ASSESSING THE PRECEPTORSHIP MODEL IN CLINICAL TEACHING OF UNDERGRADUATE NURSING AND MIDWIFERY STUDENTS IN MALAWI

DOCTOR OF PHILOSOPHY DEGREE IN INTERPROFESSIONAL HEALTH-CARE LEADERSHIP THESIS

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UNIVERSITY OF MALAWI
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By

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PhD Dissertation Presented to the Faculty of Nursing at Kamuzu College of Nursing in partial fulfillment for an award of A Doctor of Philosophy Degree in Interprofessional Health-Care Leadership

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July 2021

DECLARATION

I, the undersigned, declare that this dissertation is my own original work. Views and quotations from other researchers have been acknowledged through references.

LUCKY MACDONALD MHANGO

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Full Legal Name

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Signature

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Date

CERTIFICATE OF APPROVAL

We hereby declare that this dissertation is the student's own original work and where any additional information has been used, this has been duly acknowledged. It is hereby submitted with our approval.

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DEDICATION

To my wife Jean and our children: Elias, Memory and Omega.

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ABSTRACT

Preceptorship is one of the models applied in clinical teaching where nursing educational institutions rely on registered nurses (RNs) trained as preceptors to take the role of clinical instructors. Malawi adopted the preceptorship model in response to a critical shortage of human resources. This study, therefore, aimed at assessing the preceptorship model in clinical teaching of undergraduate nursing and midwifery students in Malawi. This explanatory sequential mixed methods study was conducted at four public tertiary hospitals; a mental hospital, Christian Health Association of Malawi (CHAM) hospital and five district hospitals. A total of 87 preceptors completed a Clinical Preceptor Experience Evaluation Tool (CPEET) and 12 participated in face-to-face individual interviews. Quantitative data were analysed through descriptive statistics while qualitative data were analysed by thematic content analysis. Results revealed that a preceptorship model is an effective approach to clinical teaching with benefits to both the students and preceptors. Post hoc comparisons using the Tukey HSD test indicated that the role domain mean scores for the respondents with 4-5 years of post-registration experience ($M = 6.61$, $SD = 0.36$) was significantly different ($p=0.02$) than those with >9 years ($M = 6.13$, $SD = 0.60$). These results showed that respondents with 4-5 years of experience were more confident than those with >9 years of experience. The study revealed some constraints in the implementation of the preceptorship model and the main challenges included the high preceptor-to-student ratio due to staff shortages, lack of resources and poor collaboration with faculty members. These factors compromised the effectiveness of the preceptorship model in facilitating student learning.

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LIST OF ABBREVIATIONS AND ACRONYMS

BSc	Bachelor of Science
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
COMREC	College of Medicine Research and Ethics Committee
CPEET	Clinical Preceptor Experience Evaluation Tool
EHRP	Emergency Human Resource Recruitment Programme
ICAP -	International Centre for Aids Treatment Program
KCN	Kamuzu College of Nursing
MOH	Ministry of Health
MOUs	Memorandum of Understandings
MSc	Master of Science
MZUNI	Mzuzu University
NEPI	Nurses Education Partnership Initiative
NMC	Nursing and Midwifery Council
NMCM	Nurses and Midwives Council of Malawi
OPD	Out Patient Department
OSCE	Objective Structured Clinical Examinations
PhD	Doctor of Philosophy
RNs	Registered Nurses
SPSS	Statistical Package for Social Sciences

DEFINITION OF TERMS

Clinical educator

Clinical nurse educators are healthcare professionals who have gained a high level of expertise in nursing. They educate and train aspiring nurses or newly graduated nurses. Clinical nurse educators hold a minimum of a bachelor's degree in nursing and also have completed a nurse educator-training program. They commonly have several years of hands-on nursing experience as well (Brennan, & Olson, 2018). In this study, the term is similar to preceptors.

Clinical instructor

Refers to the instructor who supervises the clinical education of undergraduate nursing students in the clinical setting (Dahlke, Baumbusch & Kwon, 2012). According to Dahlke, Baumbusch and Kwon (2012), clinical instructors are often hired based on their clinical expertise even though as teachers, who are usually with students in the clinical setting, need to be experts in both clinical and teaching skills. A Clinical Instructor is similar to a preceptor in this study.

Clinical teaching

This is the central activity of the teacher in the clinical setting (Gaberson, Oermann & Shellenbarger, 2015). It is viewed as a process of assisting students to acquire the required knowledge, skills and attitudes in the clinical setting to meet the standards of the nursing profession. In this study, it is the teaching done by faculty members and professional nurses (including preceptors) in the clinical setting and is considered as a core component in undergraduate nursing education programs.

Experience

Refers to the practical contact with and observation of facts or events or an occurrence which leaves an impression on someone (*Dictionary.com*). In this study, it refers to the observations and impressions that preceptors had after precepting undergraduate nursing and midwifery students in a clinical setting.

Mentorship

Mentorship is a relationship between two people where the individual with more experience, knowledge, and connections is able to pass along what they have learned to a junior individual within a certain field (Oshinkale, 2019). According to Oshinkale, the senior individual is the mentor, and the junior individual is the mentee.

Mentor

The NMC describes a mentor as a nurse or midwife on the NMC register who, following successful completion of an NMC approved mentor preparation program is entered on a local register and is eligible to supervise and assess students in a practice setting (NMC, 2010). On the other hand, Hurly and Snowden (2008) refer a mentor as a person who is responsible for assessing proficiency, who takes on the role of providing support and guidance and is a role model for nursing students in the practice setting. In this study, a mentor is similar to a preceptor.

Preceptor

An experienced nursing professional who teaches, supervises and serves as a role model for a student or graduate nurse for a pre-arranged time in a formalized program (Yonge, Hagler, Cox & Drefs, 2008). In this study, the preceptor is the one who apart from

experience, went through preceptorship training and focuses on teaching undergraduate nursing and midwifery students doing clinical practicals at the preceptors' duty stations.

Preceptorship

The model of teaching and learning in nursing education where there is a one-to-one pairing of a student nurse with a Registered Nurse for a time-limited clinical experience (Yonge, Myrick & Ferguson, 2011). In this study, it refers to the teaching and learning model for undergraduate nursing and midwifery students, which usually involves groups as opposed to the one-to-one pairing of students and RNs.

Professional nurse

Is a person who has attained a BSc degree in nursing, MSc degree or PhD from a program duly recognized in the country in which it is located, or has acquired the requisite qualifications to be registered and licensed to practice nursing by the Nurses and Midwives Council of Malawi as stipulated in section 47(e) of the Nurses and Midwives Act No. 16 of 1995 (NMCM Act No 16 of 1995).

Student

A person who is formally engaged in learning especially one enrolled in a school or college (*https//dictionary.cambridge.org*). In this study, it refers to all persons pursuing a nursing and midwifery programme.

Role

Is the position or purpose that someone or something has in a situation, organization, society, or relationship (*https//dictionary.cambridge.org*). In this study, it refers to the responsibility of preceptors while interacting with undergraduate nursing and midwifery students.

Undergraduate student

A college or university student who is not a graduate student (*https//dictionary.cambridge.org*). In this study, it refers to a student studying nursing and midwifery at a university or tertiary institution in Malawi.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

Clinical teaching plays an important role in assisting students to apply theoretical knowledge into practice and is an essential component in the education of undergraduate nursing and midwifery students. It refers to the teaching and learning that occurs near a patient and enhances nursing practice through the development of professional growth with opportunities for the application of theoretical knowledge (Atakro & Gross, 2016). Clinical teaching prepares students for the attainment of their professional roles apart from having an opportunity for applying the knowledge, concepts and skills they have learnt in the classroom. However, if students are to acquire knowledge of and skills in clinical practice, someone must be there to supervise and demonstrate how theoretical knowledge can be integrated into practice (Lambert & Glacken, 2005).

In most countries, clinical staff acting as preceptors have had the dominant role in supporting the students' learning in clinical practice, although there are some international variations (Clarke, Gibb & Ramprogus, 2003). There are several models used in the facilitation of clinical teaching and these include traditional faculty-supervised, preceptorship, problem–based learning, computer based clinical simulation, education unit, joint appointment, internship and secondment among others (Budgen & Gamroth, 2008; Vitale, 2014) In Malawi, faculty supervised model and preceptorship are utilized to facilitate students' learning during their clinical practice placements.

In the traditional faculty-supervised model, the educator provides instructions and evaluation for small groups of students on-site during their clinical experiences. While in the clinical area, students may encounter nurses prepared with a masters degree, a diploma, or a baccalaureate degree or higher (Richardson, 1998) who would also provide instructions to them. As noted by Richardson (1998), an assumed advantage of the traditional model is that better teaching of theory and research occurs when faculty members have direct responsibility for the students' clinical learning experiences. This model has the advantage of flexibility in moving students from one learning experience to another. Faculty members can choose the type of patient to whom the student is exposed and have direct knowledge about students' capabilities and progress (Nehls, Rather & Guyette, 1997; Baird, Bopp, Schofer, Langenberg & Matheis-Kraft, 1994). However, as noted by Luhanga (2018), this model has several challenges which include managing large clinical groups, missed learning opportunities, limited time for teaching and supervision as well as difficulty balancing student learning and patients' safety among others.

In agreement, Richardson (1998) indicated that difficulties with the traditional model are generally related to a large number of students for whom the instructor is responsible during clinical hours. Students may occasionally have minimal instruction from a faculty member. Richardson (1998) continues by stating that this complaint is important to consider for two reasons: first, lack of contact with the teacher means that the consumers (students) have not received full value for their tuition, and second, the patients may be receiving care from inadequately prepared students. Two other difficulties are the clinical time commitment required by faculty members, who are also responsible for research, classroom scholarship, and service; and the occasional

teaching of service skills by faculty who may not be service experts (Nehls, Rather & Guyette, 1997; Laschinger & MacMaster, 1992; Myrick & Barrett, 1994). In addition, apart from providing care to patients and clients, professional nurses have a role to teach students when they are placed in the clinical setting as stipulated in their scope of practice by the Nurses and Midwives Council of Malawi (NMCM Act 16 of 1995).

However, there are challenges such as shortage of professional nurses, commitment to their core role of patient care as well as large numbers of students allocated to the clinical area at a particular time (Omansky, 2010). This leaves faculty members to perform duo roles of the classroom as well as clinical teaching which leads to ineffective teaching and learning due to a shortage of faculty members. Benner, Sutphen, Leonard and Day (2010) admit that one of the many challenges in nursing education today is the shortage of nursing faculty. This admission is supported by a report focusing on human resources for health where the World Health Organization described a shortage of nurse faculty in the majority of its member states in 2006 (WHO, 2006). The number of nurses in the workforce continues to decrease, as does the number of nursing faculty needed to teach new nurses to ensure quality health care delivery, to study health problems, to address patient issues, and to inform health policy (Nowell, White & Norris, 2015). As noted by Reid, Hinderer, Jarosinski, Mister and Seldomridge (2013) the shortage of qualified nursing faculty is an issue of local, national, and international concern and is anticipated to worsen. Diminished nursing faculty directly impacts the ability to admit and graduate adequate numbers of students for the nursing workforce (Cash, Daines, Doyle, von Tettenborn, 2009), which further impedes resolution of workforce shortages. This is of concern because nurses spend more direct time with patients than any other healthcare professionals and play a critical

role in health outcomes (Aiken, Cheung, Olds, 2009; Cheung & Aiken, 2006). Due to the duo role on the part of faculty members as a result of the shortage, the faculty members are not adequate to fulfil their clinical supervision roles. As such, sometimes nursing students are left unsupervised as faculty members visit the clinical setting occasionally and students feel abandoned (Msiska, Smith & Fawcett 2014). This denotes that there is intermittent clinical supervision by faculty members leading to inadequate support to students.

The preceptorship model on the other hand involves an expert nurse in the clinical setting working with students on a one-to-one basis. Richardson (1998) expressed that in the preceptor model, the clinical teaching of a single student is directed by one staff RN. She further states that the faculty member is responsible for supervising the general experience but need not be present at the clinical site during the student's clinical hours. However, as noted by Richardson (1998), faculty services offered to the clinical facility, such as in-services, case management expertise, and training of new personnel, are minimal. The advantages of the preceptor model (Nehls, Rather & Guyette, 1997; Baird, Bopp, Schofer, Langenberg & Matheis-Kraft, 1994; Weber, 1993) include increased student confidence and skills acquisition because the student is taught by one staff nurse consistently. Because staff are chosen for their service expertise, students are prepared by service experts. Faculty members can supervise more students with fewer time demands. It is assumed with this model that students receive a more service-based education that prepares them for the realities of professional nursing. Students acquire knowledge, skills, competence, confidence, values, ethics and a multitude of attributes to transition into the role of a professional nurse. The transition process also

has a socialization component, which occurs through observation and role-modeling behaviour within the learning environment (Lai & Lim, 2012).

Preceptorship as an approach to teaching and learning is purported to facilitate the connection between nursing education and clinical practice, foster an ethos for critical thinking, and contribute to professional development (Asirifi, Mill, Myrick & Richardson, 2013). However, there are challenges associated with expert nurses' involvement in clinical teaching which includes a shortage of staff, time constraints and inadequate preparation of the nurses for the clinical teaching role (Nehls, Rather & Guyette, 1997; Baird, Bopp, Schofer, Langenberg & Matheis-Kraft, 1994; Weber, 1993) Although the nurses may be expert clinicians, they require specific educational support in order to carry out their student supervision role effectively (Atakro & Gross, 2016; Kalischuk, Vandenberg & Awosoga, 2013; Kamolo, Vernon & Toffoli, 2017). As a way of preparing the RNs for their role of clinical teaching, some of them are trained as preceptors (Atakro & Gross, 2016). As indicated by Kaviani and Stillwell (2000), this is based on the assumption that good clinicians are not necessarily good teachers and hence there is a need to equip preceptors with key knowledge and skills and to develop appropriate attitudes in order to carry out the preceptor role effectively.

Malawi initiated a preceptorship model of clinical education to assist nursing and midwifery students during clinical practice. This was in response to global calls for strengthening health systems and increasing access to health services through appropriate training of nurses and midwives (Middleton, Howard, Dohrn, Zinkernagel, Hopson, Aranda-Naranjo et al., 2014). A five years Nursing Education Partnership Initiative (NEPI) project was commenced in 2012 with funding from Columbia

University's International Centre for AIDS Treatment Program (ICAP). The aim of the project was to commence the training of clinical preceptors to support the attainment of the Nurses and Midwives Council of Malawi's approved standard of one (1) clinical preceptor for twelve (12) nursing students and one (1) clinical preceptor for eight (8) midwifery students (Middleton et al., 2014). Furthermore, the project focused on addressing the clinical and academic educator shortage and competency gap by supporting two nursing education institutions to implement a comprehensive faculty development strategy for nurse educators. In line with the same, RNs were trained as preceptors for six weeks and deployed in hospitals where nursing and midwifery students are allocated for their clinical practice experiences. The preceptor training was meant to assist the RNs to learn how to operationalize the nurse educator's role and how to teach in the clinical setting. Horton, DePaoli, Hertach and Bower (2012) support the need for the formal preparation of preceptors for them to function effectively in their role. Inadequate preceptor preparation was noted among contributing factors to an unstable clinical student environment in Ghana where the dominant clinical education model used is the preceptorship model (Atakro & Cross, 2016).

Horton, DePaoli, Hertach and Bower (2012) believe that formal preparation empowers the preceptors to deliver on their mandate. However, lack of guidelines defining professional responsibility as a preceptor and lack of support for preceptors with resources, information, and recognition affects their ability to effectively work in the preceptor role (M˚artensson, Engstrom, Mamhidir & Kristofferzon, 2013; Madhavanpraphakaran, Shukri & Balachandran, 2013) and Paton (2010) added that preceptors need to be acknowledged, supported, and guided in performing their unique professional teaching practice, which is different from their role as clinically competent

professional nurses. In supporting preceptors to effectively manage their roles, the cognitive learning theory emphasizes experience as a critical factor in learning and development (Paton, 2010). The preceptorship model initiated by Malawi, however, was a modified one as ideally, the preceptorship model advocates for a one-to-one preceptor-student relationship (Billay & Yonge, 2004). The one-to-one relationship is not possible due to large numbers of students requiring the attention of the preceptors. As such, the model was guided by NMCM recommendations on the preceptor-to-student ratio where one preceptor was expected to support more than one student. However, with the problem of severe nursing and midwifery shortage, higher ratios are a possibility. This, therefore, set the impetus for this study, the purpose being to assess the preceptorship model in clinical teaching of undergraduate nursing and midwifery students in Malawi.

1.2 Background Information

The preceptorship model was established in nursing education in the 1970s as a response to concerns regarding lack of individual clinical teaching and complaints of lack of preparation of newly graduated nurses (Udlis, 2008). In agreement, Omansky (2010) states that the preceptor or mentor role was established in nursing education as a response to "reality shock" with novice nurses experiencing difficulties transitioning from training to work and later expanded into undergraduate education. Due to these concerns, countries such as Australia, Canada, Sweden and the United States of America (U.S.A.) started relying on staff nurse preceptors whereby student nurses were placed with these staff nurse preceptors for additional clinical experiences (Omansky, 2010). The preceptor role is to guide student nurses from the theory of nursing to the application of nursing theory, functioning as a role model, teaching clinical skills and

clinical thinking. In the U.S.A., the American Association of Colleges of Nursing endorsed the preceptorship concept in 2003 as a response to the nursing faculty shortage (Udlis, 2008).

A preceptor refers to a nurse employed within a health care agency who mentors, monitors, teaches, provides feedback and assesses undergraduate nursing students in their workplace (Trede, Sutton & Bernoth, 2016). The preceptor is ideally a skilled clinician, a registered nurse (RN) who can provide students with the guidance and experience that are authentic and can facilitate their learning (Henderson, Alexander, Haywood, Stapleton, Cooke, Pattersson, Dalton & Creedy, 2010). Considerable advantages have been identified with the preceptorship model. One benefit is the socialization of learners into the profession that was stressed when preceptorship was introduced. Many different definitions, roles and understandings are used for the term preceptor such as mentor, supervisor or educator (Billay & Yonge, 2004; McCarthy & Murphy, 2010; Trede, Sutton & Bernoth, 2016). Preceptorship involves contact with an experienced and competent role model and a means of building supportive one-to-one teaching and learning relationship (Billay & Yonge, 2004). Furthermore, Billay and Yonge describe this relationship as short term aimed at assisting a newly qualified practitioner or nursing and midwifery student to adjust to the nursing role.

In the United Kingdom (U.K.), the preceptors are referred to as mentors, but they perform a similar role of guiding student nurses in their clinical experiences. The need for mentorship experience in the U.K. was as a result of the United Kingdom Central Council's 1999 mandate on competency principles (Omansky, 2010). The preceptor's or mentor's role is to guide student nurses from the theory of nursing to the application

of nursing theory, functioning as a role model, teaching clinical skills and critical thinking (Udlis, 2008). According to Udlis, preceptors/mentors are seen as a solution to a gap in faculty availability and student preparation. She supports this by stating that staff nurses act as preceptors or mentors for student nurses and midwives in many different configurations, from situations where students are placed with a preceptor for their final year of study, to situations where a student is placed with a preceptor for one shift.

In Africa, preceptorship was initiated around the year 1980s to pass on new knowledge, trends and skills to students and to teach, build, direct and strengthen students for future leadership as advocates (Brink, 1989; Dennis-Antwi, 2011). In the Republic of South Africa for example, around 1975, University of South Africa (UNISA) nursing lecturers were utilizing a group of experienced registered nurses in the health services to assist with the supervision of a proportion of UNISA nursing students practica in the clinical field (Brink, 1989). This system spread to other tertiary education following the re-organisation of nursing education in South Africa. Preceptors have been utilized in nursing education in Ethiopia, Ghana, Uganda and Zambia and the Republic of South Africa before Malawi (Asirifi et al., 2013; Dennis-Antwi, 2011; Monareng, Jooste & Dube, 2009). In all these countries the preceptorship model was introduced due to the challenges of shortage of staff, inadequate faculty supervision and lack of qualified nurses among others (Atakro & Gross, 2016; Brink, 1989; Jeggels, Traut & Africa, 2013).

The nursing profession in Malawi adopted a preceptorship model as a way of facilitating clinical teaching and learning to nursing and midwifery students. This

model was adopted because of the approach to nursing and midwifery education in Malawi. Malawi trains three cadres of nurses and midwives and these include the registered professional nurse-midwife at bachelor degree level, the registered nurse-midwife at diploma level and the nurse-midwife technician at certificate level. The training programme for the professional cadre of nurse-midwives is four years at local universities, while the other two cadres are trained at nursing and midwifery colleges. In Malawi nursing and midwifery education is offered at two public universities and two private universities. In addition, the country has got eleven nursing and midwifery colleges which are affiliated to different churches, and they belong to an organisation which is known as Christian Health Association of Malawi (CHAM). In total, the country has fifteen institutions which are responsible for training nurse-midwives. While there are more training institutions, there are fewer teaching hospitals. The main teaching hospitals are the tertiary level healthcare facilities which are commonly referred to as Central Hospitals. They provide specialist health services at a regional level and provide referral services to district hospitals within their region (Government of the Republic of Malawi, 2017). However, around 70% of the services they provide are either primary or secondary services due to a lack of a gate-keeping system (Ministry of Health, 2011). There are two central hospitals in the southern region of Malawi, one in the central region and one in the northern region. Apart from these, there is a mental hospital in the southern region of Malawi which is utilised as a clinical teaching area for mental health and psychiatric conditions by the training institutions. However, these are not adequate because the same institutions are used by other healthcare training institutions which lead to congestion of students and quality of teaching and learning is compromised. To address this challenge, various training institutions in the country utilise secondary level healthcare facilities as teaching

hospitals. These consist of district hospitals and CHAM hospitals of equivalent capacity and they account for 9.5% of all health care facilities and they provide referral services to health centres and community hospitals and also provide their surrounding populations with both outpatient and inpatient services (Government of the Republic of Malawi, 2017). Although these hospitals provide alternative clinical sites for students' clinical practice, they are situated away from the training institutions which has implications on the adequacy of student support and supervision during district clinical placements. This is one of the factors which led to the establishment of the preceptorship role for some RNs.

Among the challenges confronting the health sector in Malawi which significantly contributed to the adoption of the preceptorship model is the fact that there are few teaching hospitals. These are the ones used by the fifteen training institutions as practical sites for their nursing and midwifery students. The four central hospitals and one mental hospital serve as teaching hospitals not only for nursing students but for other health care professionals as well. These are tertiary level hospitals, and they provide specialist care to the Malawian population. They offer excellent learning opportunities, but they are not without problems. The challenges in these teaching hospitals include congestion of students and shortage of human and material resources. In response to this human resource shortage, the Malawi government recommended that nursing and midwifery training institutions should increase their students' intake in order to address the staffing crisis in Malawi and bring the country's staffing levels up to a level comparable to that of neighbouring countries (O 'Neil, Jarrah, Nkosi, 2010). This necessitated the training institutions to rely on professional nurses working in the clinical areas for the clinical teaching roles. Furthermore, the recommendation

presented challenges during clinical allocations leading to congestion of students in the few tertiary hospitals used as teaching hospitals and overwhelmed the professional nurses to deal with the multitude of nursing and midwifery students, which compromised students' learning. The large number of student intake posed a challenge in clinical teaching because of limited bed capacity as well as few tertiary hospitals where students could be allocated for clinical practice.

In addition, students from more than one institution would be allocated for their clinical experiences at one tertiary health institution without considering the bed capacity, the number of professional nurses as well as the nurses' preparations to work with the students. Omansky (2010) noted that large cohorts of students bring about an unrealistic clinical instructor-student ratio, where one instructor would be responsible for more than ten student nurses on a unit in a clinical facility. In agreement with this, Lethale, Makhado and Koen (2018) indicated that the shortage of professional nurses in clinical settings implies that student nurses do not receive sufficient support and contact in the clinical areas due to large numbers of students allocated to the same clinical learning area.

One of the strategies adopted to resolve this problem of congestion at the four central hospitals was the use of district hospitals as teaching hospitals. These operate as secondary level healthcare institutions meaning that they serve cases which do not require specialist's attention. The facilities offer opportunities for clinical teaching and learning but the main challenge associated with these clinical facilities is that they are situated away from many healthcare training institutions. This implies that faculty members have to travel to these clinical sites in order to supervise and teach students

which is expensive and leads to intermittent supervision. In view of this development, Malawi initiated a preceptorship model of clinical education to assist nursing and midwifery students during clinical experiences. This was in response to global calls for strengthening health systems and increasing access to health services through appropriate training of nurses and midwives (Middleton et al., 2014).

A five year Nursing Education Partnership Initiative (NEPI) project was commenced in 2012 with funding from Columbia University's International Centre for AIDS Treatment Program (ICAP). The aim of the project was to commence the training of clinical preceptors. The trainings were conducted at two universities in Malawi, namely KCN and MZUNI. These institutions embarked on the training of preceptors to assist with clinical teaching of the nursing and midwifery students. The trainings were aimed at improving the quality and relevance of clinical teaching and learning in nursing/midwifery education and clinical teaching (Horton et al., 2012). KCN trained approximately 65 preceptors while MZUNI trained 156 preceptors making a total of 211 preceptors. MZUNI conducted its last training in May 2017. During the study period, there were approximately 112 preceptors who were precepting the nursing and midwifery students. These were working in central, district and Christian Health Association of Malawi (CHAM) hospitals.

Across the globe, literature (Broadbent, Moxham, Sander, Walker & Dwyer, 2014; Kalischuk, Vandenberg & Awosoga, 2013) has commended preceptors for putting a great deal of effort into creating meaningful and positive learning experiences for students. In the same vein, Phuma-Ngaiyaye, Bvumbwe and Chipeta (2017) noted that preceptors in Malawi acted as a link between students and training institutions as well

as between the students and clinical settings for communication. However, Phuma-Ngaiyaye, Bvumbwe and Chipeta (2017) solicited these views from nursing and midwifery students only. Therefore, there was a need to solicit views from the preceptors as well on their roles. This study, therefore, aimed to assess the effectiveness of the preceptorship model in the clinical teaching of undergraduate nursing and midwifery students in Malawi.

1.3 Problem Statement

The preceptorship model was introduced in clinical education in Malawi in order to assist nursing and midwifery students during clinical practice. This was due to large numbers of students in the clinical settings which compromised the clinical teaching and learning processes. Both the faculty and professional nurses responsible for clinical education were overwhelmed with the huge numbers of students per allocation. As such, it is a challenge to implement the ideal preceptorship of a one-to-one student to preceptor relationship. The preceptorship model being implemented is therefore a modified one as it has a high preceptor-to-student ratio, unlike the recommended one-to-one ratio. Apart from the high preceptor-student ratio. The model is being implemented amidst other problems like severe shortage of professional nurses and lack of resources to be used by the implementers. Another issue of concern is that currently, the training of professional nurses to become preceptors in Malawi is donor-driven yet anecdotal evidence indicates that preceptors play a crucial role in the training of student nurses and midwives. This has made the trainings to be conducted periodically despite the need for more preceptors. This is one of the factors contributing to the high preceptor-to-student ratio. Despite all these challenges, anecdotal observations reveal some benefits in utilising the preceptorship model to facilitate students' learning during

clinical practice. However, no study has been conducted to assess the effectiveness of the preceptorship model in facilitating clinical teaching of undergraduate nursing and midwifery students from the perspective of preceptors, while the views of the students have been explored. This, therefore, set the impetus for this study.

1.4 Broad Objective

To assess the preceptorship model for clinical teaching of undergraduate nursing and midwifery students.

1.4.1 Specific Objectives

1. Describe the preceptors' role in clinical teaching of undergraduate nursing and midwifery students.
2. Describe the experiences of preceptors related to the preceptorship role.
3. Describe the professional development of preceptors during the preceptorship role.
4. Assess the preceptors' perceptions of satisfaction with the preceptorship role.
5. Identify the challenges experienced by preceptors during the preceptorship role.

1.5 Significance of the Study

The study is considered to be in the interest of the nursing profession in Malawi since it has contributed to effective clinical teaching of student nurses and midwives. It provides an emic view on the preceptorship model as it is implemented in Malawi. This feedback forms the basis for improvement in the implementation of the preceptorship model. The findings would be utilised in designing a preceptorship model that would be easily implemented in Malawi based on the current situation on the ground. Stakeholders responsible for the training of preceptors would utilise the findings of this

study to consider structured training sessions as opposed to the current periodic ones. This would help in increasing the number of preceptors required by students in the clinical settings. The findings of this study would contribute to new knowledge on preceptorship in Malawi, Africa and the world.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Literature review is a critical summary of research on a topic, often prepared to put a research problem in a context or to summarize existing evidence (Polit & Beck, 2012). The aim of this study was to assess the preceptorship model for clinical teaching of undergraduate nursing and midwifery students in Malawi. However, in order to understand the preceptorship model, it was necessary to explore preceptorship roles as well. Relevant literature on preceptors in nursing and midwifery education was reviewed globally, regionally and nationally. This was done to establish its relevance

and applicability to preceptors in Malawi. Apart from this, the literature review was done to compare the preceptorship models in the literature to the one being implemented in Malawi. Burns and Grove (2011) state that relevant literature refers to those sources that are pertinent or highly important in providing in-depth knowledge needed in studying a selected problem. In this case, the selected problem is the preceptorship model in Malawi, which is a modified one. The literature review assisted in differentiating the ideal preceptorship model from the modified one, being implemented in Malawi.

The review of the literature was undertaken through a search of databases that included Google Scholar, EBSCOhost, CINAHL, HINARI and Boolean search. Keywords used in the literature search included preceptorship in Europe; preceptorship in America; preceptorship in Africa; preceptorship in Malawi; clinical nursing education in Malawi and clinical teaching partnership in nursing. As for Boolean search, the strategy and keywords used included preceptorship AND role; preceptorship AND experience; preceptorship AND education; preceptorship AND satisfaction; preceptorship AND challenges. The strategy for literature review assisted in limiting the search results to only those containing the keywords. The review was done and narrated with reference to the study objectives and preceptorship in general. These included the preceptors' role in clinical teaching, preceptors' experiences and professional development, preceptors' perceptions of satisfaction with the preceptorship role and challenges experienced by preceptors during the execution of the preceptorship role.

2.2 Preceptors' Role

The literature identified several roles of preceptors in general which vary depending on the needs of the community as well as the organizations involved such as academic institutions and hospitals. As described by Stacy (2008), generally a nurse preceptor may provide orientation to new nurses, re-orientation for seasoned nurses and clinical assistance for undergraduate nursing students. Stacy (2008) explained that in all these roles, the ultimate benefit from the preceptor experience is the facilitation of clinical competence and confidence through a one-to-one experience. Boyer (2008) noted that preceptors have a role of being a socializer, educator and role model. In this case, Boyer (2008) agrees with Stacy (2008) who states that the preceptor roles include socialization of nursing students into their professional role done by assisting them to recognize values, attitudes, competence levels, boundaries and professionalism in the workplace. The preceptors' pivotal role is in bridging the gap in the transition from student to nurse. Lalonde and Hall (2016) agreed with this by stating that a preceptor as an experienced nurse works together with the student for a specified duration of time to assist him/her in effectively adjusting to the new role, performing the tasks, gaining a basic level of knowledge and skills and socially adapting to the practice, profession and organization, while bridging the theory-practice gap.

In the process of transition, the preceptors assume the role of an educator where they enhance the application of knowledge and skills between the classroom and the practice setting. Löfmark, Thorkildsen, Raholm and Natvig (2012) observed that if students were to acquire knowledge and skills in clinical practice, someone needed to be there to supervise and demonstrate how theoretical knowledge could be integrated into practice. The students would copy from what they observe from the one conducting the

demonstration and emulate the same in their practices. Löfmark et al. (2012) continue to state that often the person presents to conduct the demonstrations for the students would be a preceptor. Boyer (2008) agrees by stating that in the course of executing this role, the preceptor assumes the role of protector or safety administrator, which is the essential foundation of the preceptor job. In that way, the preceptor protects the patients from novice error, protects the novice from making an error that might threaten self or others, provides a safe learning environment for the novice to study and practice in, acts as an advocate for the novice and is protected from adverse behaviours of others and ensures adherence to policy and procedures (Boyer, 2008; Lalonde & Hall, 2016; Stacy, 2008).

While interacting with the students, preceptors have the opportunity to serve as role models where they lead by example. In agreement, Lave and Wenger (1991) described how learning takes place in communities of practice. They emphasized that students need to be allowed to participate in practice in order to learn. Supporting the learning process of students, Collins (2006), describes the cognitive apprenticeship model composed of six teaching methods that are embedded in authentic learning environments. The first one is modelling where the master demonstrates the object to be learned, followed by coaching which involves student observation and the provision of appropriate feedback. The scaffolding technique accesses the level of knowledge and performance the student is at and plans activities to process the student along the learning continuum. Articulation is where the teacher questions the student to elicit their problem-solving skills and encourages self-reflection on their performance. Finally, exploration encourages the student to set their future learning goals (Collins, 2006). These teaching techniques focus on performance and understanding while also giving

the students access to their metacognition bringing their thinking to the surface (Stalmeijer, Dolmans, Wolfhagen & Scherpbier, (2009). The literature indicated that students could learn effectively under the guidance of a competent senior person who interacts with them in a one-to-one situation and is available to teach them about case studies and care plans (Boyer, 2008; O'Brien, Giles, Dempsey et.al, 2014; Monareng, Jooste & Dube, 2009). Furthermore, as noted by Monareng, Jooste and Dube, there are indications that the actions of the preceptor help bridge the gap between the idealistic didactic learning and the reality of the workplace. As a role model, the preceptor demonstrates to the students, adherence to standards of practice, resolution of issues/conflict, modeling professional behaviour as well as advising and educating on the clinical and organizational challenges that arise (Boyer, 2008; Hautala, Saylor & O'Leary-Kelley, 2007). Students learn from their role models in the learning environment whether the learning was planned, intended, unplanned or unintended (Gaberson & Oermann, 2010). In the process of role modeling for students, preceptors facilitate clinical competence and confidence especially when paired with students. They provide a one-to-one learning environment for the students in the clinical setting, allowing for an expert to provide immediate direction and feedback. The one-to-one relationship between a student and preceptor is essential in assisting students' transition to safe and competent practice (Hautala et al., 2007; Sedgwick & Harris, 2012). However, as explained by Vinales (2015), not all modeled behaviour is positive or beneficial to students therefore it would be very helpful if preceptors are reminded of the role modeling role in order for them to be motivated to portray good practice.

Preceptors have other roles and commitments apart from the precepting role and responsibility leading to the workload on their part. This workload can easily lead to

stress as noted by Hautala et al. (2007) who found that 89% of the 65 RN preceptors who completed an investigator developed a questionnaire on perceptions of stress and support in the preceptor role, indicated workload as one of the reasons for stress. The contributing factor for the workload was that nurses were already responsible for many roles and commitments, and the precepting nurse would typically provide precepting experiences in addition to being accountable for a full workload (Hautala et al., 2007; Stacy, 2008). In other words, the preceptorship role was an additional role. Yonge et al. (2008) observed that shortage of staff nurses and excessive work demands affected the availability and quality of preceptors, which in return compromised the quality of the preceptorship role as the preceptors, would focus more on their core role of patient care. There are multiple demands on the part of the preceptor leading to clinical teaching occurring at a rapid pace apart from the limited time for teaching and feedback. In turn, the student might not find learning to be collaborative with the preceptor and may lack opportunities and time for reflection. Preceptors see their roles as educators and understand their responsibility for providing better training beyond academics. The preceptors perceive themselves as an integral part of the health care professionals' ethical and awareness development. They realize their influence as role models in the teaching and learning process (Girotto, Enns, de Oliveira, Mayer, Perotta, Santos & Tempski, 2019).

There is an agreement in the literature on preceptor roles as there is the provision of an opportune time for student nurses to acquire professional and personal skills, convert theory into practice and develop attitudes and values believed to be essential for joining the healthcare fields. This in turn improves the clinical teaching aspect in nursing institutions (Monaring et al., 2009; O'Brien et al., 2014; Smith, Swain, & Penprase,

2011; Yonge et al., 2008). The preceptor orientation roles accord the students to become familiar with the clinical environment, which enables them to be aware of where to get resources and assistance in the course of their learning. As noted by Broadbent, Moxham, Sander, Walker & Dwyer (2014), RNs working as preceptors in the clinical area assist students to navigate the clinical environment successfully as team leaders.

Team leading is a factor within all the work that the preceptor undertakes. In the role of team leader, the preceptor recruits colleague support and assistance for the development and observation of the novice. The preceptor builds the communication, teamwork, and interpersonal interactions that provide for successful teaching/learning while creating a workplace culture of support and nurture. The preceptor ensures communication among managers, novices, and/or educators and resolves conflicts if they arise. Ensuring colleague support for the novice is often the greatest challenge.

It takes the entire work team to create the workplace culture and socialization that ensures safe, effective practice and the retention of novice nurses. In updating the educator role, preceptors need to be taught how to develop critical thinking skills in the novices and colleagues with whom they work. Often, the selected preceptor has been in practice long enough that he or she did not receive any instruction specific to critical thinking within basic nurse education.

2.3 Clinical Learning Environment

One of the most important parts of nursing education is clinical education; it is very important for personal development and promotion of practical skills (Saaranen, Vaajoki, Kellomäki & Hyvärinen, 2015). Nursing education is closely linked to the real

work environment, and nursing students always play the dual role of direct education and participation in patient caring (Allan, Smith & O'Driscoll, 2011). From the perspective of nursing students, the clinical learning environment includes nursing instructors and staff (Saarikoski M, Warne T, Kaila P. & Leino-Kilpi H., 2009). Nurses play a vital role in the learning process of nursing students (Kilcullen, 2007). The role of instructing nursing staff in nursing education is increasing and central (Lewin, 2006). Working with an informed and education-oriented nurse can help reduce nursing students' stress levels in the clinical learning environment (Matsumura, Callister, Palmer, Cox & Larsen, 2004). Due to the lack of nursing staff for education, the learning experiences for nursing students may be painful (Parvan, Shahbazi, Ebrahimi et al., 2018). Generally, an environment where staff are happy and behave friendly, have a positive attitude and willingness to teach and mentor students has a positive impact on the students' learning (Wang et al. 2010).

Preceptors play a crucial role in creating a conducive environment for clinical learning. Clinical learning environments is an important aspect in the training of nursing and midwifery students as it may influence the students' career choices and motivation for their enrolment and continuation (Berntsen, Bjørk, & Brynildsen, 2017). As expressed by Najafi Kalyani, Jamshidi, Molazem, Torabizadeh & Sharif (2019), nursing students should employ their knowledge and skills in clinical environments to acquire the required qualifications for taking care of patients, and their success depends to a great extent on efficient clinical training (Henderson, *et al*., 2006). Clinical training is regarded as the heart and essence of learning and education in nursing (Dadgaran, Parvizy & Peyrovi, 2013; Egan & Jaye, 2009). Furthermore, the clinical learning environment plays an important role in turning nursing students into professionals and preparing them to function as nurses (Woodley, 2013).

A clinical learning environment is a combination of several physical, psychological, emotional and organisational factors affecting the students' learning and how they confront the environment (Haraldseid, Friberg, & Aase, 2015; Reeve, Shumaker, Yearwood, Crowell & Riley, 2013). This environment has considerable effects on students' positive learning and emotional well-being (Dimitriadou, Papastavrou, Efstathiou & Theodorou, 2015; Tharani, Husain & Warwick, 2017). Furthermore, students get acquainted with the realities of their profession and the functions of nursing in this environment (Clarke, Gibb & Ramprogus, 2003). However, the clinical learning environment has been referred to as a reason for either quitting or continuing the nursing profession (Joolaee, Amiri & Farahani, 2015). The complexity of this environment and the events involved causing tension make it hard to be controlled (Papp, Markkanen & von Bonsdorff, 2003). On entry into the clinical environment, nursing students are confronted with many challenges and problems which affect their learning in that environment (Joolaee, Amiri & Farahani, 2015). Duteau (2012) suggests that effective support of students in clinical practice may well reduce the high number of graduates who leave the nursing profession within the first year of post-graduate experience. Quitting the profession, fear, anxiety and confusion have been mentioned as the main reasons for nursing students' unpreparedness and concern in clinical learning environments (Christiansen & Bell, 2010; Kermansaravi, Navidian & Yaghoubinia, 2015).

As indicated by Papathanasiou, Tsaras and Sarafis (2014), a considerable gap between students' expectations and clinical learning environments, which confronted them with problems in the clinical learning environment. Identification and elimination of the

problems in clinical learning environments reduce nursing students' emotional and behavioural problems in these environments (Behere, Yadav & Behere, 2011; Melincavage, 2011). Lack of motivation (Hanifi, Parvizy, Joolaee. 2012) and psychological problems occur after entry into the clinical environment (Dadgaran et al., 2013). Therefore, preceptors have a role to prevent inefficient educational context. According to Kalyani et al. (2019), this includes inefficient educators, unfavourable educational plans and an inappropriate clinical environment. The study by Kalyani et al. (2019) showed that continued attention is required to minimize an unsupportive atmosphere in the clinical environment, as well as negative attitudes towards nursing students and the nursing profession in clinical departments and society. In this context, educators and nurses should be aware that they, as proper role models, can motivate students and enhance their clinical knowledge and skills. In addition, educators and nurses can be effective in helping nursing students properly confront the challenges of the clinical environment. As noted by Kalyani et al. (2019), the use of constructive strategies that lead to the professional development of nursing students should be enforced with the necessary instructions, and at the same time faculties and clinical environments are coordinated. In this way, clinical authorities are informed about students' expectations and clinical environments are improved, eventually enhancing students' preparedness and capabilities before entering the clinics.

Boyer (2008), argues that as professional nurses, we are constantly on guard to ensure safe and effective care for clients. At the same time, the preceptor needs to provide a safe learning environment, one where the novice feels safe to learn, to ask questions, and to even make mistakes and learn from them. Luhanga, Myrick and Yonge (2010) suggest that faculty members must create and sustain a positive and safe learning

environment that promotes honesty and allows students to make mistakes and solve problems so they may develop their moral thinking. A safe learning environment includes a teaching/learning approach that builds simple to complex, encourages independent practice, plans for success, ensures consistent observation, provides ongoing feedback/encouragement and monitors to protect the safety of both novice care providers and clients. In the protector role, the preceptor must establish a team approach to the development of novices. This requires the preceptor to be a team leader, communicator, and conflict resolver.

The preceptor recruits the full healthcare team to support both the development and evaluation of the novice. After assessing the learning needs, team members provide support and instruction as the novice develops and practices specific skills and tasks. To ensure safe and effective care for clients, the preceptors do not allow the novice to practice independently until basic capability or competence is demonstrated (Luhanga, Myrick & Yonge, 2010). Competence evaluation is another aspect of evidence-based care. Demonstration of capable practice is the evidence that is collected that validates that this person can provide care safely and effectively. However, as expressed by Dias, and Khowaja (2017), there are some implications about what can be done to safeguard the role of clinical preceptors. Clinical preceptors need to feel supported in their roles and responsibilities. The role of a clinical preceptor is hectic and arduous. Therefore, institutional support is fundamental for recognition and acceptance of a new role in the organization (Dias, Lalwani, Khowaja & Mithani, 2017). Therefore, ongoing support and recognition need to be provided both by the educational administration and by the clinical agency. Clinical preceptors look for support from their peers in the form of structured time to be involved in clinical teaching and assessment of students. Provision

of training needs to take place before the clinical preceptors take students to the clinical agencies. This can be achieved by a range of activities from workshops to seminars to online teaching and learning courses along with mentoring and guidance. The literature has also recognized that clinical preceptors need ongoing feedback on their performance to strengthen their role (Usher, Nolan, Reser, Owens & Tollefson, 1999). There is also a need to encourage the clinical preceptors to engage in education and evaluation courses. Participation in such activities enables the clinical preceptors to gain a clearer understanding of their roles and responsibilities. In addition, these activities ensure opportunities to network, socialize, connect and dialogue with other nurse educators and clinical preceptors.

Dias et al. (2017) recommend that preceptors require extensive educational preparation and ongoing support in order that they have the pedagogical competence to foster clinical competence in the students. They recommend that the program should focus on principles of teaching and learning and principles of giving feedback to students (Dias, Lalwani, Khowaja & Mithani, 2017). Ongoing mentorship and shadowing faculty prior to the start of the semester would be beneficial. Additionally, there should be opportunities for the clinical preceptors to audit lectures and they should be provided with course modules so that they can integrate theory into practice in the clinical areas (Dias, Lalwani, Khowaja & Mithani, 2017).

A conducive learning environment includes a good relationship between the student nurse and the nurse clinicians. According to Vallant and Neville (2006), it is imperative for student nurses to have a positive relationship with nurse clinicians and that these positive relationships enhance student learning. This is supported by Chan (2001) who

found that nurse clinicians played a pivotal role in student nurses' clinical experiences. In addition, Atack, Comacu, Kenny, Labelle and Miller (2000) and Turnbull (2001) verify that relationships formed between students and nurse clinicians have a critical influence on the learning experiences of student nurses in practice settings. Student nurses recognized the importance of being interested and inquiring when participating in the clinical environment and established that doing so helped broker a positive relationship with nurse clinicians who then became interested in them (Vallant & Neville, 2006). This is supported by two other studies who found nurse clinicians were more likely to accept and help students who were enthusiastic and motivated to learn (Orchard, 1999).

The suggestion that student nurses and nurse clinicians both need to show an interest in each other supports Buber's (2002) theory of relationships which suggests that positive relationships are founded on mutual and reciprocal foundations and are essential for a relationship of genuine dialogue. However, as expressed by Omer and Moola (2019), preceptor relationships are fluid, and can assume a collaborative, integrative, team approach, or take on the form of a one-to-one relationship. Although one-to-one relationships have resulted in positive experiences, leading to expanded knowledge, skills acquisition and theory-practice integration, several aspects of the dynamics of one-to-one preceptor relationships need to be explored. These aspects include understanding how the culture of support and challenges experienced affect commitment to the preceptorship relationship. The commitment of the preceptor may affect the sense of belonging of the student, who may expect different outcomes from the preceptorship relationship. A lack of professional comportment may also negatively affect the transition from student to professional. The preceptor role has to adapt to

diverse learning needs, the complex health environment and needs to recognize that ongoing support is crucial to a preceptorship relationship. Students feel a need to belong and to be seen as part of a nursing community (Andrew, McGuinness, Reid, & Corcoran, 2009). Nurse preceptors facilitate students towards becoming a part of the professional team (Sedgwick & Yonge, 2008).

A positive preceptorship relationship is a crucial step in exploring and discovering the professional role. For student nurses, preceptorships facilitate a structured process of internalizing soft skills, practical skills, theory, ethics, values and professional comportment in transitioning from student to well-adapted nurse practitioner. In the nursing profession, preceptorship relationships are intricately tied in with patient care.

According to Kolouritis (2004), the relationship-based care model aims to protect the patient as well as those providing the care through mindfulness and understanding of emotional responses of the 'self' in order to connect with professional others, the patient and family. Omer and Moola (2019) go on to state that mutual respect is imperative and confidence and trust are enhanced when learning outcomes have been achieved. Preceptors have multiple roles, all of which are enhanced when there is a caring relationship between the preceptor and preceptee.

A study by Vallant and Neville (2006) has also shown that student nurses felt their learning was enhanced when they were engaged in a relationship with the nurse clinician that was 'nurturing'. Nurturing is defined as the act of nourishing. To nourish something is to support, foster, and cherish it (Thatcher, 1980). These seemed to be the qualities that the participants were describing when they spoke of being nurtured by the

nurse clinicians. Vallant and Neville (2006) observed that when nurse clinicians were friendly and actively promoted student nurse learning in the clinical setting, students felt they gained confidence and were able to integrate and apply knowledge to practice thus achieving the goals of clinical learning. Having nurse clinicians promote and support learning was also a source of motivation to students. In agreement with this, Cooper, Taft and Thelen (2005) found out that from the perspective of new graduate nurses, the effectiveness of clinical instruction depends on certain themes, such as the role and support of the clinical facilitator or preceptor, staff interaction and attitudes in the clinical setting, the opportunity to practice clinical skills, the student's level of confidence, the degree of one-to-one instruction, and the time that the preceptor was available to spend with the student.

A comparison study of nursing students' satisfaction with their supervision from preceptors and teachers reported that the fulfillment of learning outcomes for clinical practice was rated high by preceptors (Löfmark, Thorkildsen, Råholm, & Natvig, 2012). The findings by Löfmark et al. (2012) is an encouragement that supervisors need to focus on fulfillment of learning outcomes hence the creation of a conducive learning environment is very important. As Vallant and Neville (2006) noted, nursing leaders in practice and education need to address issues that impact the experiences student nurses have during their clinical placements.

When nurse clinicians have little formal preparation in preceptorship and teaching, they believe that because of their lack of preparation for teaching students in the clinical environment there was nothing to "... foster a professional desire to teach students they were allocated". To foster positive relationships between nurse clinicians and student

nurses, clinicians need to be adequately prepared for their role as clinical teachers and in addition, need to be appropriately supported at an organisational level. Myrick and Yonge (2005) assert that support needs to occur from both the educational institution as well as the health care facility. This position is reinforced by research recommendations calling for a review of the existing models of clinical teaching/supervision and promoting an environment that is mutually beneficial to both service and education, including the student and clinician (Dyson, 2000; Macdiarmid, 2003; Orchard, 1999). Both health care organisations and education providers need to recognise that working with students in clinical settings is a vitally important role and takes time and effort. In addition, students also need to realise that the nurse clinician's primary responsibility is to ensure patient safety and that balancing the provision of a supportive learning environment whilst providing quality nursing care is complex and challenging. As such, nurse clinicians working with students need to have a reduced, realistic and appropriate patient load. However, research indicates that clinicians supporting students are frequently given a highly complex patient load which reduces the quality and amount of time available for students (Edmond, 2001).

2.4 Experience of Preceptors

Preceptors, while performing their role of precepting students, experience role ambiguity, conflict and overload when interacting with students apart from appreciating their involvement in the preceptorship role. A phenomenological approach that explored clinical preceptors' experiences and the meanings of their lives in clinical teaching identified themes such as teaching is learning, experiencing bittersweet moments, being a role model, and acting as a mother. The authors concluded that clinical preceptors experience diverse feelings, both positive and negative (Liu, Lei,

Mingxia, & Haobin, 2010). On a positive note, as described by Lillibridge (2006), nurses working as preceptors, talked about the process of teaching students in similar ways, despite implementing specific teaching strategies differently. They all wanted the student to 'fit in' and be part of the nursing team on their unit. Another common denominator was that nurses described situations in which they were role models.

Nurses sought out learning experiences for students, but also stopped short of putting a student in a situation that might be harmful to their learning or confidence. However, Omansky (2010) found that lack of a definition of the preceptor role led to role ambiguity with a large gap between the envisioned roles of the preceptor to the reality of the role. The literature indicates that this is obvious in other institutions where clinical instructors are expected to teach and supervise students, but in practice, it is the preceptors who take the teaching role (Omansky, 2010; Yonge et al., 2008). A primary goal of nursing education is to prepare safe and competent practitioners who can be held accountable for their actions (Ashcroft et al., 2008; Smith, McKoy, & Richardson, 2003). The preceptorship model of clinical teaching–learning is widely used in undergraduate nursing programs. Within this model, faculty members are not directly involved in the actual teaching and supervision of students in the clinical setting but remain the custodians of the teaching– learning process. On the other hand, preceptors provide the day-to-day teaching, supervision, and guidance of students in the clinical setting. Lillibridge (2006) described the experiences preceptors had in teaching student nurses by stating that these nurses taught through talking and by example. They were able to clarify and articulate how they worked and, in the process, created learning opportunities for students. Preceptors stated that they turned mundane parts of the day into learning experiences, but also looked for specific and specialized opportunities that

might be going on with other nurses. The very first thing that they did was to tell them that they needed to be organised as this enables things to flow due to the plan they had formulated on daily basis.

The preceptors explained that whenever they move out of the room to do something, the students are involved as they usually invite them to accompany them. In the process, they continue explaining the entire thing as they go. These include what their thought processes are of it, what they are planning to do right then, what is the immediate situation, and what is the long-term situation on the patient at hand. If they are in the clinical area for the first time, then they would probably be more involved. Lillibridge continues to state that preceptors experienced the role of being a role model even though some of them did not notice this as expressed by one of the preceptors in her study who described situations in which they functioned as a role model for students: ". . .and I try to give them as much information as what I've received in school but also received in life just trying to get them on a good course. . .. let's say if they're doing a catheterization technique and their sterile technique is not good. I'm there with an extra pair of gloves to just instruct them how to do it right. Teamwork. I think teaching them to be there for other nurses as well as for themselves. And.... I think that we all need to support one another and just continue to go in that way. . . Trying to let them know that there are things that they can do to help others. I can help them; they can help me. We're just there to develop a good person, that works well with other staff members. Not to be exclusive for themselves. Not to be defensive." As expressed by Luhanga, Myrick and Yonge (2010), when a student's level of practice is unsafe, the preceptor and faculty may face the dilemma of facilitating entry into the profession of a graduate who may be inadequate in practice (Rittman & Osburn, 1995). Such action results in harm not

only to the student but also to the profession as a whole. In other words, those who facilitate such students could be classified as being negligent in their educational and professional accountability for maintaining the standards of the profession. Preceptors and faculty have an academic, legal, and ethical responsibility to ensure that the graduates of their program are competent in providing the public with safe nursing practice (Billings & Halstead, 2005; Boley & Whitney, 2003; Smith, McKoy & Richardson, 2003). The preceptors in the study by Luhanga et al. (2010), readily acknowledged their accountability for ensuring safe patient care while facilitating student learning. They reported that if a student is unable to demonstrate the ability to provide safe care at the expected level, it is their responsibility to intervene to avoid compromising the safety of their patients.

The preceptors are subjected to this role of clinical teaching as an addition to their other roles which easily lead to role conflict. A study by Girotto et al. (2019) indicated that the majority of preceptors in that study worked as health care providers and confirmed that the primary objective of preceptorship is the training in clinical settings, as conceptualized in the literature (Mills, Francis & Bonner, 2005). As shown by Girotto et al. (2019), many of the participants in their study, work in two or more capacities such as management, education, and as a health care provider. The results re-emphasize that the preceptor is a professional who works in the health care system with general or specialized expertise, enhancing students' practical activities during their undergraduate and postgraduate education, while performing their own role as health care professionals (Heffernan, Heffernan, Brosnan & Brown, 2009; Carlson, 2015; De Fulvio, Stichler & Gallo, 2015).

Preceptors are considered facilitators in the learning process who can integrate theory and practice (Carlson, 2015; Dobalian, Bowman, Wyte-Lake, Pearson & Dougherty, 2014; Kaviani & Stillwell, 2000). One-on-one teaching helps further develop students' skills and attitudes, emphasizing the inseparability between theory and practice, given that both are essential to critical thinking, leading to a holistic health care view (Hilli, Melender, Salmu & Jonsén, 2014) This close relationship between students and preceptors transforms the latter into role models, a professional who inspires and promotes the development of others (Tempski, Martins & Paro, 2012). The qualitative data of this study showed that the main skills of the good preceptor, listed by the preceptors, were knowledge, experience, being accessible and having good communication. Preceptorship is a process of adult learning: thus, it is necessary that the preceptor knows and applies andragogy principles (Freire, 2001) Therefore, the students' previous knowledge, their culture, and life experience must be considered during the training to develop their autonomy and their ability to critical thinking (Carlson, 2015; Chang, Lin, Chen, Kang & Chang, 2015). This ability to reflect on the practice and reality is essential to the health care learning process. It prepares them for constant evaluation and changes in their future practice, leading them to search for better ways and tools to perform their work, making them better professionals (Bransford, Brown & Cocking, 2000). As indicated by Girotto et al. (2019), preceptors recognize the power of preceptorship to transform reality, as it provides students with autonomy and develops their critical vision. They go on by stating that the preceptors perceive themselves as a professional model that favours the development of technical, emotional and moral competence, training students with a commitment to the transformation of reality in which they are inserted and promotion of the quality of life of the population.

Concerning the partnership between educational institutions and the health care system, preceptors distinguish themselves as a link between the two. As such, this partnership entails a new way of training health care professionals in new educational settings where they can apply their knowledge. The study participants realize that preceptorship is a valuable way to provide this training. As noted by Omansky (2010), role conflict was expressed by preceptors due to a lack of recognition from peers or management for the extra work they perform when functioning as preceptors. According to Omansky (2010), the exclusion of the preceptor role on the majority of the institution's nurse preceptors' job descriptions makes this role to be considered unofficial therefore not worth recognizing by the preceptors' facilities. This exclusion further created anxiety, where nurse preceptors found themselves in the precarious position of teaching students without having formal facility acknowledgement. Allen (2016) revealed that being acknowledged and feeling rewarded for the role was important for preceptors. In his study, many preceptors described a sense of reward from watching the students' progress. Many, however, suggested recognition in the form of a 'word of thanks', 'a journal subscription' or 'refreshments at a lunchtime preceptor forum' would be welcome. A considerable number wanted financial rewards and were disgruntled that other disciplines enjoyed remuneration for their student supervision roles. Allen (2016) observed that managers perceived preceptorship to be integral to the nurses' role, but several agreed that more should be done to acknowledge, support and reward preceptors. On the other hand, students felt there would be clear benefits if preceptors were better supported, suggesting that preceptorship might become more consistent and of better quality. Furthermore, the lecturers reported that support sessions they had arranged were poorly attended and that preceptors were not released by their managers

in order to go. They also expressed concerns about the variable enthusiasm within trusts to establish clinical supervision and agreed that extrinsic rewards should be explored.

Lack of formal facility acknowledgement as noted by Omansky (2010) collided with the preceptor's primary responsibility of patient care leading to role conflict (Omansky, 2010). In support of non-recognition, Broadbent et al. (2014) and Yonge et al. (2008) noted that preceptors reported being sidelined in terms of information concerning students before their arrival, which compromised on their preparations. These experiences resulted in preceptors not being sure of their expected roles, which in the end led to role conflict. As for work overload, preceptors complained of a lack of time for their core role of patient care due to their involvement in the preceptorship role. According to Omansky (2010), nurse preceptors reported a need to be assigned decreased patient assignments to allow them time to work with students. It was noted that the work overload appeared to be the result of managers and co-workers not understanding what the preceptor role entailed and viewed the preceptor as having additional help when in fact the preceptor had additional responsibilities (Omansky, 2010; Murphy, 2008).

Preceptors expressed worry over the reaction of students they precepted relating to their experience and expertise. As noted by Boyar (2012) preceptors experienced resentments from students especially when the students felt that the preceptors had some shortfalls. In her observations, she concluded that the preceptors felt that some students were overly judgmental, especially considering their inexperience. However, one of the preceptors she interviewed in her study stated the following sentiments:

> "*I don't mind being assigned a student who works hard and asks relevant questions. In fact, a good student will make my day go much easier. But*

sometimes I overhear students complaining about our clinical practice. It's like they are trying to catch us making errors."

This revelation gave a negative experience in the preceptorship role, which could discourage the preceptors from continuing with this role. Preceptors attributed their preparation for their preceptorship role to past experiences where the majority of them indicated that their preceptorship role was conducted with reference to their previous experiences and not necessarily training (Yonge et al., 2008). As indicated by Allen (2016) many preceptors who participated in his study reported that they had not attended any preparation or update sessions and commented that they had only attended the obligatory 'sheep-dip' sessions which were locally arranged at the inception of a project on nurse education reforms. Allen (2016) noted that students believed that preceptors would have undergone some form of preparation and many were dismayed to find this was often not the case. Lecturers, meanwhile, identified that the sessions they put on were often poorly attended and suggested that the booklets advertising preceptor sessions and other courses seldom found their way to practitioners. Some believed that managers secreted them in order to avoid the problems that arose when staff sought to be released to attend. In attending such sessions that were run, the evaluator discovered a lack of content uniformity, that some were under-subscribed or cancelled, and that those arranged for non-mental health nurse preceptors highlighted similar concerns as those evident among mental health nurse preceptors.

Lack of preceptor preparation indicated a gap as the preceptorship role demanded knowledge in teaching methodologies, which most preceptors lacked. As clinical teachers, preceptors required adequate preparation in order for them to cope with the teaching modalities. Omansky (2010) noted that in a preceptor experience, the students

got exposure to the reality of nursing, gained knowledge, learned clinical skills, thought critically and learned role assumptions. As a result, there was a large amount of responsibility given to the preceptor and a workload increase associated with the clinical placements. This made the preceptor experience increased stress that came with these responsibilities and took a toll on the preceptor and played a part in the preceptor's burnout and retention (Hautala et al., 2007; Smedley & Penney, 2009; Yonge et al., 2008).

Preceptors reported a variety of experiences in dealing with students in the clinical area. They included feelings of relief, fear, anxiety, self-doubt, anger and frustration in evaluating students with unsafe practices (Luhanga, Yonge & Myrick, 2007). These feelings could be because of inadequate knowledge and direction in performing the clinical teaching duties, which were deemed to be more academic. According to Luhanga et al. (2007), preceptors who were comfortable to evaluate and decide on the progress of students attributed their decisions to the support gained from the faculty members who availed themselves in the practice area. This revelation indicates the importance of the role of faculty when preceptors are working with students. As noted in the study by Allen (2016), many preceptors expressed difficulties with assessing students and dealing with those who were failing. Making time for assessments, knowing what to assess and obtaining support if failing a student, were issues raised in the study. Preceptors acknowledged that sometimes they passed students when they should have failed. In reaction to this, the lecturers expressed concerns about assessing and failing, but were clear that the responsibility lay with the preceptors and that they should recognize and accept their status as 'gatekeepers to the profession'. 'You pass them, you deserve them,' was the robust message given to preceptors. The reaction by

the lectures to preceptor concerns was correct in the sense that while in the clinical area, the students are ideally under the custody of preceptors and qualified nurses and midwives.

2.5 Professional Development of Preceptors

The literature indicated that the preceptorship role helped preceptors in their personal and professional development (Broadbent et al., 2014; Chen, Lai, Li, Chen, Chan & Lin, 2011; Yonge et al., 2008). If one can base on the principle of 'teaching as learning twice', it can be established that the act of precepting enhanced the preceptors' own learning and performance (Chen et al., 2011). As the preceptors interact with students, they have a personal reflection on their knowledge and skills and review or re-learn what they teach the students. Chen et al. (2011) expressed this in a study on preceptor's professional development where they found that preceptors who had participated in a preceptorship programme had re-learned clinical skills such as counselling (87.1%), physical examination (95.2%) and interviewing (85.6%).

According to cognitivist learning theory, developing critical thinking through reflection is one of the most important components of the learning process (Torre, Daley, Sebastian & Elnicki). A review on reflection in the education of health professionals concluded that reflective capacity is regarded as an essential attribute for professional competence (Mann, Gordon & MacLeod, 2009). A survey by Chen et al. (2011), showed that preceptors reported that the mini-Clinical Evaluation Exercise (mini-CEX) they were subjected to had positive impacts on their daily clinical practice and increased their reflections on their patient care as a physician. From the starting point of reflection, the mini-CEX may facilitate critical thinking and improve professional competence.

Another principle of cognitivist learning theory is that meaningful learning results from relating new knowledge to what is already known (Torre et al., 2009). As expressed by Chen et al. (2011), knowledge, experience, and insights derived from experience are essential in helping physicians to become progressively more skillful and maintain their professional competence. Chen et al. (2011) observed that the interactions with patients and trainees during mini-CEX may stimulate preceptors to relearn something and to connect and integrate new learning into existing knowledge and skills. The findings of Chen et al. (2011) were in agreement with what Broadbent et al. (2014) found after conducting a survey on preceptor professional development where preceptors agreed strongly that the preceptor experience allowed them to identify future professional development needs (82.4%), build on existing skills and knowledge (79.4%) and maintain their professional identity as an RN (85.3%). This denotes that the preceptorship experience allowed preceptors to identify their own professional development needs and work on achieving them or improving on their shortfalls.

Many studies support the general argument on preceptorship that most nurses participating in it find it valuable for increasing their competence and confidence (Marks-Maran, Ooms & Tapping, 2013). Similarly, literature on residents-as-teacher programmes reported that many residents believed that teaching improved their clinical knowledge and skills and promoted their further efforts as self-directed learners (Chen et al., 2011). Therefore, serving as a teacher assisted the residents to improve their knowledge and skills as well as their confidence as they re-learned these through their teaching roles. Similarly, preceptors improve their knowledge and skills as they assist students when executing the preceptorship role. As noted by Broadbent et al. (2014), RNs who acted as preceptors believed that being a preceptor for nursing students was

seen as a positive part of the RN role in their workplace. Furthermore, RNs had a duty to guide students during clinical placement apart from providing nursing and midwifery care. Nurse preceptors had identified some positive aspects to functioning in this role, which included personal growth and a sense of expanding abilities (Omansky, 2010).

The preceptors have the opportunity to acquire education techniques as well as changes in behaviour and attitude by virtue of being involved as preceptors. Apart from this, the preceptorship involvement helps them to keep abreast of changes in their areas of specialty. This is in agreement with what Broadbent et al. (2014) found in her survey that RNs working closely with students ensure that their RN duties are carried out professionally and efficiently. Furthermore, the RNs reported personal benefits of discussing contemporary issues as well as reflecting on their practice and areas to update skills to meet student needs apart from being encouraged to learn.

Jeggels, Traut and Africa (2014) noted a significant change in the behaviour and attitude of professional nurses after a preceptorship training programme at the University of Western Cape, South Africa. They noted that the participants to the preceptorship training perceived a change in knowledge occurring as a result of their involvement in the preceptorship programme. These included awareness of the importance of creating learning opportunities for students, acknowledging the level of the students and giving them proper feedback. The preceptors improved their professional attributes through their involvement in the preceptorship role. As noted by Jeggels, Traut and Africa (2014), preceptors indicated changes in their clinical teaching skills as a result of being involved in the preceptorship programme. They valued some of the clinical teaching strategies that they were exposed to during the preceptorship programme. Their

observations concluded that as the preceptors were involved in the preceptorship roles, they had an opportunity to develop professionally as well as personally.

2.6 Satisfaction with the Preceptorship Role

Studies have found that preceptors expressed satisfaction with their clinical teaching role and felt positive about the preceptor role as they put a great deal of effort into creating meaningful and positive learning experiences for students (Broadbent et al., 2014; Kalischuk, Vandenberg & Awosoga, 2013). Preceptors were satisfied when they saw nursing students change in their confidence as well as execution of the nursing and midwifery roles. As noted by Broadbent et al. (2014), these were altruistic, extrinsic benefits that reflected satisfaction of contributing to and seeing others grow and learn. This denotes that apart from executing their role, the preceptors expressed personal satisfaction as one of the positive things they gained during the preceptorship programme. Lillibridge (2007) noted that preceptors were motivated by personal/professional gains to engage in preceptorship. She further indicated that preceptors who participated in her study on using clinical nurses as preceptors to teach leadership and management to senior nursing students believed that teaching students provided them with professional growth experiences as well as knowledge development.

The preceptors felt the preceptorship role accorded them the opportunity to teach and were satisfied that they were part of someone else's learning. This is similar to what Seo, Ryu, Lee, Noh, La and Kim (2018), found when they requested preceptors in their study to rank their perceptions regarding the benefits of precepting students. They responded that they had satisfaction in the improvement of professional knowledge and

performance ability and pride regarding professional activities. Professional activities included educating students and influencing the professionalization process of new practitioners. Involvement in the preceptorship programme accorded the preceptors to develop professionally and this was their source of satisfaction. This is supported by Payakachat, Ounpraseuth, Ragland and Murawski (2011) who indicated that being an active pharmacist preceptor was associated with increased job satisfaction among pharmacists. However, this fell short of the preceptors having increased career satisfaction. Payakachat et al. indicated in their study on the job and career satisfaction among pharmacy preceptors, that factors associated with the higher job and career satisfaction among their study sample included the perceived benefit of continuing education and having professionally challenging work. Literature supports the preceptors' feelings of satisfaction in watching novice new graduates develop into competent new nurses as well as observing students gaining confidence in their execution of patient care (Broadbent et al., 2014; Lillibridge, 2007).

Involvement in preceptorship roles helps RNs to improve skills and develop confidence in their role as preceptors. Singer (2006) observed that a well-planned preceptorship programme had a positive effect on the developmental growth of nurses through increased confidence, augmented organizational skills, expanded knowledge, improved communication and higher clinical efficiency. Likewise, a high level of satisfaction was reported in a formal evaluation of a preceptorship programme implemented by a mental health nursing unit, which concluded that nurses felt more competent due to their involvement in the preceptor role (Duteau, 2012). This indicated that as students gained confidence in patient care, preceptors also gained confidence in their preceptorship roles. Other preceptors, however, considered satisfaction in terms of monetary rewards.

The literature referred to this as extrinsic incentives and included an increase in wages or compensatory time or tuition, an avenue to career advancement and increasing involvement in the employing hospital (Lillibridge, 2007). Despite this observation on extrinsic incentives, Lillibridge (2007) noted that the majority of the preceptors were satisfied with intrinsic rewards, which included personal satisfaction and the opportunity to teach. In relation to what Lillibridge (2007) noted, Kalischuk, Vandenberg and Awosoga (2013) found that only 20.9% (n=24) of the preceptors out of a sample of 331 in their study indicated chances for promotion as a reason for fulfilling their preceptorship role. This denotes those extrinsic rewards were not a priority for preceptor satisfaction.

Similarly, Latessa, Colvin, Beaty, Steiner and Pathman (2013) indicated in their study on motivation and satisfaction of community preceptors that community preceptors provided much of the outpatient clinical training of health professions students (medical, pharmacy, nurse practitioner, physician assistant, and certified nurse-midwife) yet often receive little or no direct compensation. They went on to state that relying on these preceptors had been a sustainable health education model because preceptors principally taught students for intrinsic reasons, most importantly the pure enjoyment of teaching. This was observed in the responses by the study participants regarding the perceived effects of having a student in the practice area where a majority of the respondents rated teaching students as having a positive or very positive influence on job satisfaction and relationships with colleagues and staff (Latessa et al., 2013).

Apart from executing their role, the preceptors expressed personal satisfaction as one of the positive things they gained during the preceptorship programme. The analysis of

the preceptors' perceptions on satisfaction with the preceptorship role leads to the conclusion that, for many of them, their social role is intrinsic to the preceptorship concept (Girotto et al., 2019). They perceive preceptorship as a good opportunity for bidirectional development, helping the development of the future professional while contributing to their development. Many of them recognized improvements to their health care practice as a result of the students' presence, questions, and suggestions. On the other hand, the difficulties cannot be overlooked. The preceptors have often not received any training to act as educators and do not have extra time in their already overloaded schedule for teaching activities. The lack of infrastructure in the health care system and support from the health care team were also mentioned as difficulties faced by preceptors.

However, there were differences in preceptor opinion when preceptors had some training and when there was a university-trained and paid facilitator present on the ward where students were placed (O'Brien et al., 2014). Preceptor training helped the preceptors to have a clear picture of their roles and limitations and the presence of a university facilitator on the wards provided satisfaction to preceptors, as there were clear demarcations of the preceptor role and that of the university facilitator. Apart from assisting with students' supervision, the university facilitator provided support to the preceptors.

2.7 Challenges of the Preceptorship Role

The literature has reported challenges that preceptors face when executing their preceptorship roles (Broadbent et al., 2014; Duteau, 2012; Löfmark et al., 2012; Luhanga et al., 2008; Murphy, 2010; O'Brien et al., 2014). Role confusion and lack of time to precept were noted as challenges by the majority of the preceptors in the literature (Broadbent et al., 2014; Löfmark et al., 2012). The preceptors expressed that they were not satisfied with the time they had to support students whilst they fulfilled their role of providing nursing care (Broadbent et al., 2014; Löfmark et al., 2012). In support of these sentiments, Allen (2016) points out that preceptors felt more support should be forthcoming and wanted 'small measures' such as 'a phone call from a tutor' or some feedback from the education provider or the students. The majority wanted support groups for preceptors and suggested that support and education could be blended in monthly preceptor fora. Some preceptors had attended support groups set up by link lecturers. However, across the trusts, there was little consistency in terms of availability or awareness that such groups were available with some preceptors within teams aware of a support group, while immediate colleagues had no knowledge of its existence. Similarly, clinical supervision arrangements varied within the trusts and placements. Where it was established, preceptors stated that they often used supervision to discuss student issues and gain support for this element of their work.

The preceptors felt their role of providing nursing care was overtaken by the preceptorship role. This could have been compounded by a lack of support for the preceptors from training institutions that sent students during clinical placement. Furthermore, some studies have identified that factors affecting the preceptorship model included insufficient time to guide and lack of support from clinical placement

coordinators and management for preceptors to fulfil their roles effectively (McSharry & Lathlean, 2017). As noted by Kalischuk, Vandenberg and Awosoga (2013), lack of support from nursing faculty made it difficult for the preceptorship goals to be met. They observed in their study that preceptors expressed the need for a lighter workload, further educational preparation, and more time assessing and assisting students (Kalischuk, Vandenberg & Awosoga., 2013). They also felt a need for increased support from stakeholders. Increased support encourages preceptor retention and influences future nurses. The observations by Kalischuk, Vandenberg and Awosoga(2013) are similar to sentiments by McCarthy and Murphy (2010) who reported that preceptors did not feel appreciated, valued or acknowledged by hospital managers. This lack of constructive support could have easily led to a lack of interest on the part of the preceptors in their preceptorship role. In addition, there was a possibility of burnout if clinical staff had continuously taken on the preceptor role without adequate support and reward (Duteau, 2012). Inadequate time, business and pressures on the part of preceptors have continually been reported as some of the barriers to preceptorship (Odelius, Traynor & Mehigan, 2017). Therefore, there is a need for the preceptors to be supported for the services they render to students for effective preceptorship to be attained.

Generally, it is of paramount importance that the faculty members should be more involved with students during clinical practice. As complained by the preceptors, on average one would see the faculty once or twice in the whole placement and they would only be on the unit about two or three minutes unless there was a problem (Luhanga et al., 2008). As Paterson and Lane (2000) note, nursing faculty have a responsibility for their students as well as the protection of the public. They must continually weigh and

measure the ability of the student against the potential for risk to a patient. The presence of a faculty member on the wards as noted by O'Brien et al. (2014), provided satisfaction to preceptors as there were clear demarcations of the preceptor role and that of the faculty member and provision of support to the preceptors. In support of the presence of faculty members, Allen (2016) indicated that preceptors identified the link lecturer or faculty member as the most helpful mechanism that would support them in their role. However, many preceptors reported infrequent contact with their link lecturer. Some stated that they did not know who their link lecturer was, although where the link lecturer had maintained contact or helped with particular issues, reports were favourable. Students, too, wanted more contact, both for themselves and their preceptors. Students lacked clarity as to whether the link role was intended to support them, or focus on the preceptors' needs. The link lecturers were clear that their remit was preceptor support and development. However, many explained that due to their workloads, travelling to as many as 20 link areas and the other demands placed upon them, they simply could not fulfil the requirement. As indicated in a study by Löfmark et al. (2012), nursing students rated highly the supervision they had from preceptors and teachers. However, supervision by teachers was, to some extent, rated more highly than supervision by preceptors. This entails that faculty members are needed by students in the clinical area and therefore their presence is crucial. Löfmark et al. further noted that preceptors and university teachers were an invaluable resource in preparing students for the reality of their professional role. While in the clinical area, the role of the faculty members changes to where the emphasis is placed on coordination and the support of student and preceptor interaction (Saarikoski, Isoaho, Warne & Leino-Kilpi, 2009). The literature indicates that there is an increased need for university teachers to be apparent at regular intervals and to be available to both students and staff (Gillespie

& McFetridge, 2006). The higher rating for university teacher supervision found in the study by Löfmark et al. may be explained by the teachers' ability to be familiar with learning outcomes for clinical practice and how it can be reached and assessed. Calpin-Davies (2001) emphasized that teachers have a distinct advantage in comparison with preceptors in helping students, as they are very aware of the students' stage of learning, and teaching and explanations can be adjusted to their level of education. However, as observed by Löfmark et al. teaching and supervision have not been without problems for the academic and health care organizations involved in clinical education.

The demands on university teachers and clinical staff, although different, are extensive and can compromise the quality and quantity of the clinical supervision of students (Lambert & Glacken, 2005). Heavy workloads and inadequate resources to meet expectations have implied recurrent considerations of roles and responsibilities (Budgen & Gamroth, 2008), including consideration of fewer job assignments on the preceptors. Preceptors required face-to-face contact with faculty members apart from paper work as one way of appreciating their role as well as role clarity (Löfmark et al., 2012). As reported by Duteau (2012) preceptor's workload, lack of support from peers and overall, lack of support from the nursing faculty members negatively affected the role of the preceptors, leading to fatigue and burnout. This in turn promoted a lack of interest in the preceptor's continuation with the preceptorship role.

In agreement with Duteau, (2012) on the workload on the part of the preceptors, Monareng, Jooste & Dube, 2009, noted that another challenge experienced by preceptors in their role was increased workload and this, as expressed by preceptors militated against effective preceptorship. Similarly, Seo et al (2018) noted in their study

on stress and satisfaction with preceptorship that workload was a major cause of precepting-related stress and a major barrier for continuing preceptorship. They further stated that workload was frequently identified as a challenge for preceptors in teaching students and attributed this to lack of staffing as one of the reasons for the increase in workload for balancing other responsibilities. Likewise, high-stress levels and workloads were associated with lower job and career satisfaction (Payakachat et al., 2011).

The preceptors further revealed that the workload increased after they were included in the preceptorship programme. This proves that clinical teaching was an additional task to the preceptor's day to day activities of patient care. It was usually challenging to combine clinical teaching and patient care especially when the ward had many students requiring the attention of the preceptor (O'Brien et al., 2014). Preceptors needed to fulfill these equally important tasks making preceptorship to be reported as a time-consuming activity (Kalischuk, Vandenberg & Awosoga, 2013; O'Brien et al., 2014). On the other hand, as preceptors are involved in student teaching, they leave other staff members to do core ward activities. This poses a challenge to other ward staff as they believe that their colleagues spend more time with students' teaching and supervision than nursing care (Monareng, Jooste & Dube, 2009), which creates some stress among preceptors who think that their role of preceptorship is not appreciated. This is highlighted by other preceptors' demand for reduced workload when supervising students (Kalischuk, Vandenberg & Awosoga, 2013). However, any significant challenges encountered during the preceptorship period tend to undermine the realisation of the full potential of this approach for both the preceptors and preceptees (Haitana & Bland, 2011; Duteau, 2012).

2.8 Preceptorship In Non- Nursing Professions

Preceptorship has been associated with the training of nursing and midwifery professionals. However, other professions such as medicine, pharmacy and dentistry among others utilize the preceptorship model in their trainings. Preceptorship, therefore, may be defined as a simultaneous teaching-learning method used by the practice professions of nursing, medicine, pharmacy and dentistry as well as psychiatry in teaching students in clinical settings, focusing on their clinical and ethical development (Coates & Gormley, 1997; Broadbent, Moxham, Sander, Walker, Dwyer, 2014; Billay & Myrick, 2008). The preceptor is a professional with generalist or specialist training, whose function is direct follow-up and orientation regarding the practical activities carried out by undergraduate and graduate students while developing their assistance function. It is a close teaching-learning relationship, in which the preceptor acts as a model for the professional in training (Heffernan, Heffernan, Brosnan & Brown, 2009; Panzavecchia & Pearce, 2014). In this context, preceptorship is essential to improve the quality of training and, consequently, health care. In the education of pharmacists, for example, preceptors are practitioner educators and are the link in forming collaborations between schools of pharmacy and pharmacy practice sites, allowing students to gain experience on the health care team and participate in patient interventions while fulfilling necessary responsibilities for the practice site (Cox & Lindblad, 2012). Preceptors in pharmacy practice play a crucial role in student education and development throughout the experiential learning process (Tofade, Kim, Lebovitz, Leadon, Maynor, Culhane, Freeberry, Harris, & Abate, 2015). As students transition from the classroom to real-world experiences, the quality of education lies to a large extent in the hands of preceptors.

Preceptorship occurs in clinical settings in the health care system, allowing students to experience health care, to interact with the professional team, and to be exposed to the communities' reality (Mills, Francis & Bonner, 2005), establishing a connection between what is learned from medical schools and society's health care needs (Maeshiro, Johnson, Koo, Parboosingh, Carney, Gesundheit, et al., 2010; Cohen, 2000; Riddle, Lin, Steinman, Salvi, McGlynn, Kastor, et al., 2014; Scott, Schifferdecker, Anthony, Chao, Chessman, Margo, et al., 2014). However, it requires the reorganization of operations and staff at the clinical site to include preceptors and students in their routine procedures (Heffernan, Heffernan, Brosnan & Brown, 2009; van der Leeuw, Lombarts, Arah, & Heineman, 2012).

The preceptor plays an important role by guiding and role modelling their knowledge, skills and practice to increase confidence and enhance students' practice, allowing them to be moulded through positive engagement into an autonomous, decision making practitioner (Panzavecchia & Pearce, 2014). This form of learning in practice, mediated by a preceptor, is conducive to the development of a critical awareness by the student about reality. It is expected that professional training in the twenty-first century leads students for applying a critical view to their work and, when necessary, capable of taking measures for the transformation of reality (Frenk, Chen, Bhutta, Cohen, Crisp, Evans, et al., 2010). Thus, training in clinical settings can promote social responsibility in students who participate in preceptorship programs. Apart from health professions, the model is also utilised in non-health professions where it operates under different names. For example, in the general education sector, it is referred to as Teaching Practice.

2.9 Teaching Practice: An Equivalent to Preceptorship in General Education

Teaching Practice, an equivalent to preceptorship, entails a range of experiences to which student teachers are exposed when they work in classrooms and schools (Marais & Meier, 2004). It is an integral component of teacher training whose overall purpose is to expose student teachers to the actual teaching and learning environment (Komba & Kira, 2013). During the Teaching Practice, student teachers observe subject teachers at work so as to learn about teachers' skills, strategies and classroom achievements. It is also the time when they evaluate their own teaching experiences through interactions with teachers and lecturers and, through self-reflection, implement a variety of approaches, strategies and skills with a view to bringing about meaningful learning.

Komba and Kira (2013) argued that Teaching Practice is envisaged to prepare students for maximum practical and professional training in the field of education. According to them, the preparation includes: providing an experience through participation and observation under the auspices of the institutions to which students are attached; as well as providing professional skills which are acquired through planned programmes so as to meet and satisfy the needs of the profession as well as the environment to which the students are being prepared for. Practice teaching is an important component of becoming a teacher. It provides experiences to student teachers in the actual teaching and learning environment (Msangya, Mkoma & Yihuan, 2016). During teaching practice, a student-teacher is allowed to try the art of teaching before actually getting into the real world of the teaching profession (Kasanda, 1995). Student-teachers also know the value of teaching practice and they perceive it as the important aspect of their preparation for the teaching profession since it provides for the real interface between

student hood and membership of the profession (Ranjan, 2013). As a result, teaching practice creates a mixture of anticipation, anxiety, excitement and apprehension in the student teachers as they commence their teaching practice (Manion, Keith, Morrison & Cohen, 2003; Perry, 2004).

Teaching practice is a form of work-integrated learning that is described as a time when students are working in the relevant industry to receive specific in-service training in order to apply theory in practice. Researchers such as Marais and Meier (2004), Perry (2004) and Maphosa, Shumba & Shumba (2007) describe teaching practice as an integral component of teacher training. To achieve the standards required for qualified teacher status, a student teacher is required to do teaching practice in at least two schools. According to Perry (2004), teaching practice can be conducted in several forms depending on the institution. Some institutions send student teachers to go for teaching practice once a day each week; others do this over a semester; while others send student teachers in a two- to six weeks' block. To this effect, the student-teacher is expected to fulfil all the responsibilities of a teacher, which according to Perry (2004) is exciting but challenging. Perry (2004) also points out that, on the one hand, student teachers should experience the excitement of being a part of a real classroom setting, of getting to know learners, of planning and organising the classroom tasks. On the other hand, student teachers could have doubts about their ability to cope with unfamiliar situations, controlling and managing learners or establishing a working relationship with the mentor or supervisor. It is such mixed feelings that can contribute to the making or breaking of a student-teacher. Conversely, Caires, Almeida and Vieira (2012) indicated that among the participants in their study, and corroborating previous evidence, teaching practice is perceived as a particularly stressful and demanding period, which

involves considerable amounts of distress, changes in psycho-physiological patterns and an increasing sense of weariness and 'vulnerability' (Evelein, Korthagen & Brekelmans 2008; Head, Hill, & Maguire 1996; Kyriacou & Stephens 1999; Lamote & Engels 2010). Despite these difficulties, data also reveal student teachers' positive perceptions regarding their growing knowledge and skillfulness, their increasing sense of efficacy, flexibility and spontaneity in their performance and interactions, as well as the awareness of having achieved reasonable levels of acceptance and recognition amongst the school community. The results confirm previous findings that point out the multiple gains and achievements that take place during teaching practice (Caires & Almeida 2005; Kagan 1992; Tillemma 2000). More emphatically, Capel, Leask and Turner (1997) assume that teaching practice is the stage where the proficiency of a trainee teacher progresses faster and more intensively than at any other stage of his/her professional development.

As stated before, becoming a teacher depends on the interaction of multiple variables amongst which the personal characteristics and resources of the student teachers, the guidance and support from their supervisors and the characteristics of the ethos of the placement school play a major role (Assuncao Flores, 2005; Haritos 2004; McNally, Cope, Inglis & Stronach, 1997; Newman 2000). Therefore, as Caires et al., (2012) noted, it can be claimed that the warmth, acceptance and satisfactory conditions offered to these newcomers may determine not only their growing sense of 'belonging' but also (partially) their self-fulfillment regarding the teaching profession or the reasonable sense of professional identity acknowledged by these student teachers (Beck & Kosnick 2000; Caires & Almeida 2001; Assuncao Flores, 2005; Krecic & Grmek 2008; McNally et al. 1997). Additionally, the achievement and progression perceived in their skills and

knowledge may also be partially explained by the quality of their socialization process within the school community. As expressed by many other authors, discussions about the theoretical and practical issues of teaching, the sharing and/or collaborative production of materials and advice provided by more experienced teachers may all contribute to the learning process of the student teachers (Ashforth & Saks 1996; McNally et al. 1997; Olson & Osborne 1991). The findings also emphasize the important role of the supervisor figure in line with many other studies that regard him/her as a key facilitator of the ecological transitions of student teachers and as an important source of technical and emotional support (Acheson & Gall 1997; Calderhead & Shorrock 1997; Caires & Almeida, 2007; Johnston 1994). In this study, the positive assessment of their supervisors' performance (e.g., emotional support, modelling and/or logistical and technical back up) also helps to explain the positive perceptions of the achievements and progress that occurred during teaching practice (not only in terms of their conceptual, procedural and pedagogical acquisitions but also in the social and vocational arenas). Supervision is, in fact, a privileged setting for the sharing of, reflection about and discussion around the phenomenological aspects of teaching practice (Caires et al., 2012).

The sharing of experiences with their supervisors and other student teachers, the joint exploration of the beliefs, perceptions and effects involved in teaching practice and/or the joint construction of meanings can all represent a significant opportunity for self-exploration, exploration of the teaching profession, mutual knowledge and the strengthening of complicity relationships amongst student teachers, their supervisors and colleagues. These aspects may indeed help to thwart the communication problems,

competitiveness and individualism frequently emerging within the group. It may also serve as a model for future relationships to be adopted within the classroom.

This is similar to preceptorship in the healthcare sector where students are assisted to put into practice the theoretical knowledge they learnt in the classroom. The students are paired with a preceptor just like the students in the education sector are paired with subject teachers to observe them while they are working. Teaching Practice is an integral component of any teacher training programme because it provides student teachers with experience in the actual teaching and learning environment (Komba & Kira, 2013). According to Taneja (2000), Teaching Practice is referred to by a number of terms which include practice teaching, student teaching, field studies, infield experience, school-based experience or internship.

The findings of a study by Msangya, Mkoma and Yihuan (2016) on the Teaching Practice experience for undergraduate student teachers, indicated that the student teachers perceived teaching practice as an important tool of learning to teach. They noted that it promoted the development of teaching experience and prepared them for the real world of work. For teachers to play their role effectively in schools, there must be a well-designed and successfully implemented teaching practice program for student teachers that aims at producing teachers who are academically qualified, professionally skilled, and attitudinally and ethically committed to their profession (Msangya, Mkoma & Yihuan, 2016). The teacher's character and quality competence are the most significant factors which influence the education quality and its contribution to national development (Kumar & Ratnalikar, 2003).

2.10 Conclusion

The literature review that was carried out in this study has stipulated that preceptorship is a valuable component of nursing courses today and is seen as vital to the professional preparation of student nurses. This has been supported by the literature where there is an agreement on preceptorship as a strategy for clinical teaching as it provides an opportune time for student nurses to acquire professional and personal skills. In the literature, preceptors have been identified as an essential link between academic programmes and clinical practice. They facilitate the development of knowledge, clinical skills, and professional attitudes in nursing through guidance, supervision, role modeling, and the personal development of the student. They also help to orient and socialize the student to the real nursing workplace environment. The literature has revealed that preceptors have varying experiences, which they encounter during their preceptorship role. The experiences include role ambiguity, role conflict and work overload among others. It has been expressed that the preceptorship role assisted preceptors to develop both professionally and personally through re-learning of the skills encountered during the preceptorship role. The preceptors have expressed satisfaction in their role as well as challenges. The literature review also revealed that preceptorship is carried out in other professions such as in the training of teachers where it is referred to as Teaching Practice. This is similar to preceptorship where student teachers observe subject teachers thereby transferring theoretical knowledge into practice.

The literature, however, has fallen short of information on preceptorship in Malawi especially focusing on preceptors. Phuma-Ngaiyaye, Bvumbwe and Chipeta (2017)

focused their study on student nurses where they indicated that preceptorship played a role in enhancing students' confidence and competence. This study, therefore, contributes to the knowledge of preceptorship in Malawi with a focus on the preceptors themselves. Many of the reviewed studies had used either quantitative or qualitative designs alone. The current study utilised a mixed method research design where quantitative and qualitative data were collected at the same time. Therefore, it has contributed to the number of studies with a mixed method design approach on preceptorship. Information regarding years of post-registration experience for consideration to be a preceptor has not been indicated in the literature. This study included this in the quantitative design and has yielded results that contribute to the knowledge of preceptorship as regards levels of confidence. Furthermore, the literature has indicated that the preceptorship model of clinical teaching has mostly been applied in non-resource constrained settings. Although studies have been conducted to explore the preceptorship model, data about resource-limited settings that adopted the approach has been scanty. Therefore, this study provides information as regards the utilization of the model in resource-constrained settings.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter outlines the research design, setting, sampling method, data collection instruments, data collection as well as data analysis procedures of the study. Measures to ensure reliability and validity, including enhancing rigour, ethical considerations, and human subject protection have been discussed. The study focused on assessing the preceptorship model for clinical teaching of undergraduate nursing and midwifery students in Malawi.

3.2 Study Design

The study employed a mixed methods research design (MMR). This is a type of inquiry that is philosophically grounded where an intentional mixture of both quantitative and qualitative approaches is used in a single research study underpinned by pragmatism as asserted by Shannon-Baker, (2016). The pragmatic researcher is able to maintain both subjectivity in their own reflections on research and objectivity in data collection and analysis. According to Creswell and Plano Clark (2007), mixed method research is well suited when the concept under study is new and also where the findings from one approach can be greatly enhanced with a second source of data. Both the quantitative and qualitative approaches have certain weaknesses when they are used in isolation, where for example, the findings of a qualitative approach may not apply to the larger population due to its small sample size and likewise, results of a quantitative study may not provide a clear picture of the complex social world (Ansari, Panhwar & Mahesar, 2016). The integration of the two methodologies, therefore, enables the two research paradigms to complement each other resulting in a stronger research design and a

comprehensive understanding of the phenomenon being investigated. In this study, findings from the quantitative study were enhanced by findings from the qualitative study and helped to provide a more comprehensive understanding of the views of preceptors in Malawi.

The study utilized the exploratory sequential design where quantitative data collection and analysis was done followed by qualitative data collection and analysis and thereafter, data interpretation was done (Figure. 1).

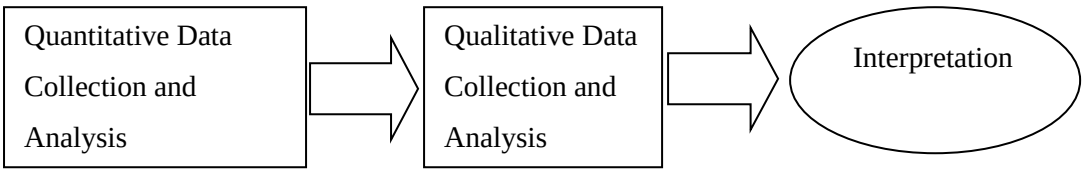

Figure 1: Explanatory Sequential Design (Creswell & Plano Clark, 2011)

The quantitative approach utilized a cross-sectional design while the qualitative approach utilised an exploratory descriptive qualitative design. The cross-sectional survey was considered to be an appropriate approach because little was known about the role of preceptors in clinical teaching in Malawi and there was limited time to collect data for the same. Exploring the preceptors' role was necessary for the assessment of the preceptorship model. The cross-sectional survey, therefore, was appropriate for this study because it allowed the researcher to collect data from a number of respondents at one point in time. Grove, Burns and Gray (2013) argue that cross-sectional studies allow understanding of phenomenon over time when time allowed for the study is limited. Hunter, McCallum and Howes (2018) assert that exploratory-descriptive qualitative design is an appropriate research design to study areas within healthcare practice that have previously received little or no attention. Accordingly, not many

studies have explored the preceptorship model as it is implemented in Malawi and therefore not much was known about this clinical teaching strategy.

3.3 Study Setting

The study was conducted at four central hospitals, namely: Kamuzu, Mzuzu, Queen Elizabeth and Zomba; five district hospitals namely: Chitipa, Karonga, Machinga, Rumphi, Thyolo; one mental hospital: Zomba mental and one mission hospital, Ekwendeni. These institutions are patronized by nursing and midwifery training institutions as clinical sites for students' clinical placements.

The settings were appropriate for the study because apart from being utilized as clinical sites for students' clinical placement, they have preceptors among the nursing and midwifery members of staff. Records from KCN, MOH and MZUNI indicated that some of the preceptors were working in some nursing and midwifery training institutions. As such KCN (Lilongwe and Blantyre campuses) were included as study sites. Data for the study were collected from May 2016 to December 2017 covering a total of 19 months.

3.4 Study Population

The target population included all 211 preceptors working in various institutions utilized by undergraduate nursing and midwifery students as clinical placement sites. The total targeted population was estimated from records of trained preceptors from KCN and MZUNI. Both quantitative and qualitative data were collected from preceptors who met the inclusion and exclusion criteria at the study sites.

3.4.1 Samples

3.4.2 Quantitative strand

The total study population for the quantitative design was estimated at 112. This was determined by utilising a cross-sectional sample size calculation formula (Reid & Boore, 1991), ($n=N/[(1+N(e)^2)]$), However, during data collection period 87 participants were available and using a census, the entire population was recruited for the study.

The inclusion criteria for the cross-sectional survey included: being a registered nurse/midwife, being a preceptor for a minimum of one year post preceptorship training, willingness to participate in the study and working at the selected study settings during the data collection period. The exclusion criteria included those that were not registered nurses/midwives, had not worked as a preceptor for a minimum of one year post preceptorship training, those not willing to participate in the study and a preceptor who was not working in any of the selected study sites.

3.4.3 Qualitative strand

The qualitative design for the study utilized individual face to face interviews and had a sample of 12 participants. This sample size was predetermined prior to data collection due to resource and time constraints since the study sites were allocated very far from each other. The principal investigator recruited the participants by purposive sampling technique at the study sites after the cross-section survey. This assisted in recruiting participants who were well conversant with issues regarding preceptorship who eventually benefited the study with their rich information. Polit and Beck (2012) stated that purposive sampling technique involves selecting cases that most benefit the study. Variations such as registered nurse qualification and years of experience as a preceptor

were considered during the recruitment process. There were six male and six female participants. Participants were recruited based on certain necessary characteristics such as experience as a preceptor and willingness to take part in the study (Creswell & Creswell, 2017). A 32-item checklist for explicit and comprehensive reporting of qualitative studies was utilised in order to report important aspects of the research team, study methods, context of the study, findings, analysis and interpretations (Tong, Sainsbury & Craig, 2007).

Samples in qualitative research tend to be small and Grove et al. (2013), state that sample sizes of 10 to 25 participants are considered appropriate for qualitative data and could even be fewer than 50. Adding to this, the adequacy of the sample size is always determined by the principle of saturation when no new concepts emerge from the review of the data. The inclusion criteria for the face-to-face interviews were based on the experiences of the preceptors. As such, it included preceptors who had precepted for three years or more at a hospital or training institution utilized by undergraduate nursing and midwifery students and participated in the cross-sectional survey. It was envisaged that these preceptors would provide the required information basing on their experiences as preceptors. Face to face interviews were included in order to complement the data that were collected in the cross-sectional survey. Three face to face interviews were conducted with preceptors at two central hospitals, one district hospital and one CHAM hospital (Total, n= 12).

3.5 Data Collection Instruments

3.5.1 Clinical Preceptor Experience Evaluation Tool (CPEET)

Data for the cross-sectional survey were collected utilizing a Clinical Preceptor Experience Evaluation Tool (CPEET). The tool had previously been used in a number

of evaluative studies and had established cross-cultural validity and reliability (O'Brien, 2014). It was used in Australia, Ireland and Canada. This signified that the tool could ably be utilized in studies to do with exploration and evaluation of preceptors and preceptorship anywhere including Malawi since the principles of preceptorship training and utilization of preceptors are similar.

The CPEET had a section on the demographic data of the preceptors that included the preceptors' gender, their registered nurse qualifications, post-registration experience, preceptors' preceptorship training institution and the preceptors' post preceptorship training experiences. The CPEET has four subscales that measure opinion in relation to the preceptor (See appendix 1). The subscales of the CPEET include the role, entailing the relationship between the preceptor and the student, role modeling and participating together; experience and education referring to enacting the role through others in their work environment and linking the student to clinical practice opportunities; satisfaction, which denotes finding time to teach and support the student in clinical practice as well as being motivated and managing one's time to take on the challenge of precepting and finally, challenges which focuses on the challenges faced when implementing the preceptor role into everyday practice.

The CPEET is a seven-point Likert scale that enabled the respondents to rate their level of agreement with 39 items related to the four subscales on the tool. The Likert scale ranged from 1, strongly disagree to 7, strongly agree. Respondents rated their level of agreement within the seven points on the scale. During data analysis, responses between 1 and 3 were considered to be leaning towards strongly disagree and responses from 5 to 7 were considered to be leaning towards strongly agree. Responses at 4 were

considered to be neutral. Permission was granted from Anthony O'Brien for the adaption of the CPEET in this study (See appendix 2). The CPEET was administered in English since the participants were preceptors trained by tertiary institutions whose language of instruction (lingua franca) was English.

3.5.2 Interview Guide

A semi-structured interview guide comprising open-ended questions was utilized in the face-to-face individual interviews (See appendix 3). The guide was formulated by the researcher with reference to literature on preceptorship. Areas of focus included the preceptor's views on preceptor roles, general experience as a preceptor, perceptions on satisfaction with the preceptor role and challenges of precepting.

3.6 Validity and Reliability

3.6.1 Clinical Preceptor Experience Evaluation Tool (CPEET)

According to O'Brien et al. (2014), the CPEET had been previously validated and utilized as a reliable survey tool in a number of evaluative studies. The internal reliability (Cronbach's alpha) for the four subscales of the CPEET was 0.96 for role; 0.79 for education and experience; 0.93 for satisfaction and 0.82 for challenges (O'Brien et al., 2014). These values suggest a relatively high internal consistency of the CPEET. This denotes that the CPEET measured the concept it was supposed to measure and yielded accurate results. The CPEET as a reliable tool had indicated a degree of accuracy (consistency, stability and repeatability) in Australia, Ireland and Canada in its measurements of study attributes. A reliable instrument should provide values with a minimum amount of random error (Grove et al., 2013). It was therefore deemed as a

valid and reliable tool for this study. Content validity was ensured by experts on preceptorship and clinical teaching.

A pretest of the CPEET was conducted prior to the main study where six preceptors possessing similar characteristics to those in the major study and who met the inclusion criteria were requested to complete the tool. This was done to ascertain the simplicity and clarity of questions in the questionnaire and the time it would take to be completed by the respondents. Apart from this, the pretest was also conducted in order to achieve face validity as well as assess the effectiveness of the data collection instrument prior to its use in the main study. The pretest was conducted at Mzuzu Urban health centre in Mzuzu. This health centre is under Mzimba North district health office and is situated in Mzuzu city. It is a busy health centre and is patronized by the surrounding communities including those who come to do business, attend conferences or other assignments in the city of Mzuzu. This health centre is where students from Mzuzu University, St John's, St John of God and Ekwendeni colleges of nursing and midwifery gain their clinical experiences. The health centre has clinical preceptors who assist students during clinical practices.

It was noted during the pretest that the preceptors who took part in the pretest were able to understand and respond to statements on the CPEET with ease. The tool proved to be effective with minor modifications in the demographic data where there was a need to include the preceptors' years of experience after the preceptorship training. This data assisted in selecting preceptors eligible for face-to-face individual interviews. The other modification was done on the duration for the preceptor to complete the tool from a maximum of 24 hours to 48 hours. It was noted that many participants in the pretest

completed the tool after 24 hours. Data obtained during the pretest were not included in the main study.

3.6.2 Trustworthiness (Interview guide)

In qualitative research, it is demanded that several criteria must be met in order to ensure the trustworthiness of the study findings. As noted by Cope (2014), the trustworthiness of qualitative research and transparency of the conduct of the study are crucial to the usefulness and integrity of the findings. In this study, the researcher followed Lincoln and Guba's strategies of trustworthiness (Lincoln & Guba, 1985) to ensure the establishment of trustworthiness for the face-to-face interview. Criteria outlined by Lincoln and Guba on trustworthiness are accepted by many qualitative researchers (Connelly, 2016). According to Polit and Beck (2014), trustworthiness is defined as the degree of confidence in the data, interpretation and methods used to ensure the quality of the study. This is the quality and truthfulness of qualitative research. Trustworthiness is established when findings reflect the meanings according to participants' constructions of the phenomena under investigation. It relates to the degree of trust or confidence readers have in the results. Trustworthiness in this study was established by meeting Lincoln and Guba's five criteria which included credibility, confirmability, transferability, dependability and authenticity (Connelly, 2016; Polit & Beck, 2012; Lincoln & Guba, 1985).

Credibility

This is the confidence in the truth of the findings for specific respondents, which enhances the belief of the findings (Polit & Beck, 2014; Lincoln & Guba, 1985). To make sure that the data collected was accurate or credible, the face-to-face interviews were conducted in an interactive way which promoted rapport with the participants.

The time for interacting with them was prolonged so that more information was obtained. The language of communication was English and there was clear evidence that the respondents understood everything that was communicated. A colleague well versed in qualitative research reviewed the analysis decisions and validated the themes that were formulated. The interviews were audio-recorded and transcribed verbatim and quotes were included.

Dependability

This refers to the stability and reliability of data over time and conditions, which promote credibility in a study (Connelly, 2016; Polit & Beck, 2014). In this study, dependability was achieved through an audit trail, which involved keeping detailed information regarding methodology notes, audio recording, interview notes and data collection instruments. Data were collected from multiple sources and the report was clear with enough information. The study was done with the assistance of a research supervisor. This determined the extent to which another researcher with a similar study would make the same observation with the respondents.

Confirmability

This is a criterion, which refers to the objectivity of the data and interpretation. It is the degree to which the results of the inquiry could be confirmed or corroborated by other researchers (Connelly, 2016; Polit & Beck, 2014). It is concerned with establishing that data and interpretations of the findings are not based on the inquirer's imagination, but are derived from the data. In this study, confirmability was achieved by the researcher's reflecting continuously on his own value bracketing of feeling and beliefs in preceptorship to avoid prior assumptions. An audit trail regarding the process and

analysis decisions including electronic and non-electronic records were kept in order to demonstrate confirmability. They included a reflective diary, transcripts, recorded interviews and field notes

Transferability

This refers to the degree to which the results of qualitative research can be transferred to other contexts with other participants (Connelly, 2016; Polit & Beck, 2014). To facilitate transferability, purposive sampling and thick description was used. A detailed description of the enquiry was provided and participants were selected purposively in order to facilitate the transferability of the inquiry. In addition to purposive sampling, thick description implying that the researcher explained all the research process from data collection, the context of the study as well as production of the final report. A thick description allows other interested researchers to replicate the study with similar conditions in other settings in order to determine the extent to which the overall findings indicated truth about the study process.

Authenticity

This is the extent to which qualitative researcher fully and faithfully shows a range of different realities in the analysis and interpretation of data (Connelly, 2016; Polit & Beck, 2014). This emerges in a report where tones of participants are conveyed and include the mood, feelings, experiences and content of their lives. This was achieved in this study through prolonged engagement by spending more time with participants during data collection and the purposive sampling technique that was used in selecting the participants. Audio taping was done to allow all information to be captured. Data

that were collected is original and correctly interpreted. Details of research findings including quotes from the participants have assisted to ensure authenticity.

3.7 Data Collection

Data for the study were collected between February and July 2017.

3.7.1 Quantitative strand

The principal investigator distributed the CPEET to the respondents by hand for completion assisted by their immediate supervisors such as Hospital Directors, Chief Nursing Officers and District Nursing Officers. The respondents were offered an opportunity to read information pertaining to the study, which included the main objective of the study, voluntary participation, use and storage of data, confidentiality and absence of risks on their part if involved in the study. Afterwards, they were requested to sign a statement of agreement indicating a willingness to take part in the study.

The respondents were provided with a timeline of 48 hours for the collection of completed CPEETs after distribution. They were allowed to complete the questionnaire at suitable locations with privacy to promote willingness to provide as much information as possible. These included special rooms and offices arranged specifically for the study. The respondents were advised to deliver the completed questionnaires to the principal investigator or their immediate supervisor in the event that they had completed the questionnaire earlier than the agreed collection time with the principal investigator. This assisted in preventing data contamination as the completed questionnaires landed in the rightful hands.

3.7.2 Qualitative strand

Face-to-face interviews lasting a maximum of 60 minutes were conducted with the assistance of an interview guide (see appendix 3). The principal investigator purposively selected preceptors who had more than three years experience and had completed the CPEET. Prior to the interviews, informed consent was sought from the participants through a detailed explanation of the objective and how the interviews were related to the cross-sectional survey that they had previously participated in. Thereafter, the participants were requested to sign a statement of agreement to indicate informed consent. Further to that consent was sought on the possibility for publication of their responses anonymously to which all of them were in agreement. Voluntary participation and informed consent ensured that the study complied with ethical requirements. Additionally, the principal investigator ensured the research participants that they could withdraw at any time without facing reprimands. Confidentiality and anonymity of the participants were observed by conducting interviews in private places and using codes for the identification of the participants. The participants were informed that the information they provided would be used to improve services. The interviews were conducted by the principal investigator in English.

Through Chief/District Nursing Officers and hospital research coordinators, special rooms were arranged for the interviews to be conducted. These were rooms that had fewer disturbances in terms of the flow of other members of staff or patients thereby maintaining privacy and confidentiality. Arrangements were put in place that the conversation was not heard outside the rooms during the interviews. An audio recorder was used to capture the data that were provided by the participants. Twelve (12) preceptors participated in the interviews. Field notes were taken to capture all elements

of the interview such as the setting and the participant's emotions and any other non-verbal information that would have contributed to or affect the findings.

3.8 Data Analysis

3.8.1 Quantitative data

Quantitative data were analysed using Statistical Package for Social Sciences (SPSS) version 20 to calculate means (M), standard deviation (SD), frequencies and percentages. These descriptive statistics were computed from the dataset to obtain a profile of the participants and an evaluation of their views on the issues highlighted in the CPEET. Mean and standard deviation were calculated from the scores of the subscales to determine the respondent's level of agreement based on items on the CPEET and were ranked based on the highest mean score. Frequency tabulations and percentages were followed when analyzing the demographic data of the respondents. All questionnaires were eligible for data entry and analysis (n= 87). Consistent with Polit and Beck (2012), a quantitative approach was used to analyze, organize, interpret and communicate numeric information to calculate frequencies and percentages. Descriptive statistics i.e. mean (M) and standard deviation (SD) were computed for each of the four subscales on the CPEET. On each subscale, the scores ranged from 7 (the highest possible average) to 0 (the lowest possible average). Analysis of variance (ANOVA) was used to determine if differences between preceptor scores on the four subscales were due to sex, educational qualification, years of post-registration experience, preceptorship training institution and post preceptorship training experience. Post-hoc analyses were conducted using Tukey's HSD (Honestly Significant Difference) to test the differences in scores. The calculated Cronbach's alpha showed that CPEET was a reliable tool with good internal consistency ($\alpha \geq .6$)

for all its four subscales: ‘Roles’ (α = .87), ‘Challenges’ (α = .70), ‘Experience and Education’ (α = .60), and ‘Satisfaction’ (α = .74).

3.8.2 Qualitative data

Qualitative data analysis refers to the reduction and display of data, verification and drawing a conclusion (Burns & Grove, 2011). In this study, therefore, data were analysed to reduce and display it, to verify it and draw a conclusion. It involved working with the data, organizing them, breaking them into manageable units, synthesizing them and searching for patterns, discovering what was important and what was to be learned. Audiotape recordings of the interviews were transcribed verbatim for the purpose of data analysis. Data were analysed following descriptive, qualitative and systematic six-step method of data reduction described by Creswell (2007). The six steps were:

Step 1: Organizing and preparing data for analysis. In this step, the researcher transcribed the interviews verbatim, optically scanning transcripts and typing field notes.

Step 2: Reading through all the data in order to obtain a general sense of information and reflecting its overall meaning. This step involved the researcher reading all the transcribed data in order to reflect on the responses obtained from the participants and assess similarities in the responses.

Step 3: Detailing analysis with a coding process. Data were grouped based on similarities and different categories emerged based on these similarities.

Step 4: Using the coding process to generate a description of themes for analysis. The researcher utilized the coding process and generated themes from the categories that had emerged in the process.

Step 5: Advancing how description and themes would be represented in qualitative narrative. This involved using a narrative passage to convey the findings of analysis as can be noted in the qualitative results section in chapter four.

Step 6: Making an interpretation or meaning of the data about the lessons learned. In this study, lessons learned included the discovery that participants were involved with dealing with personal problems of students when their core business was clinical teaching as well as participants (preceptors) being sidelined in clinical teaching by faculty members.

Conceptualization of emergent themes was thereafter, conducted followed by searching for connections between the emergent themes. A review of data scripts with the emergent themes was done to identify patterns from one script to the next. Finally, an examination for patterns of similarity across all the data scripts was conducted. Data were then grouped into themes, and common themes were identified across the full data set.

3.9 Data Management

The completed CPEETs were packed in sealed envelopes and access to the collected data was restricted by placing the sealed envelopes in locked cupboards in the principal investigator's office. The data that were entered in a computer were stored in password-

protected files known by the principal investigator alone. This assisted in protecting the participants'/respondents' personal details as well as the information supplied on the CPEET. The audio recorded data were only accessible to the principal investigator and was kept under a locked cupboard in the principal investigator's office. Data was be kept in the principal investigator's office until completion of the study which would not go beyond five years from the commencement of the study. The completed CPEETs were shredded and the audio recorded, as well as the data in computer, deleted.

3.10 Ethical Consideration

One of the responsibilities of a researcher is to conduct an ethical study as such several ethical considerations were taken into account to ensure that this study was conducted in an appropriate ethical manner. These included submitting the proposal for the study to the College of Medicine Research and Ethics Committee (COMREC) for ethical review and approval (Appendix 7). Apart from this, letters seeking permission to conduct the study were written to authorizing officers in all the study sites prior to commencement of data collection and were responded to accordingly (Appendix 8).

Informed consent for completion of the study questionnaire as well as the interviews was obtained from each respondent and participant as an indication of agreement to be included in the study (Appendix 4). The respondents and the participants were fully informed of the study and requested to participate voluntarily without coercion. They were further informed in advance that they were free to refuse to participate or discontinue their participation at any time without any negative consequences. After the explanation, they were requested to sign a written agreement to imply consent.

Obtaining both verbal and written consent from the respondents and participants ensured autonomy on their part.

To achieve fairness, respondents and participants were selected based on the study requirements, not on the vulnerability or compromised position of certain people, culture and other forms of human diversity. The non-prejudicial treatment of those who declined to participate or withdrew from the study after agreeing to participate was observed throughout data collection.

The respondents and participants were informed that the data that were collected were to be used only for the purpose for which it had been approved and collected. Regarding freedom from harm, the respondents and participants were informed that the study would not inflict any physical harm to them. Psychological comfort was a priority during data collection and the questions that were asked were formulated in accordance with the psychological comfort of the respondents. To ensure anonymity and confidentiality, numbers were used instead of names and all data that were collected were secured under lock and key. Privacy and confidentiality of study respondents and participants were ensured throughout the study by collecting data in private places. Respondents and participants were assured that information obtained would not be revealed to anyone bearing their names for privacy sake.

3.11 Strengths and Limitations of the Study

The use of participants with a minimum of three years experience as a preceptor for undergraduate students was considered as a strength since they were well vested with

the preceptorship model. The study settings covered the three regions of Malawi indicating that the results reflected the opinions of preceptors across Malawi.

However, the findings of this study might have been affected by selection bias since the study recruited preceptors who were present in the settings during the data collection period. The use of one CHAM institution was not adequate as a representative of all CHAM hospitals. Finally, the results may have been affected by participants recall bias as participants were asked things or issues that happened sometime back. These should be taken as limitations when considering the study findings.

3.12 Conclusion

This chapter has highlighted the study design where an explanatory sequential mixed method research design was employed. This involved collecting and analysing quantitative data first followed by qualitative data. The study was conducted at four (4) public tertiary hospitals; a mental hospital; Christian Health Association of Malawi (CHAM) hospital and five (5) district hospitals. A sample of eighty-seven (87) participants and twelve (12) participants were utilised in the cross-sectional survey and individual face-to-face interviews respectively. Clinical Preceptor Experience and Evaluation Tool (CPEET) and an interview guide were utilised to collect quantitative and qualitative data respectively. The reliability and validity of the CPEET were determined through Cronbach's alpha scores on previous studies that utilised the tool. Content validity was ensured by experts on preceptorship and clinical teaching while face validity, through pretesting of the data collection tool prior to its use in the main study. Trustworthiness for the qualitative data collection tool was determined through Lincoln and Guba's strategies of trustworthiness which included: credibility,

confirmability, transferability, dependability and authenticity. The chapter has also highlighted measures to determine ethical consideration for the study which included seeking permission from a research review board and authorities in the study settings. Data analysis for the quantitative design was done by computing descriptive statistics of the mean (M) and standard deviation (SD) for each of the four subscales on the CPEET. Frequencies and percentages were computed in determining the demographic characteristics of the respondents. As for the qualitative design data analysis was done thematically following descriptive, qualitative and systematic six-step method of data reduction as described by Creswell (2007). Consolidated criteria for reporting qualitative research (COREQ) were achieved through a 32-item checklist in order to report important aspects of the research team. The following chapter presents the study results and findings for both the quantitative and qualitative designs.

CHAPTER FOUR

STUDY RESULTS AND FINDINGS

4.1 Introduction

This chapter presents quantitative and qualitative results and findings respectively, of a study, which assessed the preceptorship model for clinical teaching of undergraduate

nursing and midwifery students in Malawi. Assessing the preceptorship model involved exploring the preceptorship role in clinical teaching of undergraduate nursing and midwifery students. The quantitative results are presented first, followed by qualitative findings.

4.2 Quantitative Results

Results are presented on the demographic characteristics of the respondents, the preceptors' understanding of their role, preceptors' experience and education, preceptors' perceptions of the effectiveness of the preceptorship model in clinical teaching and challenges experienced by the preceptors when executing their roles. The results were considered based on the mean scores and the relationship between the respondents' characteristics and mean scores on the Clinical Preceptor Experience and Evaluation Tool. They were determined by the frequency of responses to items on subscale domains indicated on the Clinical Preceptor Experience Evaluation Tool (CPEET). These included the role, experience and education, satisfaction and challenges domains.

4.2.1 Demographic characteristics of respondents

This study found out that more than two-thirds of the respondents were female (72.4%, n=63) and had attained their preceptorship training at MZUNI (71.3%, n=60) (Table 1). The majority of the respondents (90.8%, n=79) had a Bachelor's degree. The post preceptorship training experience of respondents varied with less than 10% of them having >6 years (Table 1).

Table 1: Demographic characteristics of respondents

Characteristics		Frequency	Percentage (%)
Sex	Male	24	27.6
	Female	63	72.4
Registered nurse qualification			
	Bachelor's degree	79	90.8
	Diploma	8	9.2
Post-registration experience			
	2 – 3 years	7	8.0
	4 – 5 years	41	47.2
	6 – 8 years	31	35.6
	>9 years	8	9.2
Preceptorship training institution			
	KCN	20	23.0
	MZUNI	60	71.3
	Other	7	5.7
Post preceptorship training experience			
	0 – 1 year	2	2.3
	2 – 3 years	28	32.2
	4 – 5 years	50	57.5
>6 years		7	8.0

KCN=Kamuzu College of Nursing, MZUNI=Mzuzu University

4.2.2 Evaluation of the preceptorship model based on the CPEET Subscales

Four domain subscales were measured and this study found out that the respondents' overall mean scores on the four domain subscales were generally high (M≥5.96, SD=1.3) with the Role domain subscale being the highest (M = 6.29, SD = 1.01) confirming that respondents were confident in performing their preceptor role. The overall mean scores and standard deviations for the other domain subscales were:

Education and Experience (M = 6.02, SD = 1.18); Satisfaction (M = 6.16, SD = 1.22) and Challenges (M – 5.96, SD = 1.3).

Table 2: Preceptors' mean scores for the Role domain Subscale of the CPEET

Item	Score	
	Mean	**SD**
Role domain subscale		
Clinical preceptors promote students' active participation in patient care.	6.68	0.62
Clinical preceptors provide clinical practice supervision for the students.	6.56	0.68
Clinical preceptors facilitate an active learning experience for the student.	6.52	0.86
Clinical preceptors are positive role models.	6.48	0.82
Clinical preceptors are support persons for students during their clinical placement.	6.44	0.90
Clinical preceptors facilitate students to make the links between theory and clinical practice.	6.39	0.88
Clinical preceptors encourage students to apply theory to the clinical situation.	6.32	1.06
Clinical preceptors treat students with respect.	6.29	0.98
Clinical preceptors facilitate students' learning by using case studies and care plans.	6.29	1.06
Clinical preceptors facilitate students to critically reflect upon clinical problems.	6.25	1.22
Clinical preceptors facilitate students to analyze clinical problems.	6.24	1.18
Clinical preceptors provide constructive feedback to the student.	6.24	0.98
Clinical preceptors support students by being available to answer questions.	6.21	1.01
Clinical preceptors' model multidisciplinary teamwork for the students.	6.17	0.96
Clinical preceptors are professional confidantes to students.	5.98	1.29
Clinical preceptors treat students fairly.	5.93	1.34
Clinical preceptors are professional friends to students.	5.93	1.38
Overall role domain subscale score	**6.29**	**1.01**

The findings in the Role domain subscale showed that respondents scored high on the item "clinical preceptors promote students' active participation in patient care" (M=6.68, SD = .62). The results further indicated that the respondents scored relatively low on the item "clinical preceptors are a professional friend to students"

(M = 5.93, SD = 1.34), indicating some distance in the working relationship between the two groups (Table 2).

Table 3: Preceptors' mean scores for the Experience and Education domain Subscale of the CPEET

Experience and education domain subscale	**Mean**	**SD**
Being a preceptor helps to expand my nursing knowledge.	6.78	0.49
Being a preceptor, I need to know what the expected level of skill competence should be for a student's scope of practice.	6.55	0.73
Being a preceptor facilitates professional reflection on my own roles as a nurse.	6.32	1.13
Being a preceptor challenges my work attitudes.	5.69	1.73
Clinical preceptors clarify the role of a preceptor with colleagues regularly to ensure the needs of the students are met.	5.39	1.54
I read updated texts and journals regularly.	5.38	1.45
Overall experience and education domain subscale score	**6.02**	**1.18**

The results in the Experience and Education domain subscale indicated that respondents scored highest on the item "being a preceptor helps to expand my nursing knowledge" (M =6.78, SD = 0.49), which was also the highest score for the four domain subscales on the CPEET. This indicates the benefit of the preceptorship role to the respondents. This domain subscale further indicated that the respondents scored relatively low on the item "I read updated texts and journals regularly" (M = 5.38, SD = 1.45) indicating that the respondents were not reading updated texts and journals regularly as required in their role as preceptors (Table 3).

Table 4: Preceptors' mean scores for the Satisfaction domain Subscale of the CPEET

Satisfaction domain subscale	**Mean**	**SD**
It is stimulating to work with enthusiastic nursing students.	6.47	0.99
I enjoy facilitating novice nurses to develop as professionals	6.45	0.94
Being a clinical preceptor is an incentive for my own professional development	6.40	1.09
I enjoy the student/preceptor interaction.	6.38	0.85
Being a preceptor is meaningful.	6.31	1.21
Being a preceptor is satisfying.	6.01	1.34
The clinical preceptors' experience breaks the monotony of daily nursing practice.	5.91	1.34
The preceptor role is an incentive to teach.	5.89	1.51
The role of the preceptor is professionally rewarding.	5.66	1.78
Overall satisfaction domain subscale score	**6.16**	**1.22**

The Satisfaction domain subscale has shown that the respondents scored highest on the item "it is stimulating to work with enthusiastic nursing students" (M = 6.47, SD = 0.99) and scored relatively low on the item "the role of the preceptor is professionally rewarding" (M = 5.66, SD = 1.78) implying that the preceptorship role is somewhat emotionally rewarding. It can also be noted that there are high mean scores on other items in this domain, reflecting satisfaction with the preceptorship role (Table 4).

Table 5: Preceptors' mean scores for the Challenges domain subscale of the CPEET

Challenges domain subscale	**Mean**	**SD**
Though I am very busy, I am willing to be a preceptor.	6.56	0.89
It is acceptable for students to clarify with the preceptor when there is a difference in practice.	6.45	0.79
I am willing to make time to support unmotivated students.	6.31	1.10
Personality clashes will not negatively affect my attitude towards a student.	6.06	1.32
Being a preceptor will not take my time away from providing direct patient care	6.06	1.40
I am motivated to precept students.	5.92	1.50
Being a preceptor is not time-consuming.	4.39	2.12
Overall challenges domain subscale score	**5.96**	**1.3**

The findings in the Challenges domain subscale revealed that the respondents scored highest on the item "Though I am very busy, I am willing to be a preceptor (M = 6.56, SD = 0.89) indicating interest in the preceptorship role. However, the respondents scored low on the item "being a preceptor is not time consuming" (M = 4.39, SD = 2.12) indicating that the majority of respondents considered the preceptorship role as time consuming (Table 5).

Further analysis using one-way ANOVA was conducted to determine if there were any significant differences in respondent scores on the four subscales based on their demographic characteristics. The findings revealed that there were significant differences in the respondents' mean scores on the role domain subscale (F (2, 84) =3.7, p=0.03) (Table 3). The differences in the respondents' mean scores on the experience and education domain subscale (F (2, 84) =2.96, p=0.06) in relation to their post-registration experience, approached significance. However, results showed that

there were no significant differences ($p>0.05$) in the respondents' mean scores on the role domain, experience and education domain, challenges domain and satisfaction domain subscales in relation to other characteristics of respondents (Table 3). Post hoc comparisons using the Tukey HSD test indicated that the role domain mean scores for the respondents with 4-5 years of post-registration experience ($M = 6.61$, $SD = 0.36$) was significantly different ($p=0.02$) than those with >9 years ($M = 6.13$, $SD = 0.60$). However, role domain mean scores for respondents with 6-8 years of post-registration experience ($M = 6.30$, $SD = 0.60$) did not significantly differ from those with 4-5 years of post-registration experience.

Table 6: Relationship between respondents' characteristics and mean scores on the Clinical Preceptor Experience Evaluation Tool

Respondents' characteristics	ANOVA Statistics											
	Role domain subscale			Experience and education domain subscale			Challenges domain subscale			Satisfaction domain subscale		
	F	Df	P	F	Df	P	F	df	p	F	df	P
Sex	0.39	1,85	0.54	0.76	1,85	0.39	0.02	1,85	0.90	0.14	1,85	0.71
Post registration experience	3.7	2,84	0.03*	2.96	2,84	0.06	2.65	2,84	0.08	2.4	2,84	0.10
Education qualification	1.78	1,85	0.19	0.39	1,85	0.53	0.65	1,85	0.42	0.05*	1,85	0.83
Preceptorship training institution	0.33	2,84	0.72	2.18	2,84	0.12	1.88	2,84	0.16	1.83	2,84	0.17
Post preceptorship training experience	0.79	3,83	0.50	0.89	3,83	0.45	1.67	3,83	0.18	1.48	3,83	0.23

*=significance level set at ≤0.05

4.3 Conclusion

Quantitative strand in this study indicated that the respondents' overall mean scores on the four subscales were generally high (M≥5.96, SD=1.3) with roles domain subscale being the highest (M = 6.29, SD = 1.01) confirming that respondents were confident in performing their preceptor role; with a good level of experience and education qualification; having good ability to deal with challenges and had high levels of satisfaction. The findings of this study further showed that respondents scored highest on item: "being a preceptor helps to expand my nursing knowledge" (M =6.78, SD = 0.49) of the experience and education domain subscale. In addition, this study revealed that respondents scored lowest on item: "being a preceptor is not time consuming" on the challenges domain subscale (M=4.39, SD=2.12). Analysis using one-way ANOVA revealed that there were significant differences in the respondents' mean scores on the role domain subscale and the experience and education domain subscale in relation to their post-registration experience. The results showed that there were no significant differences in the respondents' mean scores on the role domain, experience and education domain, challenges domain and satisfaction domain subscales in relation to other characteristics of respondents. Post hoc comparisons using the Tukey HSD test indicated significant differences in the role domain mean scores for respondents with 4-5 years of post-registration experience and those with >9 years.

4.4 Qualitative Study Findings

Qualitative findings of the study have been presented based on the narratives from the participants on their experiences as preceptors for undergraduate nursing and midwifery students. Three themes emerged from the data and they included preceptor perceptions of the preceptorship role, roles of a preceptor and challenges experienced by a preceptor

during the preceptorship role. Subthemes originated from each of the main themes. These are reflected in table 6 followed by narratives of the same.

Table 7: Themes and Subthemes

	Themes	**Subthemes**
1.	Preceptor perceptions of the preceptorship role	1. Perceptions of the preceptorship experience 2. Perceived benefits of the preceptorship role
2.	Roles of a preceptor	1. Facilitation of students learning 2. Student Support and role modelling 3. Evaluative role
3.	Perceived challenges of the preceptorship role	1. Preceptor – faculty relationship. 2. Supervision of students 3. Shortage of resources

4.4.1 Preceptor perceptions of the preceptorship role

This study revealed that preceptors had varying views of the preceptorship role. Their perceptions were based on two subthemes which included the experience they have had as they executed their role as well as the benefits following their involvement in the preceptorship role as described below:

Perceptions of the preceptorship experience

Some preceptors perceived their role as a good experience as expressed by one of the participants who said:

> *Yeah, the experience is very good because once the students know that you are the preceptor; they actually respect you. They treat you as one of the lecturers and then whatever you tell them, they listen and if you*

> *give them like assignments, they carry them out and then they are always calling for you to help them so I feel like I am being respected …Apart from this, some students who are challenged, I am able to approach them in a manner that the learning is enhanced unlike confronting them, the way I used to do sometimes back* (Participant 005).

This is supported by another participant who acknowledged that the preceptorship experience had been good due to the preceptorship training he had as it assisted him to know what to do in terms of clinical teaching by stating that:

> *The preceptorship exercise has made us know where we are supposed to be and what we are supposed to do when students come. We now know that our duty is to assist with clinical teaching in the clinical area and that if there is anything that we can do in the classroom, it has to do with hands-on activities such as demonstration and the like.* (Participant 008).

This participant hailed the preceptorship role as being good because it accorded her the opportunity to know the students better by saying:

> *In general, as a preceptor I have had the opportunity to conduct clinical teaching of students when I realized that some are slow learners, some are active and some do not follow instructions while some are self-starters.* (Participant 010).

However, some of the preceptors perceived the preceptorship role as time consuming and a disturbance to their core business of patient care. For example, one of the participants had this to say pertaining to time:

> *Being a preceptor is time-consuming because I have different roles to partake. I am the ward manager, I have to look at the patients, I have to look at the students so there are many things taking place at once. A student wants this, a patient wants this, my bosses need this…* (Participant 001).

These sentiments were supported by another participant who said:

> *Like in this ward, I am the in-charge and I am involved in so many roles. For example, when it comes to ward administration and other*

> *responsibilities, all of them fall on me such that the time factor becomes a problem* (Participant 004).

The issue of time prevented many preceptors from having adequate interactions with students as expressed by this participant who said:

> *The challenge of time disturbs our interaction with the students because the contact with the students need to be at least several hours per week and you need to be meeting maybe up to ten students for at least two or three hours for each student. However, because of the many roles that we have, it gives us a lot of challenges in terms of time* (Participant 003).

This observation is supported by another participant who stated that:

> *As a care provider you know, patients need you to provide that care and also you have students, some of them maybe it is their first time to come for clinical practice. And also, you see that even staffing, maybe you are alone at the facility so you have a challenge to say, should I concentrate on assisting the students or to do patient care* (Participant 010).

The same is supported by this participant who seemed to put his core business of patient care first by stating that:

> *I have a lot of students but first of all, I have work…my core business which is to provide patient care. From there I have to supervise students* (Participant 011).

However, another preceptor indicated that she did not perceive the preceptorship role as time consuming because to her, she was of the view that the two roles namely, her primary function of taking care of patients and the preceptorship role took place concurrently. In support of these views, the following was stated by the participant:

> *On my part, I don't see preceptorship as being time-consuming because assuming I am taking care of a woman in labour. I will be doing my day-to-day duty so the student will just be observing while I am fulfilling my core business of the day* (Participant 003).

The study found that preceptors perceived preceptorship as an additional role to their core role of patient care as noted by this participant who stated that:

> *...mmm preceptorship…being kind of an extra load to us we have challenges to allocate time to students… who are also in large numbers as well as time for the core role of patient care. Some of us are also into management…so it is really a challenge* (Participant 012).

The study findings also revealed that although preceptorship is perceived as an additional workload, there is no remuneration for the additional role as the verbatim quote illustrates.

> *…they come as novices, you train them…mmm …as a person even though you are busy eh eh…that's another extra-role…however, there is nothing which comes as an addition…I mean rewards, such as an allowance* (Participant 006).

Perceived benefits of the preceptorship role

Preceptors indicated several benefits obtained by virtue of their involvement in the preceptorship role. These ranged from upgrading themselves professionally as well as being updated in knowledge and skills. This was expressed by many participants and one of them stated that:

> *As a preceptor, I have personally updated myself because as I teach students, I also remind myself to do the right and correct things at the right time* (Participant 009).

Apart from this, another participant included learning new trends in clinical teaching and supported this by stating that:

> *Generally, the experience is good because I also update my skills, my knowledge as well as learn the new trends of what to teach the students* (Participant 011).

Preceptors utilized the preceptorship role as a means of perfecting their skills clinically as they learn new trends in the profession while teaching the students. In the process, they also learn from even the students especially on current issues in the profession

thereby being updated on such issues in the profession. This is what one of the participants said in support of this:

> *I am still a bedside midwife so I am still perfecting my skills and every day I am learning new things through teaching and the experience from even the students themselves because things are changing right now so I would say I am happy with my role as a preceptor because I am benefitting a lot* (Participant 008).

Preceptors seized the opportunity of being involved in the preceptorship role to develop themselves professionally. This was through reading in order to respond to questions and needs of students as a way of disseminating current information to the students. This was expressed by this participant who stated that:

> *I think as a preceptor, it shows that one needs to read widely so that when the students ask questions, there is a need to be familiar with the information to be given to the students in response to what they may ask* (Participant 006).

The findings in this study indicated that involvement in the preceptorship role was a contributing factor to some of the preceptors to develop an interest in teaching as well as a commitment to teaching the students. This was observed by one of them who stated that:

> *I have now developed an interest and commitment in teaching because I know if a student fails, it is me who has contributed to his/her failure somehow* (Participant 002).

Apart from being interested in teaching, the preceptors indicated that their involvement had assisted them to know how to handle students while in the clinical area as stated by another participant who said:

> *The wonderful part of it is that you know the students better in the process of following them in whatsoever they have come up with* (Participant 012).

The preceptors indicated the benefits of the preceptorship role to include knowledge on different types of students which included those that are regarded as challenged students. They indicated that the preceptorship training they underwent assisted them to consider and assist these types of students while in the clinical area as noted by this participant who said:

> *During the preceptorship training, a topic about challenging students taught me that a preceptor is there to accommodate each student and try to assist every student so that no one is left out up until they finish* (Participant 004).

This study has revealed that many preceptors improved their provision of patient care through their involvement in the preceptorship role. Preceptors agreed that being preceptors for students assisted them to improve the care they provided to their clients. This was so because they wanted to provide the best care to the clients so as to allow the students to learn the correct and safe way to conduct the procedures from them as stated by this participant:

> *It is satisfying to work as a preceptor because as a preceptor, I will see to it that the care I provide to the client is of up to date or of high quality. After all, I want my students to observe the ideal things. So because of that, I will be updating my skills as a midwife, by seeing to it that I read a lot in order to provide the ideal care for the patient. This means that I will be improving my skills while assisting the students* (Participant 003).

Preceptors indicated that the benefits of the preceptorship role were not really about monetary issues but when they met a student whom they felt was not ready to achieve what is supposed to be and they supported and intervened in their capacity as preceptors, and saw the student succeeding in what he/she was doing, to them that was the greatest source of satisfaction and beneficial. In relation to this, one of the participants stated that:

> *There is no monetary satisfaction but I am always happy to note the works of my hands on the students as they succeed in the clinical area* (Participant 008).

Another participant supported this with an addition on comparing the student's status from the time they report to the clinical area for the first time to the time they finish their allocation by stating that:

> *Apart from upgrading myself in terms of knowledge and skills, I get satisfied when I see students improving their skills and compare with the time they had just arrived in the clinical area. For example, they are not sure of what they are supposed to do during the first day in the clinical area and gain knowledge and skills as time goes. At the end of the allocation, I feel great when I see that there is a very big impact in terms of skills and of course, some knowledge gained in a real-life situation* (Participant 011).

However, other preceptors stated that they are not fully satisfied with their preceptorship role as they regard satisfaction in form of tangible rewards. He defended his views on rewards by saying that the preceptorship role is different from their core role as stated in the following narrative:

> *To me, of course, I regard satisfaction with incorporating something such as an addition towards wages since being a preceptor is another role but there is nothing, which is done. It could have been better if the institutions that send students here could have been adding something to our salaries* (Participant 006).

Preceptors felt satisfied when they were involved by the institutions that send students to their hospitals. The involvement was in form of letting them work with the faculty during skills laboratory sessions, involvement during assessments and other activities involving students at the college level. This participant supported this by stating that:

> *The motivating part is that the college itself is able to…like indulge us in different activities that involve the students such as Objective Structured Clinical Evaluation (OSCE)* (Participant 008).

Apart from being involved by the training institutions especially during activities in the skills laboratory, preceptors felt satisfied by the recognition they received from the students. This was through students' accepting them as they do with faculty members and confiding in them as people who were helpful in the clinical area. One of the participants supported this by stating that:

> *As a preceptor, you are at least recognized by the students who say this is our Tutor. When you are making frequent follow-ups, the students say, this one wishes us well so professionally, you are recognized. Students see you as someone they can easily interact with. Someone who can be regarded as their role model* (Participant 008).

Another participant supported this and added that being recognized by the students has eased up the tension they had in controlling the students and feel respected as students are able to heed their advice as stated in this narrative:

> *Before, when they were not informed that they would meet preceptors, the students were very difficult to control. But this time around they are introduced to us as their preceptors and because we are known to them, they take our advice and if they wanted to do something that was a shortcut, they would not do it in our presence. So, controlling student behaviour is now possible because the students have respect towards preceptors* (Participant 002).

4.4.2 Roles of a preceptor

Roles of a preceptor was among the themes that emerged from the qualitative data where preceptors narrated how they assisted student learning in the clinical area. They indicated that these roles were executed through facilitation of students learning, supporting students through role modelling and the execution of evaluative roles as described below:

Facilitation of students learning

Preceptors indicated that while in the clinical area, they facilitated learning through teaching students based on their objectives as well as the challenges that the students experienced while in the clinical area. The preceptors assisted the students to relate the theory learnt in class to the practical aspect in the clinical area. The teaching included demonstrations of various procedures performed in the skills laboratory at the institution. These are the ones the students are taught in the classroom and are likely to encounter in the clinical setting.

In support of the teaching role with reference to the student's daily objectives, demonstration and observation, one of the participants stated that:

> *As a preceptor, I have to see to it that the students have an objective they want to achieve on that day and I usually plan to work with each student according to his/her objective in order to fulfill that daily objective. I have to demonstrate some of the procedures that are done in the ward for the students to observe then I observe each student performing the same procedure and I do assist according to one's challenges* (Participant 003).

The preceptors expressed that they had a role to ensure that the students were able to practice or perform what they learned and practiced while in the college skills laboratory. They observed the students and taught each one of them as required. This participant supports this by stating that:

> *Whenever I feel that maybe they have not done any procedure well, I am there to correct them so that next time they should do it correctly* (Participant 004)

On the teaching role with reference to assisting students to connect theory into practice, another participant stated that:

> *Yeah, my role is to teach students in the clinical area. That is to help them connect the theory part and the clinical part* (Participant 005).

The teaching role was indicated by several participants in the study as narrated by this participant who attributed teaching as his other role by stating that:

> *My other role is that of a teacher. I need to teach the students when they come here, transforming the theory aspect into the practical one* (Participant 006).

This participant supported this and included demonstrations in the skills laboratory. She further indicated a duration used on clinical teaching of the students by stating that:

> *Basically, my role is to do with clinical teaching. Be it in the skills laboratory conducting demonstration as well as at the clinical site. So, it is 80% of my time or I can say 80% of my whole day is mainly in the clinical area* (Participant 008).

Student Support and role modelling

This study found that preceptors rendered support to students as part of the preceptorship role. This included facilitating students to make links between theory and clinical practice apart from assisting them in times of professional as well as personal needs. As students progress in their studies, they meet several challenges that make them compromise their studies due to these challenges, especially in the clinical area. While there they rely on the preceptors for support as expressed by this participant who stated that:

> *Ok, most of the time we teach the students on different types of procedures according to their objectives at that particular time and what they learned in the classroom; and again if a student has any challenges, that challenge is addressed to the preceptor in order to help that particular student* (Participant 001).

Student support also included handling and sorting students' personal issues as expressed by the same participant (001) who stated that:

> *For example, there are cases whereby a student is on duty and maybe a funeral happens at their home, the issue comes to the preceptor and you have to sort out that issue* (Participant 001).

The preceptors indicated that they advocated for the students while in the clinical area. The advocates include liaising with management from their institutions for resources and other pertinent materials that they require in order to have a conducive learning environment. On the advocate role, this participant stated that:

> *My other role is as an advocator for the students, maybe they are lacking some resources so I need to look for resources for them, maybe they have some needs, you need to work from there, for them* (Participant 006).

Preceptors supported the students in the learning process by ensuring that they had what was required in terms of achieving their daily learning objectives as explained by this participant:

> *I have to see to it that the student has an objective they want to achieve on that day and I plan to work with each student according to his/her objective to meet his/her daily objective* (Participant 003).

Preceptors observed the students and identified weak or students who faced some difficulties in the learning process and found means of assisting such students in order for them to achieve their goal at the end of their clinical allocation as noted by one participant who stated that:

> *During the preceptorship training, we were exposed to topics about students who meet challenges in the clinical area and how to handle them. Before I became a preceptor, I could not know what to do with such students but now I am able to handle them successfully most of the times* (Participant 004).

Preceptors included supervision of students while in the clinical area as some of their supportive roles to the students. They agreed that they were fully involved in this role as most of the times, the students were in the wards with them than with faculty members. Supervision is regarded as one of the important roles in preceptorship as noted by one of the participants who stated that:

> *When they are doing their procedures, I am there to supervise them. Whenever I feel maybe they have not done well I am there to correct them so that next time they should do it correctly. Yeah, the other one is allocating or providing tasks to the students that today maybe you are doing admissions, today you are going to do dressings etc.…according to their overall and daily objectives* (Participant 004).

In summary on student support, this participant expressed the need for preceptors to orient the students and creation of a conducive learning environment by stating that:

> *When students are in the ward preceptors should orient them, review their objectives together then create a conducive environment for the success of their clinical learning process* (Participant 004).

Preceptors were also aware that while working with students, they acted as role models either knowingly or unknowingly. They agreed that students copy from them during their interactions whether the action being copied is positive or negative professionally. This was noted by this participant as expressed in the following statement:

> *Of course, a preceptor is supposed to be a role model professionally. Being a role model, when the students come, whatever you do for example doing a different thing such as not putting on a full uniform, they copy that so one is supposed to be a good role model* (Participant 006).

This was concurred by this participant who related role modelling to experience by stating that:

> *To start with, being somebody who is qualified and you are already in the system, you present yourself as a role model to those who are joining the profession* (Participant 007).

Role modeling was regarded by the preceptors to be a way of instilling professionalism to the students while in the clinical area as stated by this participant that:

> *One needs to instill that professionalism status into the students by making sure that they put on a full uniform and that they behave according to the nursing and midwifery profession. You know being a preceptor, you are someone who most of the times, the students imitate from* (Participant 010).

Evaluative role

Preceptors indicated that they were involved in evaluating students in the clinical area. However, there were mixed reactions to the evaluation role as other preceptors indicated that though they were aware of their evaluation role, they felt that they were either fully involved or not involved at all in this activity. This participant agreed to being fully involved by stating that:

> *At the end of their (students) clinical practice, I am involved in assessing the students to ensure that there is an objective assessment that is done to the individual student. If they are doing an individual case, there has to be a preceptor together with someone from the institution so that there is objectivity in the assessment of these students* (Participant 008).

Other preceptors indicated a lack of involvement in the evaluation of students despite their knowledge that this was part of their preceptor role as noted by this participant who stated that:

> *On my roles as a preceptor, I am aware that evaluation is part of my roles but since I graduated as a preceptor, I have never taken part in that. I have never been involved. But I feel like it is one of the roles that I need to carry out. I recall the other time we had students here then there was time for evaluation. I just heard that the students are being evaluated. So it was the lecturers taking the students, evaluating them and then off they went and it was hard for me to actually…meet the lecturers to ask why they did not involve us…because they were not in the ward with the students. The students were in the ward with us full time. The involvement in evaluating the students is not there, according to my experience* (Participant 005).

This, however, was in contrast with Participant 002 who indicated partial involvement in student evaluation by stating that:

> *Yes, of course, I am involved in students' evaluation even though not always* (Participant 002).

4.4.3 Perceived challenges of the preceptorship model

This study found that there were challenges experienced by preceptors during the preceptorship role. These included preceptor-faculty members relationship, supervision of students and shortage of resources.

Preceptor-faculty members relationship

Preceptors mentioned a lack of a good working relationship with faculty members in the clinical area in terms of working together. They indicated that some lecturers do not recognize their presence and this made their work to be challenging as expressed by this participant who said:

> *Frankly speaking there, we don't do most of the things together…they just come, do whatever they want to do with the students, off they go, that is in most cases. We have ever had meetings on this…but they would not work with the preceptor* (Participant 004)

On the same working relationship with faculty members, preceptors expressed that it would be appropriate and necessary if the preceptor and the faculty members would work together as this would also make the students recognize the preceptors' importance as noted by this participant who said that:

> *When the lecturers come, I feel it will be necessary if we work together so that the students would appreciate that this one is maybe representing my lecturer as I am in the ward* (Participant 005).

Another participant agreed to this lack of working together between preceptors and faculty members as a challenge by stating that:

> *One of the challenges is the lack of coordination between me and the school where the students come from* (Participant 007).

This was corroborated by another one who indicated that the working relationship between the preceptors and faculty members was not effective by saying that:

> *So… it's quite challenging because even the kind of coordination that's there between us and the staff from the colleges where the students come from it's really not that effective* (Participant 009).

This participant agreed that preceptors do not work hand in hand with faculty members and this makes it hard for the preceptors to deal with students who misbehave while in the clinical area:

> *We don't work hand in hand with Lecturers. And so, because we don't do that when a certain student misbehaves, it's hard to like…to report because you don't know where to go and the like yeah…* (Participant 005).

Another participant suggested an improvement on coordination between members from service institutions and training institutions by saying that:

> *We need to improve on the coordination between the hospital staff and the institutions where the students come from* (Participant 009).

Preceptors reported conflict with colleagues who are not preceptors and attributed this as one of the contributing factors to lack of clinical teaching in the event that the preceptors are not available. These are colleagues who are unwilling to teach or respond to questions from students as stated by one of the participants who said:

> *The other challenge, I think it's not much connected to preceptors but then some of the qualified staff…they don't want to take part in teaching the students because they feel like… this one went for preceptorship…so she is the one to teach the students. So, if you are not there…if the students ask them anything…they say no, wait for the preceptor* (Participant 005).

These sentiments were supported by another participant who indicated that some of their colleagues were not willing to assist them with clinical teaching because they felt that the preceptors deliberately ignored their duty of patient care and she stated that:

> *Challenges of being a preceptor include those from fellow staff here in the sense that when you ask them to assist the students with teaching because you are tied up, they react negatively thinking that maybe you are running away from the core duty of patient care* (Participant 006).

This participant described the unwillingness of his/her colleagues to assist with teaching the students by relating this behaviour to preceptorship training by stating that:

> *Then another issue is that at times there is no support from the colleagues who have never done such a training (preceptorship) because if you have done that training, some other people (*colleagues*) feel like since you are the one who has undergone this training then everything to do with students is for you* (Participant 007).

According to this study, preceptors expressed lack of recognition by faculty members from training institutions. Apart from this, preceptors felt the faculty members were not interested to collaborate with them when they visited the clinical area as stated by this participant:

> *On recognition from faculty members, I would say there is none. There is no recognition or involvement on the issue of students' placements as well as clinical teaching* (Participant 004).

One of the participants indicated that some students were not recognizing her as a preceptor because of her age and some lecturers treated her as any other nurse, not as a preceptor. She supported this by stating that:

> *Mmm…as I said, sometimes I encounter some challenges with the students who just see me as their age mate, not a clinical teacher …and again …mmm I encounter some teachers who don't recognize…they don't recognize me as a preceptor they just take me as any other nurse in the ward… they just come and look at whatever the students are doing and off they go* (Participant 001).

In the same vein, the participant went on to state that some faculty members did not recognize assignments given to students by preceptors. She supported this by stating that:

> *Ah! ah!…like there was this other time when I gave like a case for the student to do but the teacher comes started shouting at the…eee…student why are you doing this he! he! he! you are not supposed to do this… you are not supposed to do that…but it was me who gave…yeah so it is like … some teacher conflict of interest yeah it was… are like we are on conflict…most of the time….* (Participant 001)

On recognition, another participant indicated lack of preceptor involvement when the faculty members visited the clinical area as noted in this narration:

> *…students recognize me but as for lecturers… not really… not really…there is no recognition from the lecturers. They come, work with the students without involving me* (Participant 003).

This participant agreed on lack of recognition from faculty members with an addition on the importance of preceptors working together with faculty members by stating that:

> *…they would just come, meet the students…but they will not work with the preceptor. Working together with them would make us improve on our clinical teaching especially on our working relationship with students…I think* (Participant 004).

Supervision of students

Preceptors expressed infrequent students' follow-up in the clinical area by the faculty members. They felt that institutions left the responsibility of teaching as well as supervision in the hands of preceptors as stated by one of them that:

> *Most of the times the faculty members would say we have come with the students and then off they go. They don't come to follow up and leave all the responsibilities to me. They just dump the students and off they go until closer to the end of the allocation when they give you evaluation forms and ask you to assess them. I think what we need to do is to work closely together with them throughout the time the students are allocated in the clinical area and they should be coming to find out how the students are progressing* (Participant 006).

This participant agreed with these sentiments on clinical supervision of students by indicating lack of support from training institutions as narrated in the following quote:

> *…but mostly its lack of support from may be the colleges that actually send students here in terms of supervision and direction as sometimes students come without objectives* (Participant 009).

Participants elaborated further on clinical supervision indicating that discussions have taken place between faculty members and preceptors on the need for the faculty members to follow up on students when they are allocated in the clinical area as stated by one:

> *Of course, when they come we try to talk to them to say please make sure you come here once or twice a week so that we can share the challenges that we face…we can handle these students together…mmm…can also learn or update from the lecturers on how to handle students. But most of the times they don't even come. Some just send their students here. The students stay here for maybe up to two weeks without coming for supervision so that's the major challenge that we are facing at the meantime... It may happen that you have ten students so for you to follow up with each and every student, it becomes a problem* (Participant 009).

Another participant corroborated the same and attributed the lack of clinical supervision by faculty members to contribute to challenges faced by preceptors in their core duty of patient care due to large numbers of students available in the clinical area at a particular period. The unavailability of faculty members made preceptors to be overwhelmed with caring for patients as well as assisting students as has been narrated in this quote:

> *In terms of supervision, I face a bit of challenges. I have a lot of students. First, I have work…my core business is to provide patient care. From there I have to supervise students. It's easy to supervise students that I have right away in my department, but when it comes to following the students in the other departments, that's when I face challenges because sometimes, they have not been monitored for a while…* (Participant 011).

This participant commented on the large numbers of students and compared it to the number of preceptors available to assist or supervise the students by saying:

> *The students are just too many…sometimes you are just alone on duty…you are working with first-year students that will actually need supervision for each and every activity that they are carrying out* (Participant 002).

The increased number of students was also commented by another participant who included this as one of the challenges faced by preceptors in the clinical by saying that:

> *Challenges are there. Eeh! one of them being the large numbers. They increased the intake and…eh…the…but I think the resources… are almost the same. You can talk of human resources…. we meet large groups of students and we only have five days in a week for to…like to make sure that every student meets the need. It's not easy. At the end of the day, you end up ah…maybe seeing two students because you want to deliver.* (Participant 008)

Non-reporting of faculty members for supervision contributed to preceptors having an extra number of students from their scheduled one as explained by this participant:

> *I need a certain number of students. But maybe because ah…these other students who have been allocated to a certain Lecturer who is not reporting, I am also forced to pick them because I can't just leave them. However, at the end of the day, it seems like I have a larger group of students yet I was allocated a smaller group.* (Participant 008).

Shortage of resources

In this study, shortage of resources was among the identified subthemes. These included human resources in terms of preceptors and materials. These shortages were attributed as contributing to the preceptors' challenge of following up students in the clinical area as stated by one of the participants who said:

> *Another challenge ...yeah maybe another challenge, it's few ...few preceptors…I am the only one in this ward…in number, we are around five which is not adequate…we need more preceptor trainings…maybe the other challenge about the students* (Participant 004).

This sentiment was supported by another participant who said:

> *I think we need more trainings of preceptors so that others should undergo a training…ah…no…yeah because of the work overload because two cannot manage to be in every ward so it is really needed…maybe three, four, five…or more so that in each ward there should be one or two...* (Participant 002).

Another participant agreed with the smaller number of preceptors and related it to the inadequate preceptor-student ratio by saying:

> *The other one is that if you look at the ratio between the preceptors' trained ones rather and the number of students…who are coming to the facility where these preceptors are working, you see that the gap in the ratio is just too huge* (Participant 004).

In support of this, one of the participants said:

> *Especially when you have large numbers of students coming to your facility and maybe to your department maybe you have ten students against one preceptor…* (Participant 010).

This participant included shortage of staff in general including the one involving service institution staffing levels by saying:

> *You see that even staffing levels, maybe you are alone at the facility so you have a challenge to say…where do I start from...*(Participant 010).

Preceptors indicated challenges in terms of support from training institutions as regards resources as stated by one of the participants that:

> *Mostly its lack of support from may be the colleges that actually send students here. This is in form of resources such as gloves, aprons, masks and other equipment to enable us to teach the students objectively* (Participant 002).

This was also expressed by another participant who stated that:

> *We are meeting a lot of challenges…resource issues…you see that it is full of improvisation. In so doing, it's like you…the optimal level of that knowledge and skill that you are transferring from you being a preceptor to those students is kind of compromised* (Participant 007).

This was supported by one of the participants who stated that:

> *Challenges of resources where students may come without maybe resources such as aprons, masks and so on…and they have to use the limited resources that we have at the facility* (Participant 010).

4.5 Summary of Findings

Chapter four (4) has reflected on the study results and findings as regards the demographic characteristics of the respondents where it was indicated that the study had more female (72.4%, n=63) than male participants. It has been noted that many of them did their preceptorship training at MZUNI (71.3%, n=60) and the majority of them had 4 to 5 years' post-registration (47.2%, n=41) and post preceptorship training (57.5%, n=50) experiences. The study findings also supported the use of the CPEET as a reliable tool in Malawi as evidenced by the calculated Cronbach's alpha scores of the tool.

Quantitative results interpreted through mean scores of the subscale domains of role, experience and education, satisfaction as well as challenges indicated on the CPEET revealed a high overall mean score for the four subscales ($M \geq 5.96$, $SD=1.3$), the highest being the role domain ($M = 6.29$, $SD = 1.01$). The highest score was on the item clinical preceptors promote students' active participation in patient care ($M=6.68$, $SD = .62$) of the role domain subscale. The respondents scored lowest in the item preceptorship as not time consuming ($M=4.39$, $SD=2.12$) on the challenges subscale domain.

The qualitative findings had three themes emerging from the qualitative data, which validated the quantitative results. The themes included preceptor perceptions of the preceptorship role, focusing on the preceptorship experience and benefits of the preceptorship role; roles of a preceptor which were executed through facilitation of

students learning, role modelling and execution of evaluative roles; and finally, challenges experienced by the preceptor during the preceptorship role noted through preceptor-faculty members relationship; supervision of students and shortage of resources. Quantitative and qualitative results and findings respectively have been triangulated in chapter five (5).

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter aims to discuss key issues arising from the study findings. These include the data collection tool (CPEET) which had been used in Malawi for the first time, the participants' demographic characteristics; roles of preceptors, challenges of the preceptorship role and perceived satisfaction with the preceptorship role; levels of confidence in the preceptorship role; preceptorship as time consuming; and promotion of students' active participation. Data from the cross-sectional study and face to face interviews have been triangulated in this chapter. Finally, the Conclusion implication of the study and recommendations have also been included.

5.2 The Data Collection Tool - Clinical Preceptor Experience Evaluation Tool (CPEET)

Data for the quantitative design in this explanatory mixed method research study utilized a Clinical Preceptor Experience Evaluation Tool **(**CPEET), a data collection tool that had been previously used in a number of evaluative studies and had established cross-cultural validity and reliability (O'Brien, 2014). It was used in Australia, Ireland and Canada which are non-resource constrained countries. It is evident that the tool had therefore been used in Malawi, a resource-constrained country for the first time. As such local data regarding the reliability of CPEET was lacking.

Reliability is the consistency with which an instrument measures the target attribute (Polit & Beck, 2014). It is equated with a measure's stability, consistency and

dependability apart from accuracy. According to Polit and Beck, scales and tests that involve summing items, are evaluated for their internal consistency. This study utilised a CPEET which was a seven (7) point Likert Scale composed of four (4) subscales. These subscales were summed up to find an overall mean and thereafter, evaluate internal consistency through calculation of the Cronbach's alpha (Polit & Beck, 2014; Tavakol & Dennick, 2011). The calculated Cronbach's alpha showed that the CPEET was a reliable tool with good internal consistency ($\alpha \geq .6$) for all its four subscales. Each of the subscale domains had the following results: 'Roles' ($\alpha = .87$), , 'Experience and Education' ($\alpha = .6$), 'Satisfaction' ($\alpha = .74$) and 'Challenges' ($\alpha = .7$). These findings were generally lower than those that were found by O'Brien et al. (2014), ($\alpha = .96$ for a role; $\alpha = .79$ for education and experience; $\alpha = .93$ for satisfaction and $\alpha = .82$ for challenges. Pallant (2007) asserted that a stable and reliable instrument must have a Cronbach's alpha of at least 0.7.

5.3 Demographic Characteristics

The demographic data indicated that the majority of the participants in this study were females at more than two thirds (71.3%, n=60). However, the results have revealed that both female and male participants were able to execute their roles as preceptors with confidence and good levels of education. The RN qualification played a role in considering someone to the role of a preceptor. According to the findings in this study, a BSc in Nursing degree qualification was significant (p=0.05) as it assisted the preceptors to be confident and competent in their execution of the preceptorship role. This is in agreement with the nurses' roles where RNs have the role of being an educator as one of their job descriptions. It is also in agreement with what Atakro and Gross (2016) found that in the absence of faculty members, educational institutions rely on

RNs to take on the role of clinical nursing and midwifery instructors. Walker and Dwyer (2014) also supported the utilization of nurses with RN qualifications as preceptors. This is also in agreement with a recommendation by the Nurses and Midwives Council of Malawi (NMCM) where the scope of practice for professional nurses (with RN qualifications) stipulates the role to teach students when they are placed in the clinical setting for clinical practice (NMCM Act 16 of 1995).

Post-registration experience was necessary for the preceptorship role as it assisted the preceptors in their teaching role. The preceptors were assisted as they utilized their experiences to facilitate the transmission of theory to practice by the students. As noted in the results level of confidence in the preceptorship role differed significantly based on post-registration experience. Post hoc comparisons indicated that the role domain mean scores for the respondents with 4-5 years of post-registration experience (M = 6.61, SD = 0.36) was significantly different (p=0.02) than those with >9 years (M = 6.13, SD = 0.60). This indicated that preceptors with more post-registration experiences (>9 years) were less confident in their execution of the role than those who were less experienced (4 – 5 years). This could be as a result of added responsibilities through promotions to the more experienced preceptors (>9 years) which push them away from being with students as compared to the less experienced ones (4 – 5 years). Another factor could be the fact that those with few years of experience are young and this enables them to relate easily to the students than the more experienced ones due to age differences. There is also a possibility that the less experienced preceptors are well updated on current issues and are comfortable responding and interacting with students than their colleagues who might have the current updates on issues to do with the profession.

Yonge et al. (2008) expressed that preceptor attributed their preceptorship role to past experiences but their argument was based on their inclusion in the preceptorship role without undergoing preceptorship training. This study has found that post registration experience is necessary when considering one for the preceptorship role. The post-registration experience played a big role in assisting the preceptors to adjust as well as settle down in their new role as preceptors. Teferra and Mengistu (2017) support the qualification and experience of preceptors by stating that holding an advanced degree and longer experiences are relevant factors in preceptorship.

The preceptorship training institutions differed in terms of training duration and hands-on experiences. Other institutions offered the training for six weeks, which included three weeks of hands-on interaction with students, while others were offering it for three weeks including one week of hands-on interaction with students, yet others two weeks and one week without hands-on interaction with students as practice. This discrepancy made the preceptors encounter some challenges when executing their roles after the training. These challenges included durations in terms of adjusting from performing as RNs without preceptorship training to RNs with preceptorship training. Those that had more than two weeks of training that included hands-on interaction with students in the practical area adjusted quickly than those with two weeks or less training duration especially those without a hands-on interaction with students in the practical area. The other challenge was lack of hands-on experience with students during the preceptorship training which indicated some gaps in the preceptorship role. As noted by Horton et al. (2012) there is a need for formal preparation and education of the preceptors for them to function effectively in the preceptorship role. The findings indicated that it could

have been better if the trainings had an equal duration (i.e. six weeks) because the preceptors who went through such length of training had an advantage over those who had less duration of the training period. There is a need for adequate funding so that these trainings could be arranged consistently. The study has found that the preceptorship trainings were done inconsistently possibly due to the unavailability of funds. As such, most of the trainings were donor-driven which contributed to the inconsistent arrangement.

Post preceptorship training experience was necessary as the preceptors were adjusting to their role after training. This adjustment was done within the first year of their experiences as preceptors. The preceptors needed to adjust to their new role as preceptors from their previous statuses as RNs without teaching expertise. The majority of the preceptors who underwent six weeks of preceptorship training were able to adjust to this new role within the first year after the training. Murphy (2008) noted the necessity of preparing new RNs to become functional as soon as possible to ease the adjustment of new nurses in their work environment. Likewise, preceptors needed time to adjust to their new preceptorship role and one year was adequate for this adjustment. The adjustment to the new role and responsibility would enable the preceptors to interact freely with the undergraduate nursing and midwifery students which would assist the students to settle down quickly and concentrate on their clinical learning.

5.4 Roles of Preceptors, Challenges and their Satisfaction

The roles of preceptors vary depending on the needs of the academic institutions or hospitals. They may act as a socializer, educator and role model for the students (Boyer, 2008). Preceptors work together with the students for a specified duration of time to

assist them to perform the tasks, gain a basic level of knowledge and skills and socially adapt to the practice and profession (Lalonde & Hall, 2016). Preceptors should be confident and competent in their role for them to teach and support students effectively (Zwedberg, Rosander, Berlin & Barimani, 2020). In agreement, this study found that preceptors were generally confident and competent in performing their preceptor role (M=6.29, SD=1.01); with a good level of experience and education qualification (M=6.02, SD=1.18); having good ability to deal with challenges (M=5.96, SD=1.3) and had high levels of satisfaction (M=6.16, SD=1.22).

This result can be partly attributed to the fact that nearly all (90.8%, n=79) preceptors in this study had a Bachelor's degree in Nursing. In addition, all preceptors (100%, n=87) had the required minimum post registration experience of 2 years (NMCM Act 16 of 1995). According to the NMCM Act, RNs need to have a two-year post-registration experience before being considered to enroll in nursing/midwifery educational institution as an educator. Literature suggests that students can learn effectively under the guidance of a competent senior person who interacts with them and is available to teach them (O'Brien, Giles, Dempsey et.al, 2014; Boyer, 2008; Monareng, Jooste & Dube, 2009). The two years post-registration experience is adequate to build confidence and competence in the nurse/midwife educator. As the preceptors interact with students, they may have a personal reflection on their knowledge and skills and review or re-learn what they teach the students. As expressed by Participant 006 in this study, there is an agreement that preceptors need to read widely in order to prepare for their interaction with students.

In this study, qualitative data revealed that some preceptors believed that being involved in the preceptorship role helped them to grow professionally as they were able to perfect their own clinical skills while they were teaching students. Consistent with this finding, Chen et al. (2011) asserted that the act of precepting enhanced the preceptors' own learning and clinical performance. There is evidence which shows that preceptors who participated in a preceptorship programme re-learned some clinical skills including counseling, physical examination and interviewing (Chen et al.; 2011). This may be a motivator and a source of confidence for preceptors to perform their role because they also benefit while teaching students. This is in agreement with Marks-Maran, Ooms and Tapping (2013) who stated that nurses consider preceptorship as valuable for increasing their competence and confidence in performing their duties. However, this study found that apart from being motivated as the literature suggests, there were challenges that were experienced by preceptors while executing their preceptorship role.

Qualitative data revealed that some preceptors reported that the challenges they encountered included: lack of a good working relationship with faculty members in the clinical area; conflicts with colleagues who are not preceptors; training institutions leaving the responsibility of teaching students in the hands of preceptors; and the large numbers of students they have to teach. The poor relationship between preceptors and others may be attributed to role conflict. It is documented that preceptors experience role conflict due to a lack of recognition from peers or management for the extra work they perform when functioning as preceptors (Omansky, 2010). Furthermore, the exclusion of preceptor role on the nurse preceptors' job descriptions makes this role to be considered unofficial therefore not worth recognizing by the preceptors' facilities

(Omansky, 2010). However, this differs from what Löfmark et al. (2012) indicated that in Norway, preceptorship duties are included in their ordinary nursing duties. The inclusion of the duties motivates or reminds the preceptors of their roles and responsibilities while in the clinical area. This is not the case in Malawi where many if not all clinical sites do not include the role of clinical preceptor in the job description of nurses and midwives. Conversely, the scope of practice for all nurses and midwives stipulates that they should participate in the clinical teaching of student nurses and midwives (NMCM Act 16 of 1995).

The finding of this study, which revealed that preceptors face challenges due to a large number of students is supported by Luhanga et al., (2008) who purported that higher preceptor-student ratios impede one-to-one student-preceptors relationships which is essential for effective student learning (with regard to the provision of leadership to other nurses as well as patient care). The NMCM recommended a preceptor-student ratio of one (1) to twelve (12) for nursing students and one (1) to eight (8) for midwifery students (NMCM Act 16 of 1995). However, these ratios are not achievable in many clinical sites in Malawi since the enrollment of students has skyrocketed in response to the government policy of increasing access to higher education and an Emergency Human Resource Programme that proposed a massive scale-up of pre-service training (O'Neil et al. 2010). Despite, the preceptors reporting that they face challenges in their role, quantitative data showed that preceptors had a generally good ability to deal with challenges (M=5.96, SD=1.3). This may suggest that the preceptors are able to utilize effective ways of dealing with challenges. In this study, some preceptors reported that they hold meetings with academic institutions as a way of dealing with challenges they face in performing their role. Furthermore, preceptors receive support from the faculty

members who avail themselves in the practice area (Luhanga et al., 2007). This made them be comfortable to evaluate and decide on the progress of students (Luhanga et al., 2007) and consequently, they may become satisfied with their accomplishments.

Studies have found that preceptors expressed satisfaction with their clinical teaching role and felt positive about the preceptor role as they put a great deal of effort into creating meaningful and positive learning experiences for students (Broadbent et al, 2014; Kalischuk, Vandenberg & Awosoga, 2013). Consistent with this study, preceptors had generally high levels of satisfaction (M=6.16, SD=1.22). Furthermore, some participants in this study reported that seeing students succeeding was the greatest source of satisfaction to them. On the contrary, others reported that they were not fully satisfied with their preceptorship role as they regarded satisfaction in form of tangible rewards. It is documented that preceptors feel satisfied in watching novice graduates develop into competent nurses as well as observing students gaining confidence in their execution of patient care (Broadbent et al., 2014; Lillibridge, 2007). This may motivate preceptors to keep on performing better in their role of teaching students.

5.5 Experience and Education Qualifications

Preceptors with adequate clinical work experience are a critical component of clinical education in that they are able to afford students with enculturation to their future role as nurses. Teferra and Mengistu (2017) asserted that holding an advanced degree and longer clinical work experience are relevant factors in preceptorship. In this study, nearly all of the respondents (92%, n=80) had >3 years of post-registration clinical work experience. However, there were significant differences in the respondents' mean scores on the role domain subscale ($F(2, 84) = 3.7$, $p=0.03$) based on post-registration

experience. This finding suggested that preceptors' levels of confidence in their role differed based on post-registration experience. Consistent with this finding, the literature indicates that some preceptors believed that it took some years for them to feel comfortable in their role (Nottingham, 2015).

Nonetheless in this study, the relationship between post registration clinical experience and clinical teaching performance of preceptors were found to be conflicting. Post hoc comparisons using the Tukey HSD test revealed that the role domain mean scores for preceptors with 4-5 years of post-registration clinical work experience (M = 6.61, SD = 0.36) was significantly different (p=0.02) than those with >9 years (M = 6.13, SD = 0.60). This finding suggested that preceptors with vast experience > 9 years were less confident in their role in comparison to those with 4-5 years' experience. This is different from findings in the study by Chen, Li-Ling, and Suh-Ing (2012), who identified the best preceptors as older, senior nurses who choose to precept. Conversely, it is documented that novice preceptors may not facilitate student clinical learning better as experienced preceptors would do (Nottingham, 2015). The reduced ability to perform clinical teaching by preceptors with vast work experience (>9 years) may partly be attributed to them being promoted to managerial positions which impedes them from direct provision of patient care as years go by. The new positions subjected the more experienced preceptors to new managerial roles which reduced their time of interacting with patients consequently, having no adequate time to maintain as well as improve their skills.

On the other hand, those with less work experience are the ones who provide direct patient care which helps them to sharpen their skills and be in constant contact with

students. Consequently, the inconsistent findings regarding the abilities of preceptors with regard to their post registration work experience may provide challenges to training institutions when recruiting potential preceptors. The training institutions usually consider the more experienced ones over the novices. However, the literature recommends that clinical experience, willingness to be a preceptor, and confidence should be the main qualifications for becoming a preceptor (Nottingham, 2015).

5.6 Preceptorship as Time Consuming

The study found out that preceptors regarded preceptorship as time-consuming and an additional role to them. This was evident in the respondents' scores on item: "being a preceptor is not time consuming" on the challenges domain subscale (M=4.39, SD=2.12). This revealed that preceptors considered the role of a preceptor to be time consuming which could affect the attitude and commitment of the preceptors in their execution of the preceptorship role. This is because the preceptors considered preceptorship as an additional role on top of their core role of patient care. As noted in a study by Allen (2016) there was tension among stakeholders as regards their workloads, the time available for their tasks and the expectations placed upon them. For preceptors, the reduced time that modular students spent in the placement were seen to limit preceptors' ability to 'role model', 'teach' or work alongside the student, within increasingly busy environments. Many felt there was a lot of work involved in the various aspects of preceptorship 'if you do it properly' and that this was unrecognized by their managers. Managers appeared to recognize the problem, but squaring the circles of competing priorities challenged them all. Some students stated that their preceptors had managed their time better, and provided quality time for the student. Generally, it was suggested that trusts failed to sanction time for preceptors and students

to be together and that preceptorship was usually the ‘first thing to go’. This was also noted in a study by Matua, Seshani, Raman and Fronda (2014) where the participants claimed that they were frequently preoccupied with patient care duties. In view of this, they were unable to devote sufficient time to the preceptees, thereby hindering relationship building. This was evident in their study from a comment by one of the preceptors who narrated that they have a lot of work including time to know each other, what is expected from them which take time. On top of these, the preceptor went on to state that they also have other responsibilities and therefore it was not easy to find adequate time to conduct the preceptorship role for the learners.

Validating the issue regarding preceptorship as time consuming, the qualitative findings revealed that preceptors had other roles to partake in apart from teaching students. For instance, some of them were ward managers and had to look after patients on top of assisting students. They felt that many things were taking place at the same time which was a challenge for them to handle due to time constraints. Preceptors indicated that as care providers they needed to provide care to the patients but had to work with students, some of whom had come for their first allocation. This put them in a dilemma on whether to concentrate on assisting the students or provision of patient care. The literature has expressed role confusion and lack of time to precept as challenges by the majority of the preceptors (Broadbent et al., 2014; Löfmark et al., 2012). Furthermore, preceptors expressed that they were not satisfied with the time they had to support students whilst they fulfilled their role of providing nursing care (Broadbent et al., 2014; Löfmark et al., 2012). The preceptors felt their role of providing nursing care was overtaken by the preceptorship role. As expressed by Omansky (2010), nurse preceptors requested to be assigned decreased patient assignments to allow them time to work with

students indicating the preceptorship role as an additional responsibility. This is in agreement with the study by (Hautala et al., 2007) where many of the respondents in the study commented that precepting requires increased time and energy. The extra time to both take care of a normal patient assignment and instruct a new nurse about policies, procedures, and clinical issues causes stress. Examples of comments by the respondents to indicate their stress levels included: ‘‘it can take twice as long to complete my workload,’’ and ‘‘my main stress is from lack of time. I feel obligated to spend extra time explaining procedures to the preceptee.’’ Increased responsibility was another issue that several respondents identified. One preceptor noted, ‘‘I feel I must be vigilant in looking for and helping

the student avoids making mistakes that could affect the patient’s safety.’’ Preceptors supervise students under the preceptor’s license and ‘‘your license is on the line for everything they do.’’ All these observations increased the preceptor’s consideration of preceptorship as time consuming.

The findings in this study indicated role conflict between the preceptorship role and provision of patient care. There were periods when the preceptor would be required to provide patient care and at the same time be required to do managerial work for his/her ward while the students would also be waiting for his/her assistance. This scenario made the preceptors feel that their preceptorship role was overtaking their patient care as well as their managerial roles. This created work overload on the part of the preceptors, which was made worse by lack of support from their colleagues, and institutions that sent students. As noted in the literature, increased workload made precepting to become time consuming (O’Brien et al., 2014; Kalischuk, Vandenberg & Awosoga, 2013). In support of the same, this study found that many preceptors regarded

preceptorship as time consuming as indicated by quantitative results and validated by the qualitative findings.

5.7 Preceptorship Model Of Clinical Teaching

Preceptorship refers to an educational relationship in which an experienced and skilled professional provides knowledge, skills, support, and encouragement to a nursing student in order to enhance the latter's understanding of, and level of comfort with, the nursing profession (Morton-Cooper & Palmer, 2000). The success of the preceptorship is determined by the strength of the relationship between the student (preceptee) and the professional (preceptor). This relationship forms the basis of the preceptorship model. Preceptorship in clinical learning is a model widely used in nursing to assist students to transition from novice level to their new professional clinical roles, performing their tasks, gaining a basic level of knowledge and skills necessary to apply in the nursing profession (Lalonde & McGillis Hall, 2016). The literature is consistent in demonstrating that nursing students value feeling welcomed into the clinical area as a part of the team. This feeling is generally best achieved by providing a thorough orientation and a plan outlining activities and expectations (Charleston & Happell, 2004, 2005; Morton-Cooper & Palmer, 2000; Mullen & Murray, 2002). In addition, students appreciate the opportunity to participate in nursing activities and learn from observing the practices of more experienced colleagues (Charleston & Happell, 2005; Kaviani & Stillwell, 2000; Mullen & Murray; Myrick & Yonge, 2002; Ohrling & Hallberg, 2000).

Pre-registration nursing and midwifery programmes in many countries including Malawi include a clinical practice component carried out in hospitals and the

community. Clinical learning is an essential and integral component as more than half of the formal part of nursing education is carried out in clinical environments where nursing students integrate theory and practice (Jamshidi et al., 2016; Tiwaken, Caranto, & David, 2015). The model which is utilised is the one where supervision is given by both preceptors and university teachers. As noted by Löfmark et al. (2012), preceptors are employed by the clinical setting and teachers by the university or University College. The important components of this model are the support of and co-operation for the students' professional development. As expressed by Billy and Myrick (2007), the preceptorship model as an approach to the teaching and learning process within the context of the practice setting affords students the opportunity to develop self-confidence while increasing their competence as they become socialized into the profession of nursing.

Within the preceptorship model, the three participants – the preceptor, the preceptee, and the faculty member – each have responsibilities within the triad relationship. Specifically, the preceptor has a duty to role model and socialize the student to the role of the registered nurse, while maintaining ongoing communication with the faculty member. Similarly, the faculty is responsible for facilitating not only student learning but also for supporting the teaching and learning activities of the preceptor. The student assumes the role of an active learner whose responsibility it is to become a safe, competent beginning nurse. In the preceptorship model, learning is fostered by giving students the opportunities to act, and students must take an active role. Preceptors receive study guides containing learning outcomes and assignments as the preparation and guidelines for their supervision. The student works alongside one preceptor, and sometimes supervision is shared with another appointed nurse (Budgen & Gamroth,

2008). The Preceptors plan and arrange the clinical practice to meet the intended learning outcomes and the individual student's learning needs. They also follow up on situations and reflect together with the student.

Preceptors do not receive financial compensation. Preceptorship duties are included in their ordinary nursing duties. Within this model, the teachers focus on the cooperation between the preceptor and the student and making links between theory and practice (Gillespie & McFetridge, 2006). The role is more that of counselling and support than concrete supervision in the care of the patients. As the collaboration extends over some years, the teacher is usually known to the staff. Student, preceptor and teacher meet about three or four times during a clinical period of eight weeks to clarify objectives and learning outcomes and to discuss the student's development and progress (Lambert & Glacken, 2005). This scenario, however, is far different from the model being implemented in Malawi due to various challenges including human and material resources, Malawi being a resource-constrained country.

Despite that the findings of this study have shown that overall, respondents had high scores on CPEET domain subscales ($M \geq 5.96$, $SD=1.3$), the preceptorship model being implemented in Malawi had some shortfalls as alluded to earlier on as a standalone model. There are enormous workforce challenges in the country and what was being implemented as preceptorship is far from the ideal preceptorship model. Preceptorship is a one-to-one relationship between a preceptor and a preceptee or in the context of this study, a preceptor and a student nurse, which is not possible with the problem of severe nursing shortage which is prevalent in Malawi. This is supported by literature which indicated that preceptors may supervise more than one student (Asirifi, Ogilvie,

Barton, Aniteye, Stobart, Bilash et al., 2019; Kaniaru, Nyagena, Kathuri & Chebor, 2016; Sedgwick & Harris, 2012; Luhanga et al., 2010).

However, this problem is not unique for Malawi where staffing levels of the required 1: 1 student-to-preceptor ratio is not strictly adhered to. Luhanga et al. (2010) argue that the one-to-one relationship preceptor and student is pivotal to the success of the preceptorship model. To achieve this, there is a need to consider other models of preceptorship to enhance students learning. These models may include, the Clinical Teaching Partnership (CTP) Model (Atakro & Gross, 2016), Team Preceptorship Model (TPM) (Brathwaite & Lemonde, 2011), and the Collaborative Learning Unit (CLU) (Luhanga et al, 2010). These models are eclectic and may combine different approaches in promoting and facilitating clinical teaching and learning. It is against this background that a different model of clinical teaching and learning in Malawi should be proposed.

5.8 Promotion of Students' Active Participation

The findings of this study showed that respondents scored highest on item: "clinical preceptors promote students' active participation in patient care" (M=6.68, SD = .62) in the role domain subscale. The concept of preceptorship evolved out of the necessity of preparing new RNs to become functional as soon as possible to ease the adjustment of new nurses in their work environment, to promote patient safety, and to retain nurses in an effort to decrease the cost of nurse turnover (Kaviani & Stillwell, 2000; Murphy, 2008). As noted by Horton et al. (2012), the formal preparation and education of the preceptor to function effectively in this role has been identified as one of the most important components of a successful program. The preceptors' pivotal role is bridging

the gap in the transition from student to nurse. This usually happens where the preceptor as an experienced nurse, works together with the student (Lalonde & Hall, 2016) to assist him/her in effectively adjusting to the new role, performing the tasks, gaining a basic level of knowledge and skills and socially adapting to the practice, profession and organization, while bridging the theory-practice gap.

One of the ways that students learn when working with preceptors is through role modelling which occurs while the preceptor interacts with the students. The literature indicated that students can learn effectively under the guidance of a competent senior person who interacts with them and is available to teach them (O'Brien, Giles, Dempsey et.al, 2014; Boyer, 2008; Monareng, Jooste & Dube, 2009). Apart from the presence of the competent person, the learning environment is also an important factor in the success of the preceptee's clinical orientation. This includes improving Preceptor-preceptee relationships which is a step toward the development of caring practitioner relationships (Birx & Baldwin, 2002). This study has supported this through its findings. Preceptors in this study indicated that they provide opportunities for the students to learn as well as ensuring that the students work based on their objectives.

The results for this study revealed that preceptors were role models (M=6.48, SD=0.82) to students while in the clinical area. The students imitated what the preceptors were doing when they interacted with them while providing care to patients. They also observed their mode of dressing, utilization of work policy, provision of patient care among other areas. As such, the preceptors tried to be at their best in these areas so as to be positive role models. This is in agreement with Vinales (2015), who noted that not all modeled behaviour is positive or beneficial to students therefore it would be very

helpful if preceptors are reminded of the role modeling role in order for them to be motivated to portray good practice. As stated by Monareng, Jooste & Dube (2009), preceptors had an opportunity to serve as role models for practical experiences and students could learn effectively under their guidance.

As implied by Horton et al. (2007), it is critical to understand the needs of the preceptors to better support them. Preceptors choose to employ content and skills that help them develop a new nurse into a valuable team member on the unit. Healthcare institutions are responsible for orienting newly hired nurses to become competent healthcare professionals who meet the needs of patients through the application of professional and institutional standards. Consequently, the institution must prepare preceptors to be effective facilitators of the orientation process. Because hospitals hire a number of new graduate nurses annually, it is beneficial for academic educators preparing new nurses to enter the profession and staff development educators preparing new nurses to work within the healthcare system to collaborate to create programs that would promote positive orientation experiences for the new nurses and preceptors (Wright, 2002). Likewise, if Malawi is to have well trained undergraduate nursing and midwifery students, there is a need to prepare the preceptors who eventually would instill the required knowledge and skills to the undergraduate nursing and midwifery students.

Preceptors need the support of educators and managers, especially when working with a struggling novice (Yonge, Krahn, Trojan, Reid, & Haase, 2002). Preceptors and preceptees especially need feedback from managers (Fink, Krugman, Casey, & Goode, 2008) when educators are not available in their institutions. Educators and managers can mentor preceptors to teach and model how to use appropriate communication skills

when providing effective feedback. A number of preceptors reported increased awareness of how they communicated to their preceptees and changed their communication style based on the preceptee's needs. Preceptors need meaningful assessment tools that would support their endeavours to effectively set goals and evaluate the progress of preceptees (Hickey, 2009). Educators and managers must collaborate to provide a supportive work environment that would allow preceptors to meet the many demands of their roles as educators and evaluators. They need time to do their jobs effectively, including time to teach and time to evaluate the progress of their orientees. Preceptors identify a number of stressors, but most commonly cited is the requirement to take a normal clinical workload while precepting (Alspach, 2008; Henderson, Fox, Malko-Nyhan, 2006; Hautala et al., 2007). This practice is detrimental to the preceptor, the preceptee, and the budget. The more support the preceptor has to precept effectively, the sooner the preceptee would become an effective team member (Horton et al., 2007). This practice is detrimental to the preceptor, the preceptee, and the budget. The more support the preceptor has to precept effectively, the sooner the preceptee would become an effective team member. At least for the first few weeks of the preceptorship, preceptors must be responsible for fewer patients. The inability to decrease the workload has typically been blamed on managers. Managers must put organizational structures in place to support preceptors; however, perhaps the staff of the entire patient care unit could come together to create strategies to support their colleagues when precepting.

5.9 Conclusion

The study findings support preceptorship as a valuable component of nursing and midwifery courses today and that it is vital to the professional preparation of nursing and midwifery students. The study supports the RN qualification with a BSc in Nursing

degree (p=0.05) for one to be considered as a preceptor. The qualification is key in promoting confidence and competence among preceptors in their execution of the preceptorship role. As indicated in the findings, post registration and post preceptorship training experiences were significant in the execution of the preceptorship role.

This study has indicated that the core function of preceptors in Malawi is to assist undergraduate nursing and midwifery students in the translation of theory to practice apart from providing support on personal matters. However, a one-to-one preceptor-student relationship is a challenge to preceptors in Malawi despite this being crucial and a major attribute in the preceptorship programme. The study has revealed that the preceptorship model in Malawi is a modified one as preceptorship advocates a one-to-one relationship between a preceptor and preceptee. There is a hope that the continuation of preceptorship trainings may reduce the work overload currently being experienced by preceptors. This would also improve the preceptor-student ratio which is a challenge due to the large numbers of students present in the clinical setting. Meanwhile, group teaching may be advocated in the clinical teaching of nursing and midwifery students.

There were gaps in the involvement of preceptors whenever faculty members visited students for supervision and assessment as not all of them involved preceptors when executing these roles. Preceptors expressed the need for them to work closely together with faculty members throughout the time the students are allocated in the clinical area. The findings support the need for uniformity in the involvement of preceptors to accord this opportunity to all the preceptors. In addition to this, the study results/findings support the continued availability of faculty members in the clinical area. This was also

expressed by the preceptors that they wished faculty members could avail themselves frequently to follow the progress of the students while in the clinical area.

The study revealed a lack of a good collegial relationship between preceptors and RNs not trained as preceptors. According to the findings of this study, there is a need for clarification of the preceptorship role to all members involved in patient care in order to improve this relationship It is envisaged that knowledge by preceptors' colleagues of what preceptorship entails would enable them cooperate with the preceptors and willingly assist them in times of need. The results support the need to remind the RNs of their job description especially that of an educator for nursing and midwifery students as indicated by their scope of practice (NMCM Act 16 of 1995). This would enable them to accept the teaching role and willingly work with the preceptors when students are present in the clinical area. Recognition of preceptors by management and other members of staff have been indicated as crucial in the preceptorship role in this study. Preceptors felt that they needed to be recognized by all stakeholders as they executed their preceptorship role

As indicated in this study, some preceptors expected rewards when executing their preceptorship roles. There were indications that some preceptors expected rewards in a monetary form such as a top-up to their monthly salary or an allowance for the extra assignment added to their core work. Though the results revealed that preceptors are contented with the professional rewards due to their involvement in the preceptorship role, others were not. Therefore, there is a need to review the intrinsic benefits and rewards to preceptors' needs in order to sustain the preceptorship roles in the clinical settings as was expressed by Lafrance, (2018).

5.10 Implications of the Study

The results and findings in this study revealed that the preceptorship model was useful in facilitating students' learning in the clinical setting apart from benefiting the preceptors themselves. Students' learning facilitation was noted through the promotion of student's participation in patient care (M=6.68, SD=0.62), positive role modelling (6.48, SD=0.82), provision of support to students (M=6.44, SD=0.90) apart from facilitating students to make links between theory and practice (M=6.39, SD=0.88).

The preceptors benefitted from the preceptorship role by being assisted to expand their nursing knowledge, reading updated texts and journals as well as facilitating professional reflection on their own roles as nurses. The results supported these sentiments by indicating that the preceptors were comfortable in dealing with practical skill development in the learners than theoretical aspects. This confirms the fact that although the nurses may be expert clinicians, they require specific educational support in order to carry out their student supervision role effectively as noted in the literature (Kamolo, Vernon & Toffoli, 2017; Atakro & Gross, 2016; Kalischuk, Vandenberg & Awosoga, 2013).

However, despite the model being useful, there are challenges to the implementation of the model in view that what is being implemented is a modified model because ideally, a preceptorship model involves a one-to-one relationship between the preceptor and the preceptee. The preceptorship model in Malawi was designed to have a ratio of one (1) to twelve (12) students for nursing and one (1) to eight (8) students for midwifery. This is against the real preceptorship model which advocates for a one-to-one preceptor-

students relationship. The 1:12 and 1: 8 ratio was with reference to the Nurses and Midwives Council of Malawi requirement (Middleton et al., (2012), The study, however, revealed that on the ground the ratio is higher than anticipated due to severe shortage of professional nurses in Malawi. The sentiment is supported by the findings in this study where Participant 002 stated that:

> "*…the students are just too many…sometimes you are just alone on duty…you are working with first-year students that will actually need supervision for each and every activity that they are carrying out"*

There is a higher preceptor-student ratio in the various clinical sites in the range of, for example, one (1) preceptor to fifty (50) students. The argument advanced from the study findings is that a single clinical teaching model is not effective and therefore a tripartite model of facilitating clinical teaching and learning is proposed and this is the main recommendation in this study.

5.11 Recommendations

5.11.1 Proposed Tripartite Model of Clinical Teaching

The proposed model is eclectic in that it will combine three different approaches in promoting clinical teaching and facilitating clinical learning. The three approaches will complement each other and will help to improve the quality of clinical teaching and learning. It will include preceptorship which was already being implemented, and in addition, the clinical teaching model will also include faculty and peer mentoring. The argument advanced here as the findings in this study have revealed is that preceptorship is deficient as a standalone model. There is support to this view in literature, where other models have also been proposed instead of a standalone preceptorship model.

For example, the Clinical Teaching Partnership (CTP) Model (Atakro & Gross, 2016) and the Collaborative Learning Unit (CLU) (Luhanga et al., 2010) are some of the models that have been proposed. This current study provides evidence that in Malawi, the preceptorship model cannot effectively help in the facilitation of clinical learning for nursing students. There are enormous workforce challenges such that what was being implemented in the name of preceptorship is far from the ideal preceptorship model. Preceptorship is a one to one relationship between a preceptor and a preceptee or in the context of this study, a preceptor and a student nurse, which is not possible with the problem of severe nursing shortage which is prevalent in Malawi.

The CTP model advocates for the collaboration of a clinical nursing specialist from the service institution and a faculty member from the university (Atakro & Cross, 2016). As noted by Atakro and Cross, the CTP was found to be appropriate for clinical nursing education in Ghana owing to its advantages to both the faculty member and the nursing specialist. The advantages to the faculty member included increased time to pursue scholarly activities and a direct link with clinical staff for purposes of communication about policy procedural changes and new equipment. The advantages for the nursing specialist included joint involvement with academic settings, direct avenues for collaborative projects such as writing and publication, and satisfaction in observing student's development.

Students had also indicated advantages of the CTP to include learning several roles assumed by nurses and different ways of performing clinical skills and that their ability to transfer theory learned in the classroom to clinical practice is enhanced in CTP (Atakro & Cross, 2016; Billings & Halstead, 2009). The implementation of the model

in Ghana was associated with several changes including policies to promote its effectiveness. In a CTP model, the clinical nursing specialist and the faculty member work together in clinically educating students while sharing responsibilities based on their expertise. The clinical nursing specialist handles client assignments while the faculty member schedules student experiences. However, together they jointly collaborate in evaluating assignments and the performance of the student. This study found that in the modified preceptorship model in Malawi, preceptors rarely collaborated in clinical teaching with faculty members. For instance, many preceptors indicated a lack of involvement by faculty members when they visited the service institutions for clinical supervision, which was also rarely conducted. Therefore, there is a need to advocate for collaboration between faculty members and preceptors to enhance clinical teaching. Collaboration would encourage commitment among clinical nursing specialists and faculty members as they would be striving to have their shared responsibilities completed thereby benefitting the students. However, this is not a unique problem for Malawi, literature reveals that it is a problem for both developing and even developed countries where staffing levels are far much better, the required 1: 1 student-to-preceptor ratio is not strictly adhered to. There is a variation in this ratio, implying that preceptors may supervise more than one student (Asirifi et al., 2019; Luhanga et al., 2010 & Sedgwick & Harris, 2012). A study in Kenya by Kaniaru, Nyagena, Kathuri and Chebor (2016) with regards to preceptors to students nurse ratios, results indicated that eighty-six (86) out of ninety-nine {86/99 (86%)} of the student nurses stated a ratio ranging from 1: 13 and 1: 32. While eight (8) out of nine {8/9 (89%)} of the preceptors stated a ratio between 1: 14 and 1: 20. This variation is higher than that in the literature showing that in Kenya, like in Malawi, higher preceptor-student ratios are not a surprise. As noted by Kaniaru et al. (2016), the preceptorship

model that originated from Florence Nightingale recommends that one student nurse be precepted by a single nurse. This ratio is also supported by Udlis (2008) who stated that the recommended ideal preceptor to student ratio is 1:1. However, Luhanga et al. (2010) argue that among the numerous factors which influence the effectiveness of the preceptorship model, the one-to-one relationship is pivotal to the success of the preceptorship model. It is against this background that a different model of clinical teaching and learning is proposed. Sedgwick and Harris (2012) assert that there are three key players in the preceptorship model namely, the nursing student/preceptee, the preceptor, and the supervising faculty member where each member of this triad plays a critical part in the success of the preceptorship experience. The proposed model is aimed at strengthening the effectiveness of each aspect of the triad and it is envisaged that this will enhance clinical teaching and learning among undergraduate nursing and midwifery students.

5.11.2 Preceptorship

Preceptorship is a formal one-to-one relationship of predetermined length between experienced nurses and novice nurses designed to assist the novice nurse in successfully adjusting to and performing a new role (Condrey, 2015). It is designed to help the new nurse adapt to and successfully perform essential job duties (Kalischuk, Vandenberg & Awosoga, 2013). As indicated by Burns, Beauchesne, Ryan-Krause and Sawin (2006) preceptorship has proved to be a highly useful strategy for clinical education. It allows education to be individualized, links classroom knowledge to real patient management problems, and provides for role modelling as the student develops standards and strategies for practice. Preceptorship is based on the assumption that a consistent one-to-one relation between an experienced and new nurse would refresh new nurses

training prior to undertaking with patients in a clinical setting (Luhanga, Billay, Grundy, Myrick & Yonge, 2010). The preceptorship model is an effective teaching and learning strategy most frequently employed to educate undergraduate and graduate students in the practice setting (Billy & Myrick, 2007). It is a short-term relationship between a student nurse and student midwife as a novice and an experienced staff, for instance, a professional nurse as the preceptor who provides individual attention to student's learning needs and feedback regarding performance; students experience relative independence in making decisions, setting priorities, management of time, and patient care activities (Segen's Medical Dictionary, 2012).

A successful preceptorship program can facilitate the adaptation of new nurses to the workforce and helps improve patient safety (Phillips, 2006). Following the same principle, preceptorship assists undergraduate students to adapt to the clinical area during clinical practices. While in the clinical area, the students are assisted by preceptors. Sanford and Tipton (2016) define a preceptor as a nursing staff member—registered nurse licensed vocational nurse, or certified medical assistant—who has attended a preceptor class and is charged with the orientation of a new staff member. They continue to state that the preceptor must have a job role equal to or higher than that of the preceptee. A preceptor sets expectations, provide feedback, displays passion, is confident, challenges the learner and seeks learning activities (Back, Boh & O'Sullivan, 1995). As expressed by Phillips (2006), the preceptor is a reflection of the institution and directly affects new orientees and student nurses, the quality of nursing, and ultimately, the quality of client care.

Preceptors' roles are complex and require skills in being clinical experts, knowledge experts, role models, learner facilitators, collaborators, coaches, interveners, learner advocates, and evaluators. This vital employee must be nurtured through quality preparation programs that can be offered online. The preceptor is an experienced staff member who has outstanding clinical skills, knowledge, and experience in guiding new orientees to think critically and take on up-to-the-minute roles in the clinical setting. Preceptors must be nurturing, supportive, and caring, thus providing the needed role modelling during times of lean staffing. Preceptors must fit certain qualifications set forth by the institution and, most of all must be willing to work with new learners. In terms of preceptorship, Sanford and Tipton (2016) define it as a relationship between an experienced nursing staff member and a newly hired staff member; the length of this relationship depends on the orientation period of the specific nursing unit or clinic. As noted by Condrey (2015), the preceptor-preceptee relationship is usually a short term one. As expressed by Kalischuk, Vandenberg and Awosoga (2013) preceptors and preceptorships have been a part of nursing for many years. Preceptors teach students across a variety of acute, community, and continuing care practices (Kalischuk, Vandenberg & Awosoga, 2013). They provide a safety net of experienced staff to answer questions and provide insight (Dillon, Barga & Goodin, 2012). Within the context of undergraduate nursing education preceptorship is designed to ensure that nursing students acquire quality learning experiences through contact on a one-to-one basis with preceptors who guide to promote the student's clinical competence and skills development (Myrick & Yonge, 2004; Parsons, 2007).

As discussed by Freiburger (2002) preceptorship can provide one-on-one guidance at a key time when nursing students need support and when their perceptions of the role of

a RN are highly impressionable. While there are multiple considerations for providing a preceptor experience, one study identified three themes associated with good preceptorships: a caring relationship, mutual respect, and a deep sense of responsibility (Hilli, Salmu & Jonsén, 2014). These attributes for preceptorship need to be taken on board in order to have an effective preceptorship programme. As was noted by Matua, Seshani, Raman and Fronda (2014), Successful preceptorship programmes enable preceptees to settle into clinical placements quickly and gain greater confidence in their clinical skills (Zilembo & Monterosso, 2008). If successfully implemented, the preceptorship experience is rewarding for both preceptors and preceptees. A successful preceptorship experience may positively influence preceptees to remain in the nursing profession for the entire length of their careers, while for preceptors it may enhance the enjoyment of their role and bring greater job satisfaction (Bradbury-Jones, Sambrook, Irvine, 2007; Gopee, 2011). Success for both preceptors and preceptees may also mean personal and professional growth as well as higher self-esteem and confidence levels (Glass & Walter, 2000; Greene & Puetzer, 2002). Effective preceptorship has also been linked to more positive patient outcomes through the carryover effect of enhanced student competencies (Kim, 2007). Additionally, a rewarding preceptorship experience may also result in the continued mentorship of the preceptee by the preceptor, maintaining their support and contributing to the preceptee's long-term professional growth and development (Watson, Raffin-Bouchal, Melnick, & Whyte (2012).

Dusaj (2014) described the importance of the preceptor-preceptee relationship in ensuring a successful orientation. Specific actions of the preceptor include providing a toolbox of resources and actions that prepare the new staff member to be successful. Preceptors also boost morale and confidence while making the new nurse feel a part of

the team. Many authors depict preceptors as having the experience to guide new nurses as they assimilate into the new work environment. Galsper (2010) stressed the importance of the preceptor having experience in the areas needed by the preceptee. In interviews with preceptors, Hilli et al. (2014) concluded that a good preceptor has years of work experience, allowing a sense of security in the role of a nurse. The preceptor-preceptee relationship not only guides and inspires new staff members but introduces preceptors to ideas they may not have considered (Chambers, 2009). Preceptors must be active teachers willing to share ideas and help new nurses search out answers, as well as excellent role models (Johnston & Mohide, 2009; Fowler, 2012). Additionally, they must be able to manage poor performance and develop action plans when needed. Preceptors face a broad set of teaching-learning diversity issues related to their role as clinical teachers. Being unaware of these issues may contribute to miscommunication and conflict. However, preceptors often have limited information on this diversity (Johnston & Mohide, 2009). The implication for nursing education is to prepare the preceptor for the role and thereby increasing satisfaction as well as improving the preceptee's experience.

The preceptorship adopted in Malawi however has the challenge of individual attention to the student's learning as noted in this study. This is the reason it was modified to suit the situation at hand. However, it needs to be continued as it has been noted to be effective though there are some gaps. The preceptors currently available need encouragement and mentoring. Apart from this, they need in-service education to remind them of how to have to perform as effective preceptors. As noted by Back, Boh & O'Sullivan (1995) the effective preceptor creates clear and open communication with his/her preceptees, gives timely feedback as this is essential to the development of

preceptees. The feedback is given to the preceptees while utilising various feedback methods. The effective preceptor also remembers to tailor the preceptorship role approach to the preceptee.

Mallette, Loury, Engelke and Andrews (2005) described the role of faculty in an integrative clinical preceptor programme which is worth emulating for an effective preceptorship programme. They stated that the faculty role must foster timely communication between the faculty, students, and preceptors. Faculty must be keenly aware of the quality of care provided by students. Because students are located in various rural settings, communication occurs online, via telephone, or face-to-face. The majority of online communication is asynchronous and occurs through e-mail, the drop box, and the group discussion options available through Blackboard. During the semester, faculty members are available by cell phone and pager. Students and preceptors are encouraged to call with questions and concerns. Faculty members are committed to responding immediately unless unexpected events prevent this. If a particular faculty member is unavailable for a certain period, another faculty member would assist with coverage. At the beginning of each semester, faculty members contact preceptors in person or by phone to update information and to note any changes prior to orienting the students. This is also an opportunity to identify issues that have emerged since the previous semester. On a typical day, early in the semester, faculty members are usually in the office, reviewing reflective journals, facilitating seminar discussions, or meeting with individual students. The students are able to work 1-on-1 with the faculty member in focusing and developing their projects, or they can strategize about interventions related to their client population.

Through the reflective journal, the faculty member makes comments, asks questions, and stimulates dialogue with each student. This facilitates evaluation of individual student learning early in the semester and students are less likely to get to fall behind.

Later in the semester, the faculty begins to make site visits to each agency to meet with students and preceptors. Since many of the sites are at distant locations, requiring a significant amount of driving, only 3 to 4 visits can be completed each day. In preparation for a site visit, students complete a self-evaluation and the preceptor evaluates the student based on course and individual objectives.

During the visit, objectives are reviewed and student progress is discussed. A particular focus of this visit is to ensure that the student is meeting both the service-learning component of the class and the objectives related to population-focused care.

Time is allotted to observe the students as they practice in the setting and to discuss student performance with both the student and the preceptor. Faculty members usually make 1 to 2 site visits to each student during the semester. Another important role of the faculty is to provide opportunities to recognize and celebrate the joint efforts of the preceptors and the faculty. Preceptors are encouraged to apply for adjunct faculty status and are recognized at our annual agency appreciation luncheon. Additionally, community health faculty members arrange agency-specific end-of-the-semester meetings to discuss strategies, celebrate successes, and affirm the commitment for the upcoming year.

5.11.3 Faculty Mentoring

Mentoring is the activity of supporting and advising someone with less experience to help them develop in their work and usually occurs when a senior person or mentor provides information, advice and emotional support to a junior person or student over some time (Collier, 2017; Chen, Watson & Hilton, 2016). With mentoring, more senior members of organizations in all sectors are frequently asked informally or are even required, to socialize and support new and/or more-junior members of their organizations to strengthen the latter's relevant skills, to develop potential leaders, and to build organizational capacity more generally (Fountain & Newcomer, 2016). These relationships are typically called *mentoring*, for which the following useful definition was adopted: "a reciprocal learning relationship characterized by trust, respect, and commitment in which a mentor supports the professional and personal development of another (*the mentee*) by sharing his or her life experiences, influence, and expertise" (Zellers, Howard & Barcic, 2008).

How mentoring policies and practices evolve varies, because expectations of the processes in which mentors and mentees are expected to interact are highly dependent on an organization's work culture, context, and mission (Lumpkin, 2011). Within institutions of higher education, mentoring is typically viewed as a support mechanism that helps faculty mentees acquire and develop the competencies they need to thrive as well as the constructive work relationships they need to build their careers (Bean, Lucas & Hyers, 2014; Benson, Morahan, Sachdeva & Richman, 2002; Bland, Taylor, Shollen, Weber-Main & Mulcahy, 2009). It is widely accepted in professional settings as a way to facilitate the acquisition of work-related knowledge, develop leaders and support those transitioning to new roles (Chen, Watson & Hilton, 2016). As noted by Raines

(2019), mentoring is used in a variety of professional settings. New graduates entering a professional field of practice as well as established nurses moving into a new practice setting or a new role may receive mentoring as part of the role transition process. Mentoring in a nurse-to-nurse relationship is important for developing the next generation of nurses and for supporting experienced nurses during role transitions across their careers (Raines, 2019).

As noted by Nick et al., (2012) mentoring programs have many benefits and contribute to improved faculty morale, higher career satisfaction and increased self-confidence in professional development. Furthermore, within the education literature, similar reviews have identified mentorship as improving the socialization, orientation, and career outcomes of faculty (Gibson, 2004). Nursing education institutions that have established mentoring programs reported positive outcomes for nursing faculty such as improved morale, higher career satisfaction, increased self-confidence, increased professional development, increased publication, obtaining more grants, and quicker promotion (Ronsten, Andersson & Gustafsson, 2005; Nick, Delahoyde, Prato, Mitchell, Ortiz, Ottley, et al., 2012).

Organizations have reported benefits from mentoring including developing future leaders from within the institution through nurturing commitment, retention, and teamwork (Huybrecht, Loeckx, Quaeyhaegens, De Tobel & Mistiaen, 2011). Furthermore, literature has indicated that Faculty mentorship is suggested as a way to successfully foster a collegial, caring environment; these supportive relationships are positive strategies that help to retain RNs in faculty positions (White, Brannan & Wilson, 2010). In support of this positive relationship, Barrett, Mazerolle and

Nottingham, (2017) identified three attributes necessary for positive mentoring relationships between new and experienced faculty members were active engagement, communication, and sharing similar interests. In a systematic review of mentoring in academic medicine, Sambunjak et al. (2006), found desired characteristics in mentoring relationships included mentees who take initiative and mentors who are honest and understanding of the mentee's needs. This mirrors the findings presented here. Mentees desire a mentor who is supportive, communicative, and trustworthy while providing guidance and skill development (Nardi & Gyurko, 2013). Others have found an educational dimension is necessary within mentoring, which allows the mentor to engage the mentee in the development of knowledge and skills by providing feedback and encouraging professional discourse (Allan & Aldebron, 2008). Brainstorming, feedback, and serving as role models have been found as important aspects of mentoring relationships (Nardi & Gyurko, 2013). Additionally, Sambunjak et al. (2006) found that mentoring relationships can be enhanced if expectations and communication are clear from the start and if the mentor and mentee are able to identify similarities in each other. Conversely, well-mentored preceptors are likely to continue with their preceptorship roles.

This study revealed a gap in the working relationship between preceptors and faculty members especially when they visit the clinical area for student supervision. Furthermore, the results have indicated preceptors' need to collaborate with faculty every time they come for supervision so that they can learn from them. In view of this, faculty mentoring is proposed as a way to enable this model to become effective with few challenges. Whenever the faculty members visit institutions for student's supervision, they would be compelled to conduct duo roles of teaching the students at

the same time mentoring the preceptors. This would benefit the preceptors and assist them to build confidence in their clinical teaching as well as clinical supervision roles. However, there would be a need to work on improving the relationship between the two groups for effective mentoring. Cross, Lee, Bridgman, Thapa, Cleary and Kornhaber (2019) include supportive relationships and mutuality among enablers of mentoring apart from mentor availability, expertise and responsiveness. According to Barrett, Mazerolle and Nottingham (2017), mentoring is beneficial because it provides the individual being mentored the chance to feel connected, assimilated, and eventually legitimized into his or her future role.

Furthermore, several studies have suggested that faculty mentoring has several benefits including facilitating the recruitment, retention, and advancement of faculty (Bland et al., 2009; Gwyn, 2011; McKinley, 2004); socializing apprentices into an academic unit's culture (Bland et al., 2009; Cunningham, 1999; Lumpkin, 2011; Luna & Cullen, 1995); increasing collegiality and the building of relationships and networks among apprentices and mentors (Benson et al., 2002; Borders et al., 2011; Luna & Cullen, 1995); increasing productivity among both apprentices and mentors (Falzarano & Zipp, 2012); promoting professional growth and career development for apprentices and mentors (Kram, 1985) as well as increasing productivity and organizational stability (Bland et al., 2009; Cunningham, 1999; Falzarano & Zipp, 2012). Involving preceptors as mentees for faculty members would enable them to achieve these benefits.

As noted by Fountain and Newcomer (2016), many academic institutions have adopted faculty mentoring programs given the benefits of mentoring. However, they further noted that despite the benefits of faculty mentoring, several factors appear to be

associated with effective mentoring programs. These include clearly stated purpose and goals (Lumpkin, 2011; Luna & Cullen, 1995); support from faculty and leadership (Peters & Boylston, 2006; Zeind, Zdanowicz, MacDonald, Parkhurst, King & Wizwer, 2005; evaluation for continuous improvement (Lumpkin, 2011; Luna & Cullen, 1995); visible support from senior administration (Zeind et al., 2005); adequate resources (Zeind et al., 2005); inclusive design that instils mentoring as a cultural value and core institutional responsibility (Bean, Lucas & Hyers, 2014; Gaskin, Lumpkin & Tennant, 2003). Therefore, there is a need to consider these factors when considering preceptor mentoring for effective mentoring programmes. Preceptor mentoring by faculty members would enable the preceptors to improve on their teaching, supervision and evaluation expertise when interacting with students. However, the students would also benefit from each other through peer teaching or mentoring.

5.11.4 Peer Mentoring

Peer learning refers to the process through which learners acquire knowledge and skills through active helping and supporting among status equals or matched companions. It involves individuals from similar social groupings who are not professional teachers helping each other to learn and learning themselves by so doing

(Topping, 2005). As noted by Lupu (2009) peer learning strategies have been associated with the development of generic skills (transferable skills): critical thinking, intellectual curiosity, problem-solving, logical and independent thought, communication and information management skills, intellectual rigour, creativity and imagination, ethical practice, integrity, and tolerance. In support of the same, Leijten and Chan (2012) found that peer learning often results in an improved classroom environment and enhanced collaboration and teamwork. As indicated by Mustafa (2017), peer learning/mentoring,

as a teaching-learning strategy, is highly productive and demanding at the same time. It assumes that learners have many potentials to share with others. Mustafa further noted that at the time of rapid technological development, exchanging information is necessary for broadening learners' minds.

Peer learning would change the nature of learning to be pleasant, beneficial and meaningful, as learners become more positive and deeply involved. Peer learning is a method that encourages 'meaningful learning' which involves students teaching and learning from and with each other (Keppell, Ada Ma, & Chan, 2006). It involves exchanging ideas, knowledge, and expertise among peers. Peer-learning schemes now exist on all continents and hold relevance for students of all cultures (Keenan, 2014). It becomes one of the main features of the process of learning and teaching in universities (Sneddon, 2015; Evans, 2015), and it is one of the most cost-effective learning strategies (Topping, 2005). Peer learning provides an immense improvement in student performance and leads to high rates of attendance (Liou-Mark, Dreyfuss, Han, Yuen-Lau & Yu, 2015). It encourages students to develop their learning to support their academic success and assists graduates to be well equipped for lifelong learning (Skalicky & Brown, 2009). In terms of benefits, Roberts (2005) concluded that there are many benefits to collaborative learning. Academic benefits include the enhancement of critical thinking skills, the active involvement of students in the learning process, the improvement of classroom results, and the reinforcement of students' problem-solving techniques. Socially, collaborative learning develops social support for students, constructs mutual understanding between staff and students and provides a positive atmosphere for practice and corporation. Psychologically, it increases students' self-esteem and develops positive attitudes towards teachers. Peer

learning is not just "putting children together and hoping for the best" (Topping, 2005). It is a form of interactive learning in which instructors heavily make use of in-class structured activities, ask questions, reply to students interrogates and correct misunderstandings. Students are encouraged to talk to each other, work with partners or in teams. Peer tutoring and cooperative learning are the longest established and most intensively researched forms of peer learning. Peer tutoring is characterized by specific role-taking as tutor or tutee, with a high focus on curriculum content and clear procedures for interaction.

Peer mentoring describes a relationship where a more experienced student helps a less experienced student improve overall academic performance and provides advice, support and knowledge to the mentee (Collier, 2017). Additionally, mentoring occurs when a senior person or mentor provides information, advice, and emotional support to a junior person or student over some time" (Lev, Kolassa & Bakken, 2010). The mentor is typically older and more experienced in the institutional/ organizational context, and draws upon her experience to guide and support the mentee's efforts to advance within that same context (Collier, 2017). Peer mentoring is also referred to as peer learning and the term "peer" can also refer to people who have equivalent skills of different experiences (Green, 2001.) Peer learning is also described as a two‑way reciprocal learning activity which includes sharing knowledge, ideas, and experiences in a way that has some benefits for both groups of peer and student (Boud & Lee, 2005). Similarly, a mentor in clinical teaching is the one who is in a class/year above the mentee or one who has equivalent skills with different experiences for proper direction and support. Traditionally, clinical skills are taught using a modelling technique, in which an academic demonstrates skill with a return demonstration from students (Gray, Wheat, Christensen & Craft, 2018).

However, this method can impact student's education and learning due to time constraints, lack of student engagement, large class sizes and greater faculty demand and limited faculty resources (McKenna & French, 2011; Brannagan, Dellinger, Thomas, Mitchell, Lewis-Trabeaux & Dupre, 2013; Dennison, 2010). The underlying educational philosophy of peer learning is students teaching students, which has mutual benefits for both the peer tutors and the peer learners (Williams, Olaussen & Peterson, 2015). Peer mentoring has been used as a student-centred retention strategy that provides an avenue for constant mentor-mentee interaction, and it has been documented to have a positive impact on the success of undergraduate students in higher education (Jeffreys, 2012; Robinson & Niemer, 2010). The literature describes the impact of peer mentoring strategies in reducing anxiety (Szlachta, 2013), improving self-confidence (Brannagan et al., 2013), increasing personal and professional growth, and increasing effective communication, cooperative learning, and critical thinking (Cooper, Martin, Fisher, Marks & Harrington, 2013).

In nursing education and practice, peer mentoring has contributed to professional skills acquisition (Fogle, 2011) and provides a student-centred retention strategy that enhances mentor-mentee interaction in a nonthreatening environment. Benefits for the peer tutors are widely expressed, including enhanced confidence in perceived knowledge and clinical skill level, increased leadership abilities, communication skills, problem-solving skills, reflective practice, self-esteem, along with an enhancement of deeper learning and an appreciation for how much they have learnt and how much they are yet to learn (Evans and Cuffe, 2009; Roscoe & Chi, 2007). As noted by Igbo and Sule (2019), playing the dual role of mentor-mentee exposes students to new materials

and continuous review of old materials, thereby encouraging retention of information learned earlier in the program. Furthermore, guidance by peer mentors resulted in increased knowledge among mentees and greater utilization of facilities and resources (Igbo & Sule, 2019). The peer mentees displayed increased confidence and empowerment and verbalized satisfaction at the benefits of the program, which included improved course grades. The peer mentors expressed self-fulfillment and improved leadership skills.

As a benefit of peer learning, it seems necessary to appreciate friendship in clinical learning environments among nursing students. In other words, more flexibility with students at clinical learning environments in interacting with their peers, whom they trust as friends, can facilitate earlier integration into the students' community and, hence, enable peer learning for support (Roberts, 2009). A review of studies has shown the use of the peer learning method in nursing education. Results of most of these studies that have been designed as a quantitative approach indicate that peer learning encourages interaction, facilitates engagement with learning, and increases personal development (Kamali, Shakour & Yousefy, 2012; Botma, Hurter & Kotze, 2013). As expressed by Ravanipour, Bahreini and Ravanipour (2015), the advantages of peer learning were better learning with no stress and reduced anxiety in performance and a decrease in stress and practical mistakes. They were largely due to mentors judging the students' practical and scientific disabilities. Ravanipour, Bahreini and Ravanipour (2015) indicated that one of the students said, "When the peer was our classmate, our stress got less; it was easier to talk about our problems to him/her than to the teacher. The teacher could criticize us for why we hadn't learned such cases yet. Naturally answering our friends was much easier." They go on to state that the student's comment on the accuracy of the work and self‐confidence had two aspects which are increasing

the accuracy of the work and reducing the mistakes. It consequently increased the confidence due to the work done. They also observed that if the students did such things alone, they could increase their accuracy in order to avoid mistakes. Besides, the confidence would increase due to the work done independently (Ravanipour, Bahreini & Ravanipour, 2015). A systematic review of peer teaching and learning in clinical education suggested that when the students evaluated their own learning and reported increased confidence in leadership roles when working with a peer (Secomb, 2007). It has also been emphasized that students adopting the peer mentor role get some benefits like leadership and teaching skills from peer teaching and learning experience (Duchscher, 2001). Effective management of clinical skills learning and teaching in simulated environments is therefore crucial.

Peer-to-peer teaching is seen as a learning partnership between nursing students, where education is delivered reciprocally through shared knowledge, experiences and ideas, traditionally without the immediate influence of an academic (Ravanipour, Bahreini & Ravanipour, 2015). Furthermore, with increasing student numbers and economic pressures on universities, peer tutors serve as a cost-effective way to provide one-on-one attention, feedback and performance correction to junior peers while decreasing demand on faculty members (Dennison, 2010; Bensfield, Solari-Twadell & Sommer, 2008; Stone, Cooper & Cant, 2013; Reid, Chau & Thalluri, 2016). Students may contribute significantly to each other's learning as peers through support and shared learning. Irvine, Williams and McKenna (2018), described the benefits of near-peer teaching to include creating a safe supportive learning environment, learners viewing near-peer teachers as effective role models and increased confidence experienced by learner and teacher. Furthermore, an understanding and experience in educating and

confidence in supervision and leadership for the peer tutors is a transferrable and core competency to their future careers as registered nurses, specifically when dealing with unskilled staff, patients and students in the workplace (Christiansen & Bell, 2010; Williams, Olaussen, & Petersonc, 2015; Christiansen et al., 2011; Ravanipour, Bahreini & Ravanipour., 2015; Stables, 2012; Ten Cate & Durning, 2007). The scope of practice for professional nurses in Malawi for example stipulates that they have a responsibility to teach nursing and midwifery students while in the clinical area (NMCM Act, 1995).

Secomb (2008) suggests that peer-to-peer learning elevates some of the aforementioned issues with a reduction in anxieties towards studies and those held towards future clinical placement. Furthermore, a number of studies and systematic reviews found that peer-to-peer learning provided enhanced critical thinking skills, an enriched sense of self-determination, empowered learning and improved student collaboration (Evans & Cuffe, 2009; Stone, Cooper & Cant, 2013; White et al., 2010; Christiansen & Bell, 2010; Brannagan et al., 2013). Many of the benefits for peer tutees arose from the informality of the learning environment. Colvin and Ashman (2010) identified that a more relaxed, supportive, non-threatening environment promoted reduced anxiety in the students. This is what happens during peer-to-peer teaching Additionally, McKenna and French (2011) and Bensfield, Solari-Twadell and Sommer (2008) suggest that this relaxed environment made the peer tutors more approachable than academic staff the instructors. This reduced anxiety facilitated discussion, problem-solving, and reflective knowledge building, explorative learning and challenged wrong assumptions without judgement or intimidation (White et al., 2010; Christiansen et al., 2011). With the adoption of peer-to-peer teaching in nursing education, peer tutors are better positioned to understand and appreciate the difficulties and barriers that current nursing students

face, more so than academic tutors, and therefore can tailor their teaching approaches to target individualised education (Ravanipour, Bahreini & Ravanipour., 2015; Carey, Kent & Latour, 2016).

Peer tutors are able to draw on past experiences in their given course, on which they can capitalise to create an environment that can be comforting and non-judgmental for student learners (White et al., 2010). Stone, Cooper and Cant. (2013) identified this in a systematic review, as they suggest that a successful peer learning environment is one in which peers teach peers who are close in experience or stage in the course to offer a more relaxed and less intimidating environment than one offered solely by a registered nurse academic. This type of learning is helpful as it enables continuity in the learning process due to the availability of mentors as opposed to faculty members whose presence is limited due to their increased job demands (Collier, 2017). Some students are more comfortable learning from their peers, therefore may use each other as a resource to learn. Several studies reported that learners had increases in knowledge and skills or were able to acquire knowledge from the experience of being taught by a senior peer (Christiansen and Bell, 2010; Christiansen et al., 2011; Dumas et al., 2015). As noted by Collier (2017), in a peer mentoring relationship, new students first watch more experienced student mentors use role-related knowledge in the form of problem-solving scripts to deal with a range of college adjustment issues. Mentees are then provided with the opportunity to practice enacting the role themselves while receiving feedback to further refine their performances. This type of learning, however, usually takes place informally. It would be of help to formalize this through the proposed tripartite model where students would be aware of the need to assist one another in the clinical setting. Despite the numerous benefits of peer mentoring, it would be of help to inform the

students of the challenges they would be subjected to in this model of clinical teaching and learning.

Several studies have found that although peer-to-peer learning provides positive aspects to nursing education, there are several negative aspects (Loke & Chow, 2007; Carey, Kent & Latour, 2016). Stone, Cooper and Cant. (2013) suggest that supervision and observation from a registered nurse is required in peer-to-peer education to ensure that correct information and techniques are offered. The utilization of a registered nurse in this aspect would be different from the scenario where the nurse is involved in clinical teaching as she would only be required to oversee the peer-to-peer education being carried out by the peer teachers. Literature has indicated that questions of a peer tutor's capacity for effective teaching were widely challenged, suggesting that peer tutors may not possess the necessary experience and knowledge required for effective teaching and learning (Brannagan et al., 2013; Loke & Chow, 2007; Christiansen and Bell, 2010; Carey, Kent & Latour, 2016; Williams, Olaussen & Peterson, 2015).

Inaccurate information is a risk that may be detrimental to tutees assessment and clinical performance (Stone, Cooper & Cant, 2013). Furthermore, variance in teaching with opposing knowledge gaps and teaching styles between the peer tutors may present a disadvantage to student groups (McKenna & French, 2011). From the students' point of view, peer mentoring as an educational process had some disadvantages such as lack of any chance for them to show their capabilities, acquiring the ideas in wrong or limited ways from peers, dependence on peers, and so on. There can be some disadvantages in the form of competition, along with feelings of being misunderstood, leading to hurt and making unhelpful comparisons with others in peer-assisted ways (Jones, 2008).

There are also many serious barriers to mentors that include the difficulty of role modelling care work in the context of nursing roles which are increasingly concerned with more technical work (O'Driscoll, Allan & Smith, 2010). Thus, quality assurance of learning with this model may be difficult, as senior peers are not experts in the profession (Christiansen & Bell, 2010).

Several studies identify the importance of peer tutor supervision and suggest that it is imperative for effective learning to counteract the knowledge gaps and inexperience of student tutors (Ravanipour, Bahreini & Ravanipour, 2015; Stone, Cooper & Cant, 2013; Owen & Ward-Smith, 2014). In view of this observation, Loke and Chow (2007) suggested that lecturers should be made available as a resource to student tutors. This would assist in addressing the common frustration of inadequate knowledge of the tutors as described by student tutees throughout their study. Although several studies identified the importance of academic supervision, limited studies identify the advantages of academic support for peer tutors in peer-to-peer clinical skills teaching for the Bachelor of Nursing degree (Ravanipour, Bahreini, Ravanipour, 2015). This is supported by Brannagan et al. (2013) who identified that overall, the presence of faculty was valued with greater critical thinking and problem solving when supported by the instructor. Additionally, it was also noted that student tutors may have helped to alleviate the anxiety that may be normally directed at the instructor, further supporting the learning environment (Brannagan et al., 2013). It is therefore very important that these challenges should be considered and possible ways to control them should be provided before initiating the model.

Ravanipour, Bahreini and Ravanipour (2015) considered introducing peer learning to students earlier. According to the participating students in their research study, the

value and importance of peer learning provided a less stressful and more respectful learning environment. Because of the importance of independence in giving care to patients, most of the students advocated the early application of this teaching method in learning, after which the process of learning could be handled by each student individually (Ravanipour, Bahreini & Ravanipour, 2015). Thus, they considered this learning method to be more effective during the early days of learning. Ravanipour, Bahreini and Ravanipour. (2015) observed that because of the students' high collusion in giving high scores to each other, their inability to have a comprehensive approach, and their consideration of different aspects of the evaluation, they assumed that peer assessment roles were inefficient. Most of the students mentioned this as teamwork learning which helped them identify their own and their peers' characteristics much better. Moreover, some points were showing the socialization process of students, i.e. students' awareness of their negative characteristics and the ways to control or overcome them while working with others, respectful training, and preserving the peers' characteristics, condemning jealousy or humiliating peer groups' mistakes. The students who participated in the study were completely relying on learning from their peers and had taken this seriously as they expected an educational role from their peers like from their own teachers (Ravanipour, Bahreini & Ravanipour, 2015).

One of the important points about role-playing is that students, after some self-consciousness about the role, quickly settle down to project their own character and values into the role (Quinn. 2001)). It is the role play element of peer practice learning that also appears to provide some of the wider benefits highlighted in the study, such as increased empathy, improved communication skills, and enhanced decision-making ability (Hilton & Barrett, 2009). The findings of another study

revealed that the third-year nursing students who play the role of peers for the first-year students commented that the peer learning experience allowed them "to review their skills," allowing them to "evaluate their knowledge base," whereas the first-year students focused on the personal attributes of the third-year students, rather than their teaching ability, with comments such as "my third-year student was a friendly partner who was very patient with me." (Goldsmith, Stewart & Ferguson, 2006). In some cases, it is thought that there are links between confidence and learning, as confident students are allowed more access to patients (Roberts, 2009).

5.11.5 Continuing Professional Development (CPD)

The study found that post registration experience though crucial in selecting those to be considered for preceptorship roles, had a significant difference. Preceptors with more years of experience were less confident in their execution of the preceptorship role in comparison with novice preceptors. Therefore, the study recommends that the concerned preceptors (i.e. > 9 years of experience) should be encouraged to get involved in continuing professional development (CPD). Preceptors are expected to have the skills to be able to form an effective learning environment and facilitate a constructive clinical learning experience for students and new employees (Bengtsson & Carlson, 2015). As noted by Friedman & Phillips (2004), professionals are motivated to participate in CPD due to various reasons including viewing CPD as a means of keeping up-to-date with current issues in their profession. These tend to focus on learning that is specific to their profession and may look to their professional association to notify or warn them when new ideas or approaches were emerging in their field. Thus, they may want at least part of the content of their CPD to be externally directed. Similarly, as noted in this study, the concerned preceptors (i.e. > 9 years of

experience) need to be directed on areas they need to focus on during the CPD sessions. Friedman & Phillips (2004) further clarify that individuals are more likely to get involved in CPD activities if personal development and career progression is the motivation for CPD participation. Individuals are more likely to review their CPD records and/or plan their CPD in the light of what they perceive as their own future requirements as well as what is currently needed. Therefore, explaining to the concerned preceptors the need for them to be involved in CPD sessions as a means of keeping themselves up to date with current issues would motivate them. It is envisaged that involving them in CPD would assist them in improving and broadening knowledge, skills and attitudes necessary for the provision of quality nursing and midwifery care thereby promoting their confidence. According to the Continuing Professional Development Logbook by the Nurses and Midwives Council of Malawi (CPD Logbook, 2019), CPD is a process of lifelong learning aimed at improving and broadening knowledge, skills and attitudes, which are necessary for the provision of quality nursing and midwifery care. It is continuing because there are always new developments happening in nursing and midwifery which must be incorporated into practice. The study found out that preceptors with > 9 years' experience were less confident to practice possibly because of their new roles as managers which pushed them away from practice and needed to be updated on the new developments. The CPD Logbook (2019) further indicates that CPD is professional as it is directly linked to professional competence which is necessary for nursing and midwifery practice. It would therefore be necessary to let the preceptors identify their shortfalls in preceptoring the undergraduate nursing and midwifery students so that they realise the need for CPD. One method for identifying personal areas in need of improvement involves reflective practice (Tofade et al., 2015). Reflection helps one discover other

perspectives after experiencing an event, allowing for a thorough analysis and the creation of new ideas (Schön, 1983). Additionally, when implemented in a structured manner, such as through the use of a portfolio, reflection can track an individual's progress over time, which can have beneficial, lasting effects on the expertise of an educator. By setting individualized professional short-term and long-term goals, educators can use the portfolio to help monitor their progress in achieving these goals (Ricchetti & Jun, 2011; Kuhn, 2004) Through the process of reflective practice and the identification of strengths and weaknesses, preceptors can gain confidence in their continued accomplishments Pinsky & Fryer-Edwards, 2004). Reflection has been shown to be beneficial in health professions and education, but it must be guided properly and pertain to the specific environment in which changes would occur (Mann, Gordon & MacLeod, 2009). As noted by Davis, Mazmanian, Fordis et al. (2006), there is a need for reflective training because all practitioners do not consistently provide accurate self-assessments. A lack of skills and experiences in reflective practice may be a reason why reflective practice is not routinely used to achieve professional growth (Gunn & Goding, 2009). these weaknesses in reflective practice need to be prevented in order to achieve a desired CPD outcome in the affected preceptors.

5.11.6 Promoting a Good Working Relationship among Preceptors, their Colleagues and Faculty Members

Study findings revealed a lack of good working relationships between preceptors, their colleagues who are not trained preceptors as well as inadequate numbers of trained preceptors against an increased number of nursing students. This ends up piling pressure on the available preceptors as they cannot cope with the student numbers as well as their double binding roles which combines patient care and clinical teaching.

This indicated a lack of preceptor support, which made the preceptorship role to be a burden to the preceptors. It would, therefore, be very important to improve the working relationship between preceptors and faculty members. This could be in form of periodic meetings where preceptors and faculty members would interact instead of waiting for the time students would come for clinical placements. The joint meetings could be utilised to inform the members concerned about the roles of preceptors and the need for collaborative efforts in clinical teaching. Furthermore, when the students are in the clinical area for practice, the faculty members need to follow up to briefly provide an overview of the course objectives. The faculty member must share the current course syllabus with the preceptor including any changes in the curriculum. This helps to ensure the preceptor's integration with the nursing and midwifery program. It is the responsibility of the faculty member to ensure that the student has met the requirements of the institution where the student is coming from.

As indicated by Horton et al. (2007), nursing faculty must understand the role of the preceptors who would be working with the new graduates so faculty can convey the expectations of the preceptor to students. New graduates need to understand the demands of a preceptor. Educators can explain the many roles of the preceptor as well as the stressors. Faculty can prepare the new graduates to be active learners and assist the preceptor in the orientation process. Orientation is an active process, and new graduates should be able to articulate their own learning needs to the preceptors. Faculty can meet with each student at the end of the senior year for a thorough assessment in which, together, they identify the student's learning needs as a new graduate. Graduates can share their learning needs with the preceptor so graduates and preceptors can incorporate these learning needs into the orientation plan. There is a need therefore to

improve the working relationships between the preceptors, faculty members and workmates who are not preceptors in order to enhance effective clinical learning and teaching experiences among nursing students. Within the preceptorship model, the three participants, namely the preceptor, the preceptee and the nurse educator have unique responsibilities (Lethale et al., 2018).

Furthermore, the available registered nurses should be encouraged to enrol and be trained as preceptors to increase the number of nurses who can competently teach students within the clinical sites. Nursing colleges should agree and put together financial resources and provide scholarships to practicing registered nurses for them to be trained as preceptors. This is because preceptors teach students from all the training institutions. There is also a need to engage nurses not trained as preceptors to change their mindset and begin to work with their colleagues in supporting nursing students during clinical practice. Joint working relationships between faculty members and preceptors should be encouraged to promote students' respect for preceptors as the study has revealed that students respected their Lecturers/Tutors more than they respected the preceptors. There is a need for teamwork every time faculty members visit the clinical area for supervision and clinical teaching. As expressed by Löfmark et al. (2012), both teachers and preceptors have their own roles within the supervision system. Preceptors are the experts on clinical practice, whilst university teachers can provide a more theoretical perspective of the clinical area. The preceptorship model portrays the importance of collaboration for the production of knowledgeable, skilled and competent graduates (Happell, 2009).

Preceptees depend on preceptors, staff members and nurse educators to achieve specified learning outcomes. Preceptors perceived themselves as having a good

relationship with unit managers, students and other professionals in clinical areas. This emphasizes the importance of the triad relationship for ensuring that effective clinical learning. Lawal, Weaver, Bryan and Lindo (2016) indicated that over 50% of their study participants desired improved relationships between the nursing training institutions and the clinical units. Furthermore, faculty members and preceptors should jointly assess and evaluate students which would promote students' trust in preceptors. It would also motivate the preceptors to continue assisting the students as they would feel being recognized by the faculty members.

5.11.7 Promoting a Reading Culture among Preceptors

Findings in this study indicated that preceptors were not reading books/journals as expressed in the statement "I read updated texts and journals regularly (M =5.38, SD=1.45)" which was rated the lowest by the participants in the study. This finding revealed that the respondents were not reading texts and journals as expected of them as preceptors for undergraduate nursing and midwifery students. Therefore, there is a need to promote a reading culture among the preceptors as they need to have updated information which the students require in the clinical area. This could be in form of encouraging the preceptors to utilize nursing and midwifery training institutions libraries to access journals and other reading materials. Hospitals should be encouraged to have reading areas with current and up to date reading materials for use by the preceptors.

Faculty members also need to recommend texts or journals to the preceptors so that they can ace those journals and read. Another action by the faculty members would be to bring different reading materials to the preceptors for their perusal. With an increase

in technology, it would be important for preceptors to try online studies in preceptorship. As indicated by Burns et al. (2006), preceptor education is vital to the success of healthcare institutions. Preceptors' roles are complex and require up-to-the-minute programs reflecting crucial mentoring responsibilities for orientees in multifaceted working environments. Finding the time to properly educate preceptors while maintaining quality bedside care is a challenge for staff development educators during the nursing shortage. Offering a preceptor education program online can assist preceptors in the adoption of role changes promptly. If preceptors enroll in an online preceptor education, they would be encouraged to read in order to meet the requirements for the online education. In the end, the preceptors would be up to date with current issues evolving in the nursing and midwifery profession.

As indicated by Ohrling and Hallberg (2001) another way to support the preceptors in increasing their teaching competence could be to create networks between preceptors in the region and the faculty members.it is envisaged that apart from increasing the teaching competencies, the networks would assist in promoting a reading culture among the preceptors. One other way could be to engage faculty members as reflective partners for preceptors and to hold reflective meetings regularly (Ohrling & Hallberg, 2001). Through such strategies, the linkage between the preceptors' contextual working knowledge and competence and the faculties' research-based theoretical knowledge could be interwoven and promote each other, to the best advantage of the students' learning.

5.12 Areas For Further Research

This study did not measure the effectiveness of preceptorship in facilitating students clinical learning because it was beyond its scope. However, it is necessary that further research is conducted to generate local evidence on effective models of preceptorship. This would help in promoting clinical teaching and learning of students during placements in Malawi. A study to solicit views from undergraduate nursing and midwifery students may be conducted with a focus on the students' experiences working with preceptors. It would be interesting to inquire from the students who have worked with preceptors and relate the findings to what the preceptors indicated as their role in clinical teaching of undergraduate nursing and midwifery students in Malawi.

Research should be conducted to investigate the working relationship between preceptors and faculty members whose findings may assist to improve collaboration thereby enhancing clinical teaching and learning. The findings in the study have revealed that there is less inclusion of preceptors whenever faculty from institutions that send students come for supervision and teaching. Therefore, there is a need to find the reason for this development as it is expected that these two groups should work in collaboration. Collaboration between the two groups would enhance effective clinical teaching and learning.

The study findings have revealed that some preceptors expect rewards when executing their preceptorship roles. There are indications that some preceptors expect rewards in monetary form such as a top-up to their monthly salaries. Though the results have revealed that preceptors are contented with the professional rewards due to their

involvement in the preceptorship role, others are not. Further research on motivation to involvement in the preceptorship role would assist institutions to find ways of sustaining the programme. The findings of such a study would reveal what the preceptors require for them to be contented with their role. the evidence would help the training institutions in terms of including the preceptor motivation in their budgets.

5.13 Study's Contributions to Malawi

The study has contributed to research studies in Malawi in the following ways:

Firstly, it has revealed the utilisation of CPEET as a reliable tool for use in Malawi on studies concerning preceptorship. The tool was utilised for the first time and proved to be reliable by Cronbach's alpha calculations of the four domains which indicated good internal consistency.

Secondly, the study has indicated a significant difference in the level of confidence based on post registration experiences. It had been a general conclusion that the more experienced one is the more level of confidence and competence he/she would have. However, the study indicated that the more experienced preceptors were less confident as compared to those with few years of experience. This revelation would assist training institutions when hiring Lecturers/Tutors when beefing up their academic staff members. They would not only base on experience alone but possibly other characteristics such as interest in teaching as well.

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APPENDICES

Appendix 1: Data Collection Tool

Participant Number……...

SECTION A Demographic data of the preceptors

a. Gender
   Male [ ] Female [ ]
b. Registered Nursing qualification
   MSc [ ] BSc [ ] Diploma [ ]
c. Post-registration experience
   0 – 1 years [ ] 2 – 3 years [ ] 4 – 5 years [ ]
   6 – 8 years [ ] ≥9 years [ ]
d. Preceptorship training institution
   KCN [ ] MZUNI [ ] Other [ ]……
e. Post preceptorship training experience
   0 – 1 years [ ] 2 – 3 years [ ] 4 – 5 years [ ]
   ≥6 years [ ]

SECTION B CLINICAL PRECEPTOR EXPERIENCE EVALUATION TOOL (CPEET)

	Item	Strongly Disagree 1	2	3	4	5	6	Strongly Agree 7
	ROLE DOMAIN							
1	Clinical preceptors are a professional confidante to students.							
2	Clinical preceptors are a support person for students during their clinical placement.							
3	Clinical preceptors are a professional friend to students.							
4	Clinical preceptors are a positive role model.							
5	Clinical preceptors facilitate active learning experience for the student.							
6	Clinical preceptors promote students' active participation in patient care.							
7	Clinical preceptors provide clinical practice supervision for the students.							
8	Clinical preceptors provide constructive feedback to the student.							
9	Clinical preceptors encourage students to apply theory to the clinical situation.							
10	Clinical preceptors facilitate students to make the links between theory and clinical practice.							

11	Clinical preceptors facilitate students to analyse clinical problems.							
12	Clinical preceptors facilitate students to critically reflect upon clinical problems.							
13	Clinical preceptors model multidisciplinary teamwork for the students.							
14	Clinical preceptors support students by being available to answer questions.							
15	Clinical preceptors facilitate students' learning by using case studies and care plans.							
16	Clinical preceptors treat students with respect.							
17	Clinical preceptors treat students fairly.							
	EXPERIENCES AND EDUCATION DOMAIN							
18	Clinical preceptors clarify the role of preceptor with colleagues on a regular basis to ensure the needs of the students are met.							
19	Being a preceptor, I need to know what the expected level of skill competence should be for a student's scope of practice.							
20	I read updated texts and journals regularly.							
21	Being a preceptor facilitates professional reflection on my own roles as a nurse.							
22	Being a preceptor challenges my work attitudes.							
23	Being a preceptor helps to expand my nursing knowledge.							
	SATISFACTION DOMAIN							
24	Being a preceptor is meaningful.							
25	Being a preceptor is satisfying.							
26	The role of preceptor is professionally rewarding.							
27	The preceptor role is an incentive to teach.							
28	I enjoy the student/preceptor interaction							
29	Being a clinical preceptor is an incentive for my own professional development.							
30	I enjoy facilitating novice nurses to develop as professionals.							
31	The clinical preceptors experience breaks the monotony of daily nursing practice.							
32	It is stimulating to work with enthusiastic nursing students.							
	CHALLENGES DOMAIN							
33	It is acceptable for students to clarify with the preceptor when there is a difference in practice.							
34	Personality clashes will not negatively affect my attitude towards a student.							
35	Though I am very busy, I am willing to be a preceptor.							
36	I am motivated to precept students							
37	Being a preceptor will not take my time away from providing direct patient care.							
38	Being a preceptor is not time consuming.							
39	I am willing to make time to support unmotivated students.							

Appendix 2: Permission to use the CPEET

Dear Tony O'Brien and Michelle Giles,

I am Lucky Mhango writing from Malawi. I am currently pursuing a PhD degree with the University of Malawi. As a requirement for the said degree, I have to conduct a study towards the attainment of the same. I have come across your article evaluating the preceptor role for pre-registration nursing and midwifery student clinical education. In this study, you used a Clinical Preceptor Experience Evaluation Tool (CPEET). I am in the process of developing a research study similar to yours entitled Evaluating the preceptorship role for undergraduate nursing and midwifery students in Malawi. I feel I can use the CPEET for my study basing on the variables I am focusing on. I am hereby requesting permission to utilize the CPEET or adapt it in my study. If possible, I am further requesting if you can send me a copy of the tool so that I can critically have a look at it.

Waiting to hearing from you soon.

Thank you.

Lucky Mhango <mhangolucky@gmail.com> 7/16/16

Tony O'Brien <Tony.O'Brien@hnehealth.nsw.gov.au> 7/19/16

Go for it Lucky - please share your data so we can compare results and collaborate in a paper together. Everything you need is in the paper but don't forget extra comparisons using total scale score against demographics.

Kind regards

Tony

Appendix 3:In-Depth Interview Guide

Date of interview……Interviewer……Interviewee No…..

Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi

1. Describe your role as a preceptor for undergraduate nursing and midwifery students at this institution.
2. Can you relate the preparation you had on preceptorship to the actual encounter you have so far experienced as a preceptor?
3. In general, tell me more about the experience you have had as a preceptor.
4. What do you perceive as satisfying in your involvement as a preceptor for undergraduate nursing and midwifery students?
5. What are the challenges for you as a preceptor for undergraduate nursing and midwifery students?

Appendix 4: Informed Consent

Dear participant,

I am Lucky Mhango, a Doctor of Philosophy (PhD) degree Candidate in Inter-professional Healthcare Leadership at the University of Malawi, Kamuzu College of Nursing. In partial fulfillment for the award of the PhD degree, I am required to conduct a study related to the course I am pursuing. My study is on exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi. I would like to request you to participate in this study owing to your experience as a preceptor for undergraduate nurses and midwives.

The purpose of this study is to explore the role of preceptors in clinical teaching for undergraduate nurses and midwives in Malawi. If you agree to participate in this study, you will be required to complete a Clinical Preceptor Experience and Evaluation Tool (CPEET) which will be provided to you. The completed tool will be kept under lock and key for confidentiality and later be destroyed after a final report has been handed to Kamuzu College of Nursing.

This study is non-experimental and there are no known risks associated with it. Your participation is voluntary as such there is no payment attached to your participation. You will be expected to complete the CPEET within a maximum of two days. You are free to withdraw or stop participating in this study when you feel uncomfortable at any time. Your withdrawal from the study will not have any negative effect on you. No name shall appear on the questionnaire and the final report instead, numbers will be used to ensure confidentiality and anonymity.

I should be very grateful if you can take note of my request and accept to participate in this study. If you have any questions concerning this study, you can call me on 0888317244 or 0995421648.

Statement of participation

I have read and understood the above information. I have been given the opportunity to ask questions and withdraw my consent at any time. I fully understand that my participation is purely voluntary. I fully wish to participate in this study of my own will without coercion.

Participant: Signature:.....…….. Date:..……

Researcher: Researcher's Signature:……. Date:……

Appendix 5: Sample Transcripts

Participant 005
Describe your role as a preceptor for undergraduate nursing and midwifery students at this institution.
"…yeah my role is to teach students in the clinical area. That is to help them connect between the theory part and the clinical part…supervision is one of them, mentoring is one of them…yeah evaluation is also part of my role but since I graduated as a preceptor, I have never taken part in that…I have never been involved. But I feel like it's one of the roles that I need to carry out…ok the other time we had students then there was this time for evaluation. I just heard that the students are being evaluated. So it was the lecturers taking the students, evaluating them and then off they went so it was hard for me to actually ah…meet the lecturers to ask why they did that because they were not in the ward with students. The students were in the ward with us full time…the involvement in evaluating the students is not there…according to me."
Can you relate the preparation you had on preceptorship to the actual encounter you have so far experienced as a preceptor?
"…yeah…the preparation…there is that relationship because during preceptorship training yeah…we were taught to actually…when the students are in the ward we should orient them, we should review the objectives together then we should create a conducive environment …all those so I feel like there is that relationship…they are related, yeah." "When I…when I was prepared to become a preceptor...*pause*…the other things which I learned I can apply them here and relate them here. For example, initially, I was…when I…when I was…when I came from college starting … to start working here, I knew that it was my role to teach as an SRN but my way of teaching was haphazard. Initially, I was teaching students without having an interest in teaching…and understanding whether…without assessing them whether they understand or not. But now when I find a chance I am able to review books…mmm…to go back to see if…what is going on here …whether I am making headway in my teaching or not. Secondly, the way I am handling students now is different from the way I used to handle students before being trained... Some students who are…who have…who are challenging…challenged, I am able to …to approach them in a manner that…the learning will be enhanced unlike confronting them, the way I used to do sometime back".
In general, tell me more about the experience you have had as a preceptor.

"…yeah…the experience is very good because once the students know that you are the preceptor, they actually respect you. They treat you as one of the lecturers and then whatever you tell them, they listen and if you give them like assignments they carry them out and then they are always calling for you to help them so I feel like I am being respected…I am that important like lecturers…on involvement, mmm…I should say there is very little…minimal involvement. Because most of the time they just ask…where are my students? Oh…they are in the labour ward…ok, then they go there. They start working with the students; off they go…I am not there…yet I am a preceptor."
What do you perceive as satisfying in your involvement as a preceptor for undergraduate nursing and midwifery students?
"yeah…it is satisfying because when we were just working as nurses we just work for the sake of working and helping the patients off they go. But then when you help somebody acquires knowledge and skills off she goes and she performs better because you have helped him/her it's sort of satisfaction. On continuation of preceptorship training, I would say it's better to continue but then during the training itself, I would like to suggest if we could have more time for clinical practice…the theory should be less but the practical aspect should be more. I was trained for six weeks…but then…then…for the clinical part we were supposed to do them in our respective institution…places but then the supervision was not all that enough so we were relaxing…I should say…yeah"
What are the challenges for you as a preceptor for undergraduate nursing and midwifery students?
"…yeah some of the challenges are the ones that I have already highlighted that we don't work hand in hand with lecturers. And so because we don't do that when a certain student misbehaves, it's hard to like…to report because you don't know where to go and the like yeah…on the other hand, working with them would help us reflect on our teaching skills as some of us…mmm are new in teaching. The other challenge is number of students at a time. It may happen that you have ten students so for you to follow up with each and every student, it becomes a problem. The other challenge is sometimes the students are placed in your ward, they are there just for two weeks or three weeks off they go, then they will come back after some time so it's hard to like assess them, to follow them yeah…the other challenge, I think it's not much connected to preceptors but then some of the qualified staff…they don't want to take part in teaching the students because they feel like… this one went for preceptorship…she ate money so she is the one to teach the students. So if you are not there if they ask them…they will say no, wait for the preceptor…yeah."

On recognition, I would say there is none…there is no recognition…oh…previously we were being involved like on...like on the issue of placements. The allocation, they were saying we should be involved because when this institution is sending its students to the institution you should be involved so that you should be able to say …no there are too many…no that time we will be having students from this institution so please can you choose another time but then we are not all that involved…yeah…so we are not all that recognized I should say…yeah. *On records of preceptors*…I think they don't have the records…I think I should add one thing on the issue of the challenges. The other challenge is like we are only four on duty and then I have the students…like me, I spend much time in theatre…I like spending much time in theatre so it means the contact between me and the students is very little as they do not work in theatre where I spend much of my time."
Participant 007
Describe your role as a preceptor for undergraduate nursing and midwifery students at this institution.
"eeh! Really, there are several roles that I would mention. And some of them is that…to start with, being somebody who is qualified and you are already in the system, you present yourself as a role model to those who are joining the profession. Ah…in other circles you are there as probably an instructor whereby you are trying to give professional instructions that are required in the course of modelling our students who are yet to become qualified in the long run. And also…at times it's like you work like a bridge between the college where the students are coming from and also the hospital…the teaching environment where they are coming to attain their practical ah…skills, knowledge and attitude. So you are also there to advocate ah…for the students, say they are meeting this, how can we do this. There are several roles that I would mention…yeah."
Can you relate the preparation you had on preceptorship to the actual encounter you have so far experienced as a preceptor?

"yeah...there is a huge relationship. Very big one ah…because before you undergo that type of… well-stipulated training…to do with preceptorship…that you use more or less like basic knowledge that you have had…at the time you were doing probably your upgrading course or wherever you are studying…you use that knowledge up until you go to that training that's when you really try to marry the two. So when you as ah…accept and really feel the experience that the students are going through the challenges and also you are also accorded you know…a chance to know the skills on how you can assist the students. I will give one example that before doing this at time I would feel that when a student is troublesome or he proves to be troublesome or not to be committed…cooperative in the training you would say to hell, I have got nothing to lose. Up until you learn the…in the…especially the topic about challenging student then you are there to accommodate each and every student…try to assist them so that they are not left out up until they finish…so these are some of the issues…so really there is a very big relationship that really helps to…how to handle the students in the clinical placement when we are working."
In general, tell me more about the experience you have had as a preceptor.
"ah! It has been so good of course the challenges are there because for you to perform, you need also support from other quarters…mmm…from the college where the students are coming from…you need resources such as gloves, aprons, face masks and other protective equipment. You also need to be discussing with the students, to interact with them ah..per…at least once in a while, you need to have a postmortem with them…what are the challenges…for me, I would say mmm…it has really assisted me anyway…ah…ah. I have really felt the impact of doing this and even the students, some of them have even come to say mmm…you have really assisted us unlike before…before being trained in that particular concept."
What do you perceive as satisfying in your involvement as a preceptor for undergraduate nursing and midwifery students?

"yeah…satisfaction is there. Of course not about monetary issues but when you meet a student whom you feel ah…this one seem not ready to achieve what is supposed to be but he/she deserves support and all…when you have really intervened in your capacity as a preceptor using the skills, knowledge and attitude that you have acquired after undergoing that training and you see the student re-performing or achieving or succeeding in whatever she is doing…to me I feel that is the greatest source of satisfaction…*ntchito za manja anga…(the work of my hands)…*you really feel it that at least I have done something and you even leave a mark in the mind of that particular student. You end up creating friendship. Whenever you meet, greetings…with …you feel proud that really I think God had blessed me to acquire that particular responsibility and transfer to these youngsters."
What are the challenges for you as a preceptor for undergraduate nursing and midwifery students?
"ah! one of it is the coordination between me and the school…the other one is that if you look at the ratio between the preceptors trained ones rather and the number of students…who are coming to the facility where these preceptors are working, you see that the ratio is just too huge. Like here, we are only two so as…if I may take you to a recent situation whereby, we have about…about fifty students coming to the facility and yet ah…you are just alone probably in your ward there about twelve or fifteen…on top of your daily routine. So, it really comes as a burden to a certain extent. It requires one really to work on the…not categorizing the time…planning how I can do this…or this but then it doesn't really make you to reach where you would feel you would have done if at all you were a number of you looking at these students. Then another issue is that at times there is no support from the colleagues who have never done such a training because if you have done that training, some other people they feel like since you are the one who has undergone this training then everything to do with students is for you. But that is not ok because when you come out of that particular training, you try to brief others…you give a second hand information anyway because they are not meeting the tutors or facilitators of all that but still more you tell…you give them the basics on how they can really do that even though they have not undergone that training. So, there is also lack of coordination or support from colleagues who are left behind in this particular issue. When these students are learning, let's say in their block…they come to the ward. They expect to meet what they have done in class. Equally, when you are also

teaching them…it's like you know the right things, you know the right materials but with the setup that we are working…you know our Malawian setup…we are meeting a lot of challenges…resource issue …you see that it is full of improvisation. In so doing, it's like you…the optimal level of that knowledge and skill that you are transferring from you being a preceptor to those students. So, these are some of the challenges just to mention a few that I know."

Appendix 6: Letter of Support

University of Malawi
KAMUZU COLLEGE OF NURSING

ACTING PRINCIPAL
Prof. E. Chirwa, DipNurs, MRM,
B.Sc., MN, PhD

P/BAG 1, LILONGWE, MALAWI
TELEPHONE:265 (0)1 751 622/200
TELEGRAMS: NURSING
FAX: 265 (0) 1 756 424
EMAIL: principal@kcn.unima.mw
Website: www.kcn.unima.mw

Our Ref.: KCN/DPGSR

October, 13th 2016

The Chairperson
COMREC
Private Bag 360
Chichiri
BLANTYRE 3

Dear Sir,

RE: SUPPORT LETTER FOR MR LUCKY MHANGO

Mr Lucky Mhango is a student at Kamuzu College of Nursing pursuing a PhD in Interprofessional Health Care Leadership. As a requirement for the fulfilment of his PhD, he is required to submit a Dissertation. I am therefore writing to support the submission of his proposal titled: *"Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi"*.

Mr Lucky Mhango has worked with his supervisor and the proposal is now ready for submission.

Thanking you in advance for considering his proposal.

Yours Sincerely,

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING
2016 -10- 13
DEAN OF POSTGRADUATE
STUDIES & RESEARCH
PRIVATE BAG 1, LILONGWE

Abigail Kazembe, PhD.
DEAN FOR POSTGRADUATE STUDIES AND RESEARCH

AK/mk

Appendix 7: Certificate of Ethics Approval

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled

P.11/16/2015 - Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi by Lucky Mhango

On 27th January 2017

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

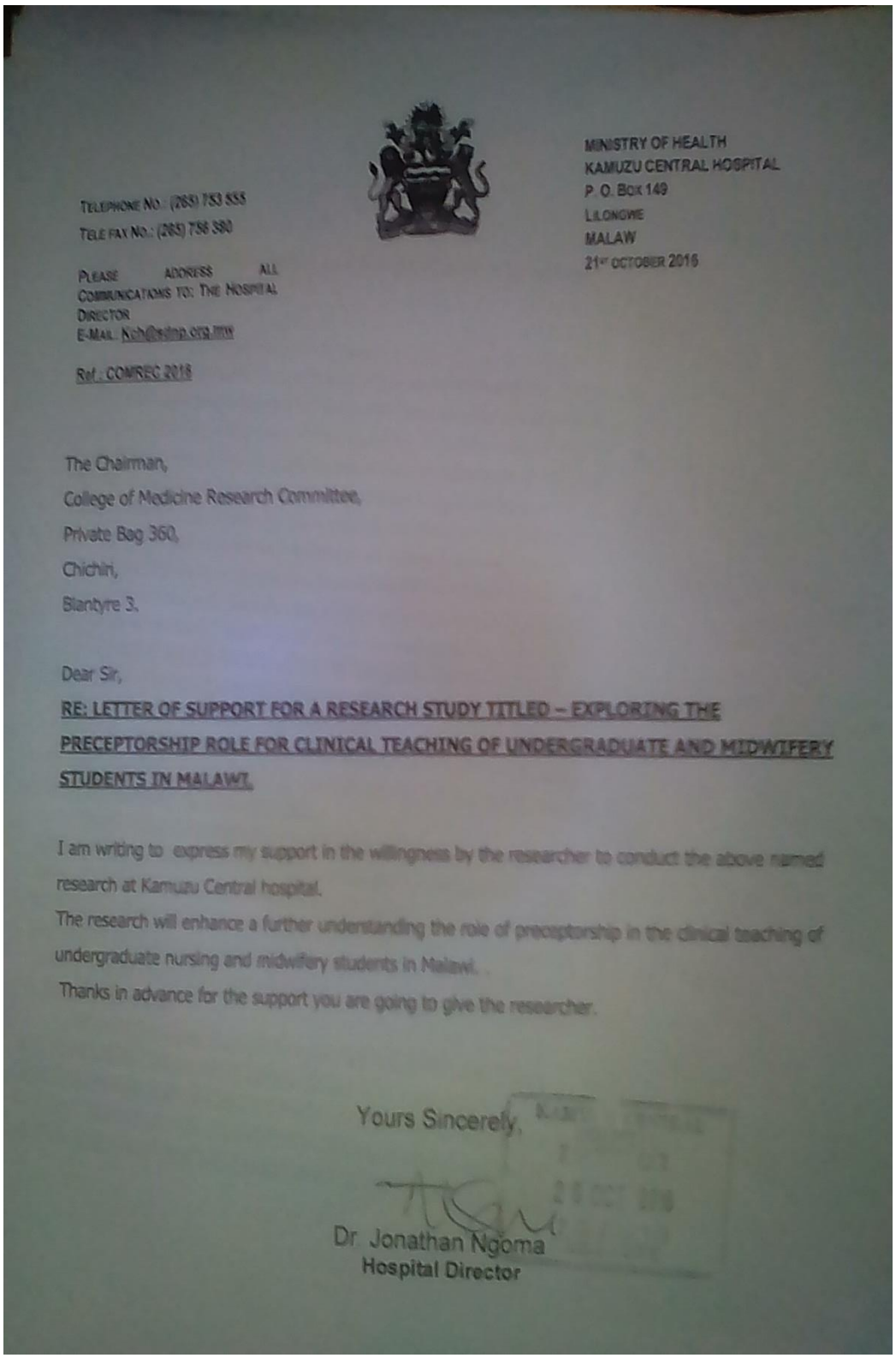
Dr. Y. Mlombe- Chairman (COMREC)

Approved by College of Medicine 27 JAN 2017 (COMREC) Research and Ethics Committee

27/1/2017

Date

Appendix 8: Approval Letters from Study Sites



MINISTRY OF HEALTH
KAMUZU CENTRAL HOSPITAL
P. O. BOX 149
LILONGWE
MALAW
21st OCTOBER 2016

TELEPHONE NO.: (265) 753 555
TELE FAX NO.: (265) 756 380

PLEASE ADDRESS ALL COMMUNICATIONS TO: THE HOSPITAL DIRECTOR
E-MAIL: Kch@sdnp.org.mw

Ref.: COMREC 2018

The Chairman,
College of Medicine Research Committee,
Private Bag 360,
Chichiri,
Blantyre 3.

Dear Sir,

RE: LETTER OF SUPPORT FOR A RESEARCH STUDY TITLED – EXPLORING THE PRECEPTORSHIP ROLE FOR CLINICAL TEACHING OF UNDERGRADUATE AND MIDWIFERY STUDENTS IN MALAWI.

I am writing to express my support in the willingness by the researcher to conduct the above named research at Kamuzu Central hospital.

The research will enhance a further understanding the role of preceptorship in the clinical teaching of undergraduate nursing and midwifery students in Malawi.

Thanks in advance for the support you are going to give the researcher.

Yours Sincerely,

Dr Jonathan Ngoma
Hospital Director

Telephone: 01 320 916 / 878
Fax: 320223/320973/270
directormch@malawi.net

In reply please quote No.....
The Hospital Director,
Mzuzu Central Hospital,
Private Bag 209,
Luwinga, Mzuzu 2.

27 October 2016

Lucky Mhango
Mzuzu University,
Department of Nursing
Private Bag 201
Luwinga Mzuzu 2

Dear Sir,

APPROVAL TO CONDUCT RESEARCH STUDY AT MZUZU CENTRAL HOSPITAL Refer to your letter Submitted on 10th October, 2016 in which you requested for permission to conduct a study titled ***"Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi"*** at our institution (Mzuzu Central Hospital). I am pleased to inform you that your request has been approved. You may use this as a **"Letter of Support from an Institution"** to COMREC/NHSRC.

When you are ready to collect data at our institution, you will be required to present the approval letter from COMREC and this letter to the in-charge of the department you have selected before you can start your data collection.
Please note that you will be required to sign an agreement form at our institution before you start your study.

Yours sincerely,

THE DIRECTOR
Mzuzu Central Hospital
26 OCT 2016
Private Bag 209, Luwinga

Master R. Chisale
MZCH Research and Publication Committee Chairperson
For: THE HOSPITAL DIRECTOR

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director

In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref. No. QE/

28th March, 2017

Lucky Mhango
Mzuzu University
Department of Nursing and Midwifery
Private Bag 201
Luwinga
MZUZU

Dear Lucky,

PERMISSION TO CONDUCT A RESEARCH AT QUEEN ELIZABETH CENTRAL HOSPITAL

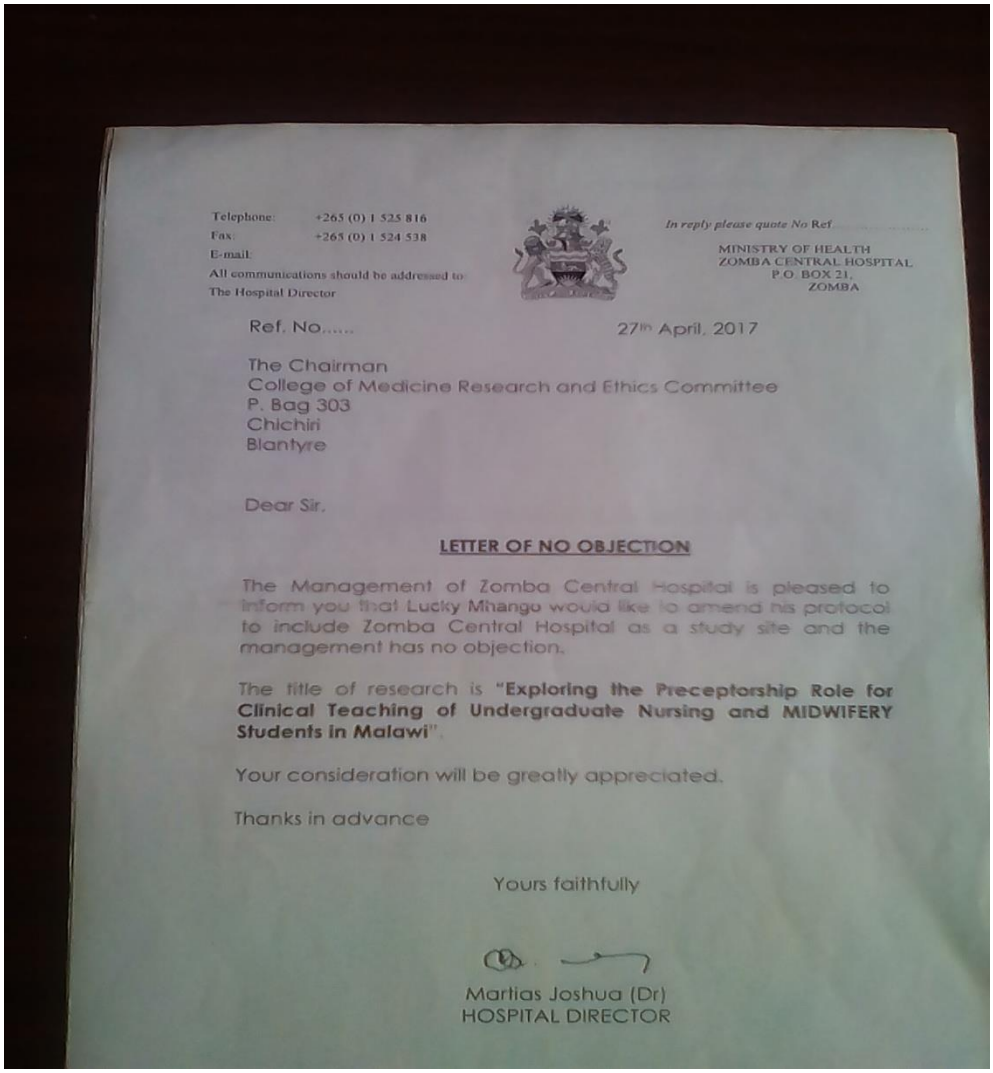
I am pleased to inform you that management has no objection for you to conduct a research project on "***Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi***" at Queen Elizabeth Central Hospital.

Remember to provide a copy of your findings to the hospital.

All the best in your studies.

Yours faithfully,

Chewere
L. Chewere
ACTING DEPUTY HOSPITAL DIRECTOR



Telephone: +265 (0) 1 525 816
Fax: +265 (0) 1 524 538
E-mail:
All communications should be addressed to:
The Hospital Director

In reply please quote No Ref.....

MINISTRY OF HEALTH
ZOMBA CENTRAL HOSPITAL
P.O. BOX 21,
ZOMBA

Ref. No.....

27th April, 2017

The Chairman
College of Medicine Research and Ethics Committee
P. Bag 303
Chichiri
Blantyre

Dear Sir,

LETTER OF NO OBJECTION

The Management of Zomba Central Hospital is pleased to inform you that Lucky Mhango would like to amend his protocol to include Zomba Central Hospital as a study site and the management has no objection.

The title of research is "**Exploring the Preceptorship Role for Clinical Teaching of Undergraduate Nursing and MIDWIFERY Students in Malawi**".

Your consideration will be greatly appreciated.

Thanks in advance

Yours faithfully

Martias Joshua (Dr)
HOSPITAL DIRECTOR

Ref. No.
Tel. No. 01- 524344/01-950 596
Telefax No. (265) 1 525 200

E-Mail:
zombamental@gmail.com

Please address all communications to:
The Director of Mental Health Services

MINISTRY OF HEALTH
ZOMBA MENTAL HOSPITAL
P.O BOX 38
ZOMBA
MALAWI

REF. NO. ZMH/GC/66

24th October, 2016

Lucky Mhango
Mzuzu University
Department of Nursing and Midwifery
P/Bag 201
Luwinga
Mzuzu

Dear Sir

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

Reference is made to your letter dated 10th October, 2016 on the above issue.

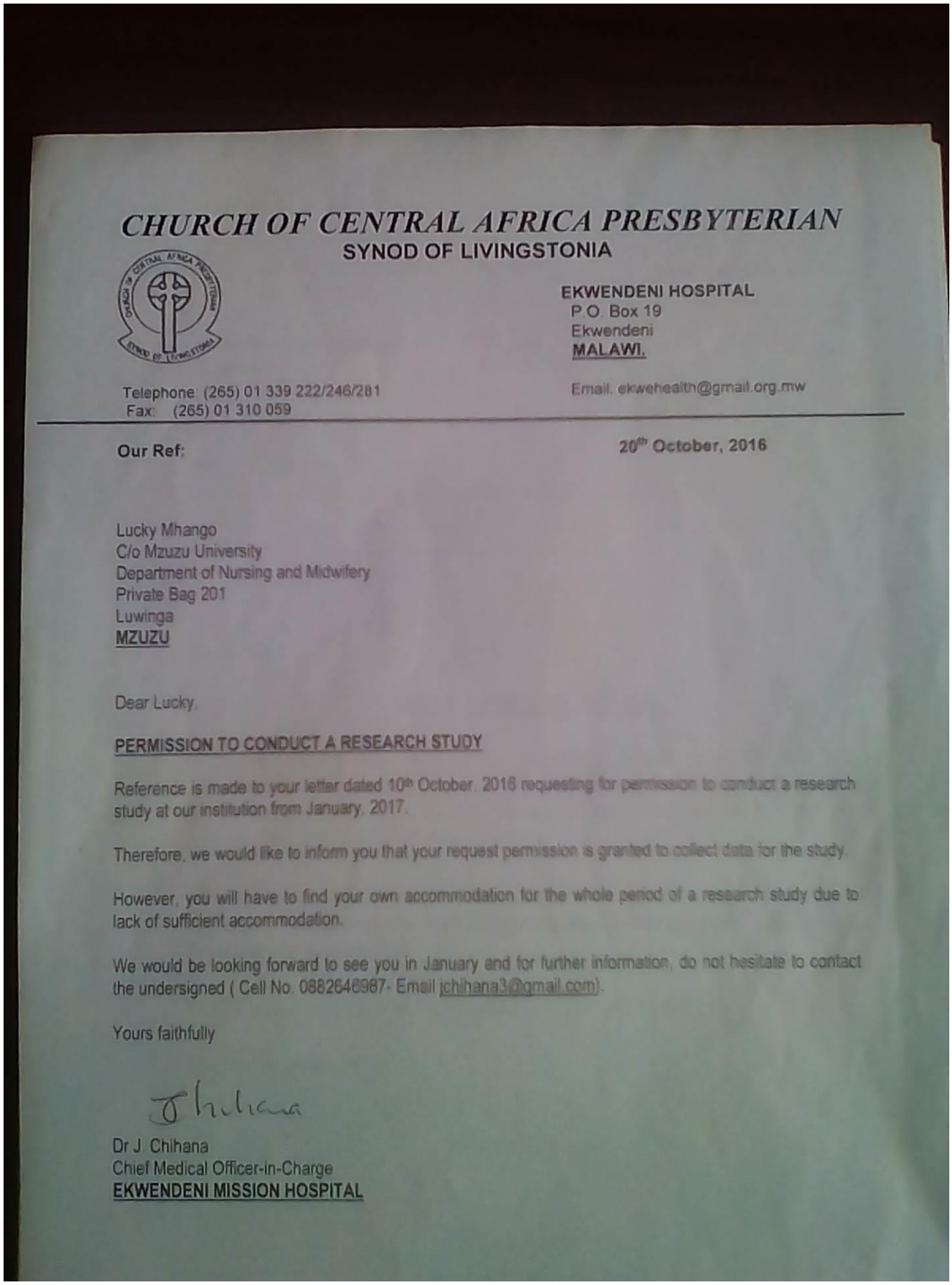
Zomba Mental Hospital Management is pleased to inform you that your request to conduct a research has been accepted. The hospital is looking forward to working with you during this study time. Please remember to remind the hospital management two weeks before the study starts.

In this regards the Matron at Zomba Mental Hospital has been informed for support during the study time.

Yours faithfully,

THE DIRECTOR OF MENTAL HEALTH SERVICES
24 OCT 2016
ZOMBA MENTAL HOSPITAL
P.O. BOX 38, ZOMBA

Mrs. I. Chamangwana
DIRECTOR OF MENTAL HEALTH SERVICES



CHURCH OF CENTRAL AFRICA PRESBYTERIAN

SYNOD OF LIVINGSTONIA

EKWENDENI HOSPITAL
P.O. Box 19
Ekwendeni
MALAWI.

Telephone: (265) 01 339 222/246/281
Fax: (265) 01 310 059

Email. ekwehealth@gmail.org.mw

Our Ref:

20th October, 2016

Lucky Mhango
C/o Mzuzu University
Department of Nursing and Midwifery
Private Bag 201
Luwinga
MZUZU

Dear Lucky,

PERMISSION TO CONDUCT A RESEARCH STUDY

Reference is made to your letter dated 10th October, 2016 requesting for permission to conduct a research study at our institution from January, 2017.

Therefore, we would like to inform you that your request permission is granted to collect data for the study.

However, you will have to find your own accommodation for the whole period of a research study due to lack of sufficient accommodation.

We would be looking forward to see you in January and for further information, do not hesitate to contact the undersigned (Cell No. 0882646987- Email jchihana3@gmail.com).

Yours faithfully

J Chihana

Dr J. Chihana
Chief Medical Officer-in-Charge
EKWENDENI MISSION HOSPITAL

Tell: +265 1 382 764
Fax : +265 1 382 238

All communications should be
Addressed to
The District Health Officer

Chitipa District Council
Chitipa District Health Office
Box 95
Chitipa

MINISTRY OF HEALTH

Lucky Mhango
Mzuzu University
Department of Nursing and Midwifery
P/Bag 201
Mzuzu

Dear Lucky,

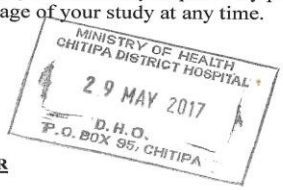
PERMISSION TO CONDUCT RESEARCH IN CHITIPA DISTRICT

Following your letter in which you requested for permission to conduct research at Chitipa District Hospital, I am glad to inform you that you have been granted permission for the study titled

"Exploring the role of preceptors in clinical teaching for undergraduate nursing and midwifery students"

You are therefore requested to carry out the study as per study protocol as any deviations may lead to stoppage of your study at any time.

Yours faithfully,



Dr. Ted Bandawe
THE DISTRICT HEALTH OFFICER

Telephone: +265 888 382 973
+265 992 265117
Email: phiniasmfune@gmail.com
phiniasmfune@yahoo.com

All Communications should be addressed to:
DISTRICT HEALTH OFFICER

In reply please quote no. REF DHO/17/5/1
MINISTRY OF HEALTH
The District Health Officer
Karonga District Health Office
Private Bag 1
Karonga
MALAWI

25th May, 2017

RE: Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi

TO: College of Medicine Research Ethics Committee (COMREC)

This letter is to confirm Karonga District Health Office's support and commitment to work with ***Mr Lucky Mhango,*** a PhD candidate in Inter-professional Healthcare Leadership under University of Malawi, Kamuzu College of Nursing on his research entitled: *"Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi"*. I am the District Health Officer for Karonga where the study will be conducted. I am committed to seeing the study implemented in conformity with the COMREC requirements.

I thank you.

Dr. Phinias HK Mfune
DISTRICT HEALTH OFFICER – KARONGA

Telephone: Liwonde
01 542 205/542 287
Fax: 01 542 446

COMMUNICATIONS TO BE ADDRESSED TO:
THE DISTRICT HEALTH OFFICER

In reply please quote No. .....
THE DISTRICT HEALTH OFFICER
MACHINGA DISTRICT HOSPITAL
P.O. BOX 44
LIWONDE
MALAWI

14 March 2017

Lucky Mhango
C/o Mzuzu University
Department of Nursing and Midwifery
Private Bag 201
Luwinga
MZUZU

Dear Lucky,

REF: PERMISSION TO CONDUCT A RESEARCH IN MACHINGA

Reference is made to your letter dated 10th October, 2016 requesting for permission to conduct a research study on **Exploring the Preceptorship Role for Clinical Teaching of Undergraduate Nursing and Midwifery Students in Malawi** at our institution from January, 2017.

On behalf of Machinga District Health Management Team, I am pleased to inform you that your request has been accepted. It is however our expectation that you will adhere to the protocols in your proposal without any alterations. The hospital is looking forward to working with you during the research study period.

Please remember to remind the hospital one week before commencing your data collection.

By copy of this letter, the District Nursing Officer is informed of this study for support as necessary.

For further information, do not hesitate to contact the undersigned.

MINISTRY OF HEALTH
MACHINGA DISTRICT HOSPITAL
DISTRICT MEDICAL OFFICER
16 MAR 2017
P. O. BOX 44, LIWONDE
MALAWI

Yours faithfully

Dr Innocent Mhango
DISTRICT MEDICAL OFFICER (MACHINGA)

Telephone: (265) 01 372222/ 287/ 212
Fax: (265) 01 372338
All communications should be addressed
The District Health Officer

In reply *Please quote RDH/*
Rumphi District Hospital
P.O. Box 225,
Rumphi.
MALAWI

22nd May, 2017

Lucky Mhango
Mzuzu University
Department of Nursing and Midwifery
Private Bag 201
Luwinga
MZUZU

Dear Lucky,

PERMISSION TO CONDUCT A RESEARCH STUDY

Reference is made to your letter dated 12th May, 2017 requesting for permission to conduct a research study at our institution from mid-June, 2017 entitled: "*Exploring the preceptorship role for clinical teaching of undergraduate nursing and midwifery students in Malawi*"

Rumphi District Hospital Management is pleased to inform you that your request to conduct a research study has been accepted. The hospital is looking forward to working with you during the research study period. Please remember to remind the hospital one week before commencing your data collection.

By copy of this letter, the District Nursing Officer is informed of this study for support as necessary.

Looking forward to interacting with you during your data collection period. For further information, do not hesitate to contact the undersigned.

Yours faithfully,

Dr. S. Macheso.
District Health Officer
RUMPHI DISTRICT HOSPITAL

Telephone: + 265 1473 411
Facsimile: + 265 1473 409

All Communications should be addressed to:
The District Health Officer

In reply please quote No. TDH/

MINISTRY OF HEALTH
Thyolo District Hospital
P.O. Box 21
Thyolo.

31st October, 2016.

Lucky Mhango
C/o Mzuzu University,
Department of Nursing and Midwifery,
Private Bag 201,
Luwinga.
MZUZU.

Dear Lucky,

PERMISSION TO CONDUCT A RESEARCH STUDY

Reference is made to your letter dated 10th October, 2016 requesting for permission to conduct a research study at our institution from January, 2017.

Thyolo District Hospital Management is pleased to inform you that your request to conduct a research study has been accepted. The hospital is looking forward to working with you during the research study period. Please remember to remind the hospital one week before commencing your data collection.

Looking forward to seeing you in during data collection. For further information, do not hesitate to contact the undersigned.

Yours faithfully,

Dr Michael Murowa
DISTRICT HEALTH OFFICER