. *MEDSURG Nursing*, 12 (2), 117-123.

- Halse, K. & Hage, A. (2006). An acute hospital ward, densely populated with students during a 12-week clinical study period: Research briefs. *Journal of Nursing Education*, 45 (4), 133-136.
- Hardy, M. & Conway, M. (1988). *Role Theory: Perspectives for Health Professionals* (2nd ed.). Norwalk, CT: Appleton & Lange.
- Hayhurst, A., Saylor, C., & Stuenkel, D. (2005). Work environmental factors and retention of nurses. *Journal of Nursing Care Quality*, 20 (3), 283-288.
- Li, M. K. (1997). Perceptions of effective clinical teaching behaviours in a hospital-based nurse training programme. *Journal of Advanced Nursing*, 26 (6), 1252-1261.
- Lo, R. (2002). Evaluation of a mentor-arranged clinical practice placement for student nurses. *Collegian*, 9 (2), 27-32.
- Lofmark, A., & Wikblad, K. (2001). Issues and innovations in nursing education: Facilitating and obstructing factors for development of learning in clinical practice: a student perspective. *Journal of Advanced Nursing*, 34 (1), 43-50.
- Louisiana State Board of Nursing. (2005). *Legal Guide to the Practice of a Registered Nurse in Louisiana*. Retrieved August 24, 2006 from http://www.lsbn.state.la.us/documents/selfstudy/npa_s_s.pdf
- Louisiana State Board of Nursing. (1995). *Rules and Regulations: Title 46, Professional and Occupational Standards, part XLVII. Nurses, Subpart 2. Registered Nurses*. Retrieved August 24, 2006 <http://www.lsbn.state.la.us/documents/rules/fullrules.pdf>
- National League of Nursing. (2003). Position statement: Innovation in nursing education: A call to reform. Retrieved August 26, 2006 <http://www.nln.org/aboutnln/PositionStatements/innovation.htm>
- National League of Nursing. (2005) Position statement: Transforming nursing education. Retrieved August 26, 2006 <http://www.nln.org/aboutnln/PositionStatements/transforming052005.pdf>
- Magnussen, L., & Amundson, J. (2003). Undergraduate nursing student experience. *Nursing and Health Sciences*, 5, 261-267.
- Matsumura, G., Callister, L.C., Palmer, S., Cox, A. H., & Larsen, L. (2004). Staff nurse perceptions of the contributions of students to clinical agencies. *Nursing Education Perspectives*, 25, 297-303.

- Miles, M.B., & Huberman, A. M. (1994). *An Expanded Sourcebook: Qualitative Data Analysis, second edition*. Thousand Oaks, CA: Sage Publications Inc.
- Morse, J. M. (1994). *Critical Issues in Qualitative Research Methods*. Thousand Oaks, CA: Sage Publications Inc.
- Morse, J. M. (1991). *Qualitative Nursing Research: A Contemporary Dialogue* (Edited by J. M. Morse). Newbury Park, CA: Sage Publication Inc.
- Moustakas, C. (1994). *Phenomenological Research Methods*. Thousand Oaks, CA: Sage Publications, Inc.
- Mrayyan, M. T., & Acorn, S. (2004). Nursing practice issues in Jordan: student-suggested causes and solutions. *International Nursing Review*. 51, 81-87.
- Munhall, P. L. (1994). *Revisiting Phenomenology: Nursing and Health Science Research*. Hudson Street, New York, NY: National League for Nursing.
- Papp, I., Markanen, M., & vonBonsdorff, M. (2003). Clinical environment as a learning environment: Student nurses' perceptions concerning clinical learning experiences. *Nurse Education Today*, 23, 262-268.
- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc.
- Rice, R. (2003, April). Guest Editorial: Collaboration as a tool for solving the nursing shortage. *Journal of Nursing Education*. 42(4) 147-148.
- Regan, W. A. (1973, October). Collegiate nursing education-Legal aspects. *Nursing Law*. 14 (6) 1.
- Rossmann, G. B., & Rallis, R. S. (2003). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks, CA: Sage Publications, Inc.
- Seigel, H., & Lucey, A. (1998). Arranging a clinical practicum in a health care facility. *The Journal of Continuing Education in Nursing*. 29(6), 253-256.
- Schofer, K., Langenberg, A., Matheis-Kraft, C., Baird, S., & Bopp, A. (1996). A nursing service-nursing education collaboration. *Nursing Management*. 27(3), 59-61.
- Stone, C., & Rowles, C. (2002). What rewards do clinical preceptors in nursing think are important? *Journal for Nurses in Staff Development*, 18(3), 162-166.

- Suen, L. K., & Chow, F.L. (2001). Issues and innovations in nursing education: Students' perceptions of the effectiveness of mentors in an undergraduate nursing programme in Hong Kong. *Journal of Advanced Nursing*, 36(4), 505-511.
- Wells, M. (2003). An epidemiologic approach to addressing student attrition in nursing programs. *Journal of Professional Nursing*, 19(4), 230-236.
- Wengraf, T. (2001). *Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Methods*. Thousand Oaks, CA: Sage Publications Inc.
- Williams, R., & Widman, K. (1998). Partners in quality. *Nursing Management*. 29(11), 22-26.

VITA

Donna Lynn Coffey Hathorn was born on June 26, 1955, in Ringgold, Louisiana, to Patsy Ruth McDaniel Coffey and the late Donnie Max Coffey. She attended elementary and secondary school in Ashland, Louisiana, and graduated with honors in 1973. Donna obtained a Bachelor of Science in Nursing degree in the spring of 1977 from Northwestern State University of Louisiana. In the fall of 1986 she earned the degree of Master of Science in Nursing from Northwestern State University. Her specialty clinical tract is in maternal-child nursing with a functional emphasis in nursing education. She will graduate from Louisiana State University and Agricultural and Mechanical College with the degree of Doctor of Philosophy in December 2006. Donna has experience working as a staff nurse, charge nurse, and briefly as a head nurse. She has worked in medical-surgical, pediatric, postpartum, and labor and delivery nursing units. She also has experience working as an infection control practitioner and presently holds certification in infection control from CBIC (Certification Board for Infection Control). Donna has teaching experience in theory and clinical courses related to maternal-child nursing and psychiatric clinical courses. She has taught in a vocational technical school for a Licensed Practical Nursing program and has been an instructor of nursing for three Baccalaureate Nursing Programs within Louisiana. Currently she is an instructor of nursing at Southeastern Louisiana University where she teaches theory and clinical components of the childbearing family and newborn nursing. She has 15 years of teaching experience.

She became certified in In-House Obstetrics by the Nurses' Association of the American College of Obstetrics and Gynecology in 1991, and received certification in advanced fetal heart monitoring. She was inducted as a charter member of the Sigma Theta Tau International Nursing Honor Society, Nu Tau Chapter, in 1993. Donna is also a charter member of the Rho Zeta

Chapter of Sigma Theta Tau. She has been a member of the American Red Cross and taught safety and first aid. Donna was also certified to teach cardiopulmonary resuscitation (CPR) by the American Heart Association and has taught CPR within the community. She holds membership with the American Nurses' Association and the Louisiana State Nurses' Association.

Donna presently resides in Holden, Louisiana, where her husband Jeff has been pastor of the First Baptist Church of Holden for 10 years. She and Jeff have been married for 32 years and have four sons Jeffrey Jr., Jared, Jason, and Joshua. She also has a daughter-in-law, Candice Courtney Neil Hathorn.