Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona

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Abstract

Undergraduate nursing students are supervised in the clinical setting by adjunct faculty who often have little or no nursing pedagogy preparation. Despite the publication of Clinical Nurse Educator Competencies (CNEC) in 2018, a paucity of scholarly literature exists on their use in nursing education. The purpose of this qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. Transformational leadership theory supported by novice to expert nursing education leadership theory provided the study's theoretical framework. Key research questions explored participant perceptions of how CNEC use informed orientation and evaluation processes for novice clinical nurse educators and how using CNEC improved those processes. The target population was undergraduate nursing education leaders serving in fully approved Arizona State Board of Nursing programs. Data instruments included an online questionnaire and individual follow-up recorded telephone interviews. Synthesized responses from the 16 participants were coded and analyzed utilizing Braun and Clarke's thematic analysis model. A key finding of the study is CNEC use lacked intentionality and thoroughness. Study recommendations include collaboration among Arizona nursing program leaders to develop CNEC implementation guidelines with the aim of promoting student success and competent client care by graduate nurses. A replicated study including the perspective of clinical nurse educators is recommended.

Keywords: clinical learning experience, clinical judgment, clinical nurse educator, clinical nursing pedagogy, competencies, evaluation, orientation, role transition, transformational leadership

Dedication

To my husband, Robert Rozell, my greatest earthly supporter. Without your encouragement and constant love this project would have been impossible.

To my four children, Nick, Kirk, Scott, Jenny, and their families, whom I love dearly. May my example inspire you to achieve everything your many gifts and talents have in store for you.

To my mother and her parents, whose lifelong support of the value of education provided inspiration and courage to enter the doctoral program and continue through each challenge with determination to succeed.

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Chapter 1: Introduction

Undergraduate nursing student education is delivered through didactic and clinical learning experiences. Didactic educators are often full-time residential faculty with strong ties to the parent academic institution and ready access to professional development and collaborative workflow (Shellenbarger, 2019). In the clinical setting, students are supervised and mentored by clinical educators who are primarily adjunct faculty with little or no nursing pedagogy preparation (Beiranvand et al., 2021). The lack of formal clinical education pedagogy preparation and limited peer interaction with didactic nursing program faculty lead to disparate preparation between didactic and clinical educators. Nursing programs may provide orientation, professional development, and mentoring to support novice clinical nurse educators transitioning to the role of educator from being a clinical practitioner (Ross & Dunker, 2019).

This study focused on the preparation and evaluation of undergraduate clinical nurse education faculty by examining the implementation of the National League for Nursing (NLN) Clinical Nurse Educator Competencies (CNEC) in Arizona nursing programs and how their implementation informed and improved the orientation and evaluation of clinical nurse educators. A qualitative approach allowed for an investigation of the experiences and perceptions of nursing program leaders about improvements in clinical nurse educator orientation and evaluation resulting from CNEC implementation. Ross and Dunker (2019) explained the crucial need for expertly prepared clinical educators to guide competency development in nursing students, noting the implications for the health and safety of community members for whom graduate nurses will provide care.

According to the Arizona State Board of Nursing, 37 undergraduate nursing programs were operating at the time of the study (Arizona State Board of Nursing, 2021). Arizona nursing

program leaders constituted the target subject population because they had the institutional authority to implement and evaluate professional development for clinical nurse educators employed by their academic institutions. In large nursing programs with multiple levels of administration, the authority to implement CNEC for orientation and evaluation of clinical nurse educator faculty may be delegated to clinical coordinators by the nursing program director (Shellenbarger, 2019). Understanding how nursing education leaders use CNEC to inform orientation, professional development, and evaluation of clinical nurse educators will advance the profession of nursing education, promote nursing student learning, and improve client care outcomes locally and globally (Christensen & Simmons, 2020; Owens, 2018). The background of the problem, problem statement, study purpose, study significance, research questions, theoretical framework, definition of terms, assumptions, scope and delimitations, limitations, and summary follow.

Background of the Problem

The scope of practice for academic nurse educators was published by NLN in 2005, followed by a professional practice analysis assessment spanning 2010 to 2017. The resulting set of evidence-based competencies for the specialized role of certified nurse educator, which primarily focused on didactic methods and practices, defines the scope of practice for academic nurse educators (Christensen & Simmons, 2020). In 2015, an NLN task force identified and developed core competencies for the role of clinical nurse educator. The task force work culminated in the 2018 publication of six CNEC with evidence-based statements and references which define the scope of practice for the specialized role of the clinical nurse educator (Shellenbarger, 2019).

Few scholarly research articles are available that focus on CNEC use in nursing education (Christensen & Simmons, 2019) despite broad support in the literature for establishing standards and guidelines for clinical nurse educator orientation, professional development, and evaluation (Beiranvand et al., 2021; Dunker & Manning, 2018; Rodger, 2019). A thorough exploration of the relevant scholarly nursing education literature, books, and primary sources about nursing pedagogy revealed the theoretical framework concepts used to guide the study. An analysis of the current scholarly literature on clinical nursing pedagogy, synthesized with the CNEC concepts, revealed five foundational themes common to clinical nursing education and CNEC. The five emergent themes were orientation and role transition, effective clinical instruction, clinical judgment, faculty development and mentoring, and leadership.

Shellenbarger (2019) identified the need for further investigation of how the effective implementation of CNEC may inform and improve the orientation and evaluation of clinical nurse educators. CNEC could be an effective tool to foster continued professional growth and faculty retention for the dynamic role of clinical nurse educator (Christensen & Simmons, 2020). Shellenbarger cited the NLN 2014–2015 Faculty Census Survey, in which nursing programs reported faculty vacancies of 2–34%, observing 83% of programs are actively seeking to hire new faculty. The nursing faculty shortage impacts schools' abilities to enroll qualified applicants. Ross and Dunker (2019) reported more than 64,000 nursing student applicants were denied admittance to undergraduate programs in 2016. A lack of qualified faculty partially hindered applicant acceptance. By 2024, there will be an estimated shortage of 1.1 million registered nurses, a problem compounded by the lack of qualified faculty (Dunker et al., 2021).

Statement of the Problem

The problem was a lack of understanding of how undergraduate nursing program leaders

in Arizona implemented the CNEC and the degree to which their implementation improved the orientation and evaluation of clinical nurse educators. Professional development programming needs for orienting novice clinical nurse educators are well established in the literature (Rodger, 2019; Schoening, 2013). Wenner and Hakim (2019) reported this global problem is impacting undergraduate nursing education management and the health of clients for whom graduate nurses will care. The need for expertly trained clinical nurse educators relates to promoting community health, advancing the nursing profession, and addressing projected nursing faculty and clinical practice shortages (Christensen & Simmons, 2019). Rosseter (2019) reported a 7.2% nursing faculty shortage in the United States. Senior (2021) noted 76% of nurse manager respondents reported having difficulty recruiting new nurses, with nearly 71% stating their nursing units had increased openings for nurses over the previous year.

Competencies and task statements related to CNEC, published in 2018, provide tools for nursing program leaders for the orientation and evaluation processes for clinical nurse educators serving in their programs. What was unknown is how CNEC components provided input to inform the orientation and evaluation needs for clinical nurse educators and how their implementation in these faculty development processes improved the orientation and evaluation outcomes. Since their 2018 publication, limited research has been available on nursing school implementation of CNEC and the resultant process improvement for clinical nursing education (Beiranvand et al., 2021; Christensen & Simmons, 2020). This study aimed to address the gap in scholarly research regarding CNEC use by nursing education leaders in Arizona.

Purpose of the Study

The purpose of this qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their

implementation informed and improved the orientation and evaluation of clinical nurse educators. This study addressed a gap in the scholarly literature about how Arizona nursing schools implemented CNEC and the extent to which their use informed and improved the orientation and evaluation of clinical nurse educators. The preparation of qualified clinical nurse educators is a current global issue (Phillips et al., 2019), affecting faculty attrition, workforce shortages (Christensen & Simmons, 2019), and community health and safety (Wenner & Hakim, 2019).

Gaining an understanding of how nursing program leaders implemented CNEC and their opinions about the processes and results of implementing CNEC led to selecting a qualitative methodology for the study. Using a basic qualitative study design, qualitative methodology is best suited to answer the general research question of how nursing program leaders implemented CNEC and how their implementation improved the orientation and evaluation of clinical nurse educators (Bellamy et al., 2016; Merriam, 2009). The researcher is the primary research instrument in qualitative studies. Using open-ended questions, exploratory discussions, and interviews provides a rich data field for the qualitative researcher to gain insight into the personal perspectives of subjects recounting how they made sense of life experiences (Creswell & Creswell, 2018; Polit & Beck, 2012). The data collection plan for this study included an open-ended online questionnaire and formal semi-structured telephone interviews with nursing program leaders in Arizona. Barrett and Twycross (2018) explained qualitative questionnaires and interviews provide insight into participants' beliefs, decision-making processes, and interventions.

Significance of the Study

Understanding how nursing program leaders implemented CNEC to orient and evaluate

their clinical faculty and the perceived improvements to the orientation and evaluation processes will promote the ongoing development of clinical nursing education (Shellenbarger, 2019). Nursing education leaders may use the knowledge they acquire from the study results to prepare clinical nurse educators to provide undergraduate nursing education in the practice setting, leading to improved health and wellness outcomes for community members for whom graduate nurses will care (Wenner & Hakim, 2019). The lack of preparation of qualified clinical nurse educators is a current global issue that is negatively affecting faculty attrition, student enrollment, and nursing workforce shortages (Christensen & Simmons, 2019; Phillips et al., 2019).

CNECs define the roles and responsibilities of the registered nurse specialty area of clinical nurse educator. Nursing program leaders' experiences and perceptions of CNEC implementation in Arizona nursing programs may provide a resource for policy change for the orientation and evaluation of clinical nurse faculty by program leaders nationally and globally. Improvements in orientation programs for part-time clinical nurse educators will address the role transition stress and resultant faculty attrition often experienced by novice clinical educators (Rodger, 2019; Sousa & Resha, 2019). Expertly prepared clinical nurse educators will be a key factor for reducing the nursing workforce deficit through increasing undergraduate nursing student enrollment and successful graduation rates (Dunker et al., 2021; Phillips et al., 2019). Positive social change is expected to result from the improved preparation of clinical nurse educators, who can then better prepare graduate nurses to enter the workforce.

Research Questions

Formulating open-ended research questions demonstrated alignment with the research methodology and design, research problem, and purpose of the study. It was unknown how

nursing program leaders used components of CNEC to inform the orientation and evaluation processes for clinical nurse educators and how their implementation improved orientation and evaluation processes. The following research questions guided the study:

Research Question 1: How are CNECs used to inform the orientation of novice clinical nurse educators?

Research Question 2: How are CNECs used to inform the evaluation of clinical nurse educators?

Research Question 3: What improvement in orientation and evaluation processes for clinical nurse educators in Arizona resulted from the implementation of CNEC?

Theoretical Framework

Educational leadership theories supporting the study were transformational leadership theory (Ross et al., 2014), supported by novice to expert nursing education leadership theory (Benner et al., 2010). Transformational leadership theory applied to nursing and nursing education promotes improved client care and education outcomes through inspiration, shared vision, creativity, and mentorship (Burns, 1978; Suratno et al., 2018). The fast-paced, evolving nature of healthcare and the need for collaboration among interdisciplinary team members demands creative, inspirational leadership characterized by transformational leadership (Carrara et al., 2017; Kantar, 2021). Aspects of transformational leadership that apply directly to clinical nursing education are the leader's ability to motivate, increase commitment, foster shared vision and loyalty, and act as a change agent (Suratno et al., 2018). Benner's novice to expert theory lists five levels of nursing student development: novice, advanced beginner, competent, proficient, and expert.

During their undergraduate program, nursing students progress through Benner's five stages of knowledge and skill acquisition (Benner et al., 2010). In the same way novice nursing students are often overwhelmed with the amount of knowledge and level of responsibility required to complete their programs, novice clinical nurse educators experience significant stress and may feel overwhelmed as they begin teaching with little or no experience or training in clinical nursing pedagogy (Owens, 2018; Ozdemir, 2019). The creative, positive, inspiring aspects of transformational leadership promote the role transition of novice clinical nurse educators entering pedagogy from clinical practice (Suratno et al., 2018). Transformational leadership theory, blended with Benner's novice to expert theory, supported the purpose of the study by providing a structural and motivational framework to guide the formation of research questions, data collection instrument primary and follow-up questions, and data analysis. Chapter 2 provides a more thorough discussion of the theoretical framework as applied to the study.

Definition of Terms

Providing definitions for terms and concepts that are not part of common knowledge or potentially may have dual meanings will enhance the study's clarity and readability. Study terms emerged from the literature review, and a citation accompanies each term definition.

Clinical learning experience is defined as the portion of nursing education wherein students care for clients in a facility setting as they are supervised and mentored by a clinical nurse educator employed by the academic institution (Ross & Dunker, 2019).

Clinical judgment is defined as the process of decision-making involving problem-solving, critical thinking, and clinical reasoning to promote best practices outcomes (Rodger, 2019).

Clinical nurse educator is defined as a registered nurse who is an expert at client care and employed by a nursing school to supervise and lead learning experiences for undergraduate nursing students in the client care arena (Christensen & Simmons, 2019).

Clinical nursing pedagogy is defined as the teaching practices and theory-driven tools used by the clinical nurse educator to promote student competency attainment (Labrague et al., 2020).

Competencies is defined as official statements that define the scope of practice and role of specialized practice areas of nursing or nursing education (Shellenbarger, 2019).

Didactic instruction is defined as theoretical knowledge delivered primarily through in-person or online teaching methods (Docherty, 2018).

Evaluation is defined as the multidimensional assessment and documentation process of clinical judgment and skills according to competency standards (Kantar, 2021; Shellenbarger, 2019).

Orientation is defined as the professional development and pedagogical training needed by novice clinical nurse educators to effectively transition to an academic role (Owens, 2018).

Role transition is defined as the process in which a novice clinical nurse educator gains the knowledge, skills, attitudes, and experience necessary to help students bridge the gap between didactic nursing theory and clinical nursing competencies for students in a clinical learning environment (Dunker et al., 2021).

Transformational leadership is defined as the behaviors and characteristics of leaders who can inspire and motivate followers to work with creativity and innovation (Suratno et al., 2018).

Assumptions

The first assumption was nursing program leaders, as study subjects, were either aware of CNEC's existence or familiar with CNEC concepts. Second, it was assumed the study subjects had an orientation protocol or plan for novice clinical nurse educators (Sousa & Resha, 2019). Third, it was assumed the study subjects regularly evaluated clinical nurse educators serving in their programs. The final assumption was semi-structured telephone interviews and member checking would provide a sufficient opportunity for subjects to honestly share details about their experiences and perceptions of the effects of CNEC implementation on their program's orientation and evaluation processes.

Scope and Delimitations

This qualitative study aimed to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and the degree to which their implementation informed and improved the orientation and evaluation of clinical nurse educators. Delimitations defining the study participants' tertiary educational employment and the programs' Arizona State Board of Nursing approval status provided clear boundaries for the study (Arizona State Board of Nursing, 2021). A geographic delimitation decision was the selection of Arizona for the study location as opposed to multiple state inclusion. Delimitation decisions followed feasibility and convenience factors for the study and aligned with researcher interests (Bloomberg & Volpe, 2019).

Nursing program leaders who were study participants included undergraduate nursing program administrators, division chairs, clinical coordinators, or designees. Participants held employment in Arizona nursing programs, either registered nursing or practical nursing, approved by the Arizona State Board of Nursing (Arizona State Board of Nursing, 2021). No participant was personally or professionally related to the primary investigator. Nursing program

administrators whose programs the Arizona State Board of Nursing identified as having an active decree of censure or consent for probation were excluded from the study for clarity and replicability. Determination of exclusion criteria fostered bias minimization and maintained the integrity of the data's relevance (Creswell & Creswell, 2018).

Recruitment and research commenced following written approval from the American College of Education Institutional Review Board (IRB) (see Appendix A) and site permissions from the nursing program leaders' academic institutions (see Appendices B and C). Prospective participants received emailed recruitment information and an invitation to participate in the study (Dilmi, 2012). The Invitation to Participate recruitment letter (see Appendix D) included information about research procedures, subject privacy and anonymity, security and disposal of data, and the ability to opt out of participation at any time. Prospective participants who did not respond to the emailed invitation to participate received a phone call invitation to participate in the study, using the same script as the emailed invitation. Data collection occurred through an online questionnaire and audio recorded telephone interviews. Subjects identified the most convenient date and time for their telephone interview. The delimitation of potential subjects and data collection methods promoted the study's transferability and reproducibility (Bloomberg & Volpe, 2019).

Scholars often refer to trustworthiness when describing reliability in qualitative research. Validity in qualitative research is often referred to as believability, which is accomplished when study methods and procedures measure what is intended for measurement and make predictions about future results plausible. Believability promotes the transferability of findings to extended similar populations (Polit & Beck, 2012). Study objectives appropriate to a basic qualitative design defined and delimited the participant inclusion and exclusion parameters. The inclusion of

clinical nurse education faculty and exclusion of didactic instruction faculty promoted the transferability of results. Narrowing the focus by excluding other qualitative designs further promoted transferability (Bloomberg & Volpe, 2019).

Limitations

Limitations inherent to qualitative research include the potential of researcher bias influencing findings and conclusions because the researcher is the primary instrument in qualitative research. Qualitative data are non-numerical and non-linear, requiring an inductive approach to analysis. Limitations inherent to qualitative research are threats to reliability and validity of the study. Maintaining a reflective attitude during the study helped address these inherent limitations (Bloomberg & Volpe, 2019). Reflexivity and journaling promoted awareness of how participant responses and personal biases may simultaneously affect the study process. Reflections on bracketed notes during the data collection minimized researcher bias and improved the study's rigor and believability (Baksh, 2018). Triangulation through multiple data sources and methods helped capture rich, thick data to understand participants' perceptions about implementing CNEC in the orientation and evaluation processes for clinical nurse educators who taught in their undergraduate programs.

Measures to improve transferability and dependability included having subject matter experts (SME) review the study instruments, conduct field testing, and provide input into instrument finalization (Zamanzadeh et al., 2015). Methods to increase trustworthiness included transparency regarding the investigator's work in the field of clinical coordination with inherent bias. Taking a reflexive approach improves connection with reality, according to Merriam and Tisdell (2016). The transparency of the study design, data collection, and data analysis methods promoted trustworthiness through the vigilant exposure of subjective perspectives about

implementing CNEC in personal practice. Objectivity was not claimed; rather, an open awareness of and engagement with personal biases systematically challenged the investigator's methodological processes throughout the study (Bloomberg & Volpe, 2019).

Chapter Summary

This study focused on understanding how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and the degree to which their implementation informed and improved the orientation and evaluation of clinical nurse educators. The introduction of the study contains an explanation of the background of the problem, problem statement, purpose of the study, significance of the study, presentation of the research questions, and theoretical framework of the study. A section defining the background meanings for terms and concepts not generally used in society improves the study's readability and readers' understanding of clinical nursing education and CNEC. The scope and delimitations, and limitations of the qualitative study explain the measures taken to improve transferability and dependability, which promoted credibility. Presentation of a scholarly nursing literature review related to clinical nurse educator role transition, orientation and evaluation of clinical nurse educators, and ramifications for the client care community's well-being follow in the next chapter.

Chapter 2: Literature Review

The purpose of this qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. A qualitative methodology, following basic qualitative design, was used for the research. Undergraduate nursing student education is delivered through didactic and clinical learning experiences. In the clinical setting students are supervised and mentored by clinical instructors who are most often adjunct faculty with little or no nursing pedagogy preparation (Ross & Dunker, 2019). Competencies for the advanced specialty area of clinical nurse educator were published in 2018, but few scholarly research articles focus on their use in nursing education (Christensen & Simmons, 2019). Using a qualitative approach was helpful for understanding the experiences of nursing program leaders during the implementation of CNEC.

The problem was a lack of understanding of how undergraduate nursing program leaders in Arizona implemented the CNEC (Shellenbarger, 2019) and the degree to which their implementation improved the orientation and evaluation of clinical nurse educators. Since their 2018 publication, limited research has been available on nursing schools' implementation of CNEC (Beiranvand et al., 2021; Christensen & Simmons, 2020). This study addressed a gap in the scholarly literature about how CNEC is implemented by nursing schools and to what extent their use informs and improves the orientation and evaluation of clinical nurse educators. The preparation of qualified clinical nurse educators is a current global issue (Phillips et al., 2019) affecting faculty attrition, workforce shortages (Christensen & Simmons, 2019), and community health and safety (Wenner & Hakim, 2019). Orientation and evaluation of novice clinical nurse educators is the responsibility of an academic institution's nursing leadership.

Educational leadership theories supporting the study were transformational leadership theory (Ross et al., 2014), supported by novice to expert nursing education leadership theory (Benner et al., 2010). An analysis of the current extant scholarly literature on clinical nursing pedagogy, synthesized with the CNEC, revealed five foundational themes common to clinical nursing education and CNEC. The five emergent themes were orientation and role transition, effective clinical instruction, clinical judgment, faculty development and mentoring, and leadership. These five themes comprise the major sections of the literature review. Chapter organization includes the literature search strategy, theoretical framework, research literature review, and chapter summary.

Literature Search Strategy

The literature search strategy was to explore the relevant scholarly literature, books, and primary sources about clinical nursing pedagogy and the theoretical framework concepts used to guide the study (Burns, 2021). Peer-reviewed scholarly sources comprise most of the literature sources for the literature review, providing reliability and validity of the study (Noble & Heale, 2019). Current scholarly literature was identified using the American College of Education databases and various search engines specialized for nursing education research such as CINAHL Complete, Ovid Nursing Full Text Plus, and MEDLINE Complete. Key search terms and a combination of terms were generated from the study purpose, problem, and research questions (Graves et al., 2018). Key search terms for the literature search were *nursing education*, *clinical education*, *clinical supervision*, *clinical competence*, *clinical competencies, nursing instructor*, *clinical nurse educator*, *clinical instructor*, *transformational leadership*, *Benner*, *novice to expert, novice clinical instructor,* and *role transition*.

Theoretical Framework

Two leadership theories were selected to create the study's framework: novice to expert nursing theory and transformational leadership theory. The study is grounded in the novice to expert theory of nursing education applied to leadership (Benner, 1982). Operationalization of novice to expert theory is often facilitated through transformational leadership theory in nursing education (Ross et al., 2014). The application of transformational leadership theory and novice to expert theory also guided the creation of the study's survey question verbiage, which allowed for an inquiry into how nursing education leaders implemented the NLN CNEC.

A blended view of the two theories supported the purpose of the study by providing a structural and motivational framework to guide it. Research question composition, response data code formulation, and the interpretation of results were accomplished using the novice to expert structure and the motivational themes of transformational leadership. Participant responses were analyzed and interpreted through the combined lens of transformational leadership and novice to expert theories (Burns, 2021). The developmental concepts of novice to expert theory may be effectively implemented in nursing education through inspiring motivational leadership (Ozdemir, 2019). Like Ozdemir's (2019) observations, the study's combined theoretical framework was applied to the qualitative design to explore how nursing program leaders used each of the six CNEC to guide clinical nurse educator orientation and evaluation.

Transformational Leadership Theory

Transformational leadership theory has been applied to nursing to promote improved client care and education outcomes (Burns, 1978; Ross et al., 2014). The fast-paced, evolving nature of healthcare and the need for collaboration among interdisciplinary team members demands creative, inspirational leadership (Carrara et al., 2017; Kantar, 2021). Aspects of

transformational leadership which apply directly to clinical nursing education are the leader's ability to motivate, increase commitment, foster shared vision and loyalty, and act as a change agent (Suratno et al., 2018). Research questions two and three were most influenced by the transformational leadership theory because they directly relate to supervisory functions. Transformational nursing leaders use inspiration, shared vision, creativity, and mentoring during faculty evaluations and to improve education processes (Suratno et al., 2018). The predicted results accounted for nursing and the nursing education profession's reliance on using evidence-based practice to energize and drive processes. Anticipated results were most nursing program leaders either were currently using some form of CNEC or had a plan to use CNEC to update their program's orientation and evaluation processes.

Carrara et al. (2017) studied nursing leadership in Latin America and the Caribbean, finding the most frequently used theoretical framework was transformational leadership. An important aspect of transformational leadership for nursing identified by Carrara et al. was the leader's ability to discover and promote individual potential in reports. Rafii et al. (2019) concurred with Kantar (2021) about the effectiveness of applying transformational leadership characteristics to the role of clinical nurse educator. Transformational nursing leadership inspires and motivates undergraduate students by providing them with personalized instruction to address their unique learning styles and competency level development needs.

Novice to Expert Theory of Nursing Education

Benner described the development of nursing competencies for the undergraduate student using a novice to expert skill acquisition model (Benner, 1982). Benner's novice to expert theory includes five levels of nursing student development: novice, advanced beginner, competent, proficient, and expert. In the same way novice nursing students are often overwhelmed with the

amount of knowledge and level of responsibility requisite to program completion, novice clinical nurse educators experience significant feelings of stress and overwhelm as they enter the teaching arena with little or no experience or training in clinical nursing pedagogy (Owens, 2018; Ozdemir, 2019). Research question one drew directly from the novice to expert theory. Effective role and competency development of undergraduate students mirrors the role development of an expert nurse clinician taking on the role of clinical nurse educator as a novice (Dunker et al., 2021; Quinn, 2020).

Thomas and Kellgren (2017), in agreement with Ozdemir (2019) and Quinn (2020), applied Benner's novice to expert model to the unique learning needs of the specialized role of nursing simulation facilitator. Thomas and Kellgren observed nursing simulation facilitators enter their field with little or no pedagogical preparation, which is like the lack of pedagogy preparation of novice clinical nurse educators discussed by Dunker et al. (2021). Novice nurse educators across all fields progress along a paradigm of learning that corresponds to Benner's novice to expert model, as they develop pedagogical skills and learn to function in leadership roles (Benner et al., 2010). The novice to expert theory informed the prediction that nursing education leaders design orientation at a novice user level, which progresses to greater levels of expertise for faculty development programming. It was anticipated most nursing program leaders either were currently using CNEC in some form for orientation or had a plan to use CNEC to update their new clinical faculty orientation plan.

This qualitative study explored how nursing education leaders implemented the NLN CNEC and how their implementation improved orientation and evaluation of faculty (Dunker & Manning, 2018; Rodger, 2019). Study questions were composed to allow for a qualitative exploration of leadership style elements among nursing education leaders specific for clinical

nurse educator orientation and evaluation. Using a blended approach of novice to expert and transformational leadership theories helped elucidate participants' leadership behaviors and motivations.

Novice to expert implementation strategies were explored through the interview questions, and notes made about elements of transformational leadership in the participants' responses. It was anticipated nursing program leaders' approaches to clinical educator orientation and evaluation would demonstrate use of the novice to expert model to guide their orientation and evaluation processes (Dunker et al., 2021; Quinn, 2020). The literature related to clinical nurse educator competency development and role transition demonstrates a focus on transformational leadership theory in a novice to expert framework (Ozdemir, 2019; Quinn, 2020).

Research Literature Review

Founded in 1893, the NLN is the world leader and standard-bearer for nursing education (National League for Nursing, n.d.) (Wenner & Hakim, 2019). The NLN set standards of practice for academic nurse educators and clinical nurse educators, and certification examination procedures and standards, for global use by professional nurse educators and nursing schools. A professional scope of practice for academic nurse educators was published in 2005, followed by a professional practice analysis assessment spanning 2010-2017 which resulted in a set of evidence-based competencies and certification exam for the specialized role of certified nurse educator (CNE) (Christensen & Simmons, 2020).

The increasing demands on the preparation level of undergraduate nursing program completers entering the workforce make it imperative for nursing schools to provide expertly trained academic and clinical nurse education faculty (Beiranvand et al., 2021; Kantar, 2021;

Phillips et al., 2019). In 2015, the NLN convened a task group to identify and establish competencies and create a certification exam for the specialized role of the academic clinical nurse educator (Christensen & Simmons, 2019). A pilot test conducted over the summer and fall of 2018 established and refined competency task statements and psychometric standards for NLN certification of the specialized role of the certified academic clinical nurse educator (Christensen & Simmons, 2019; Shellenbarger, 2019).

The need for formalized professional competencies, orientation guidelines, and evaluation standards for the clinical nurse educator is widely accepted in the nursing education scholarly literature (Beiranvand et al., 2021; Dunker & Manning, 2018; Rodger, 2019). Standardization for the role of clinical nurse educator was addressed by the NLN through development of CNEC (Shellenbarger, 2019); yet this has not been fully implemented globally to date. Studies from the United States, United Kingdom, Lebanon, and South Africa document the limitations to the implementation of clinical nurse educator standards (Coffey & White, 2019; Gcawu et al., 2021; Kantar, 2021; Lanada & Forde-Johnston, 2021). Competencies for the specialized clinical instructor role, such as those recently established by the NLN, may be used by nursing schools to develop orientation and evaluation materials (Beiranvand et al., 2021; Shellenbarger, 2019).

Scholarly literature selected for the review explored the most current knowledge about the role of clinical nurse educators and the competencies identified by practice and nursing education specialists (Graves et al., 2018). Transformational leadership development (Suratno et al., 2018) following Benner's novice to expert model (Benner, 1982) guided the literature search, analysis, and synthesis. Findings from the scholarly literature review were analyzed and integrated with CNEC. The resultant synthesis informed research to address study questions

about the implementation of CNEC and how their implementation improved the orientation and evaluation of clinical nurse educators (Beiranvand et al., 2021; Shellenbarger, 2019). Five themes emerged from the scholarly literature analysis and CNEC synthesis: orientation and role transition, effective clinical instruction, clinical judgment, faculty development and mentoring, and leadership.

Orientation and Role Transition

Schools of nursing are limited in their ability to enroll qualified students because of nursing faculty shortages, compounding the nursing faculty and workforce shortages (Owens, 2018; Wenner & Hakim, 2019). To meet the challenge of the nursing faculty shortage, nursing schools often hire adjunct faculty for the position of clinical nurse educator. These part-time clinical faculty are experts in their nursing field but novice to academia with little or no nursing pedagogy background (Owens, 2018). Guidance for nursing schools to meet the orientation and role transition needs of novice clinical nurse educators is found in the six CNEC (Shellenbarger, 2019).

Novice Clinical Nurse Educators

A significant nursing workforce deficit is projected to continue through 2024, limiting the number of qualified nursing faculty and affecting nursing school's ability to enroll students (Dunker et al., 2021; Phillips et al., 2019; Sousa & Resha, 2019). To meet the demand for qualified nursing career entrants, undergraduate nursing schools often hire part-time adjunct faculty to teach nursing clinicals (Beiranvand et al., 2021). These novice clinical nurse educators generally have little or no teaching preparation and experience (Dunker et al., 2021; Dunker & Manning, 2018). Although they are experts in providing client care, these novice clinical nurse

educators require an effective orientation to prepare for the academic role (Rodger, 2019; Sousa & Resha, 2019).

Need for Clinical Education Pedagogy Preparation

Novice clinical educators are often expert nurse practitioners with little pedagogy background, who experience a significant role transition during the orientation period (Merrill, 2019; Rodger, 2019). Because most clinical educators work full time in client care settings, their opportunities for meaningful academic peer interaction and integration into an academic role are limited (Sousa & Resha, 2019). A lack of academic partnerships contributes to role identity confusion and stress (Wenner & Hakim, 2019).

Gcawu et al. (2021) described levels of preparation for the clinical educator role using Benner's five-step novice to expert model. Professional development modules or in-service programs were the suggested methods to enhance clinical instruction competence. Gcawu et al. agreed with Sousa and Resha (2019) about the need for novice clinical educators to develop clinical pedagogy expertise but differ in the method proposed. Gcawu et al. argued professional development or in-service would be effective, while Sousa and Resha found newly hired clinical educators should participate in a structured orientation program.

Sousa and Resha (2019) conducted a descriptive quantitative study examining the role development of novice nursing clinical instructors. Sousa and Resha surveyed 106 adjunct clinical faculty to determine a rating to reflect the perceived importance of various orientation topics. The results were heavily populated under *important* and *very important* ratings, demonstrating the vast amount of information about the new role and participants' perceptions about the importance of competency development. Sousa and Resha concluded there was a need for structured, role-specific, and ongoing orientation for novice nursing clinical instructors, a

finding also identified by Beiranvand et al. (2021). Rodger (2019) discussed the nursing educator's clinical educator judgment development, agreeing with Sousa and Resha. Structured, role-specific, ongoing orientation is a concept supported by the novice to expert learning theory, operationalized by transformational leadership theory (Ross et al., 2014; Suratno et al., 2018).

Results of Ineffective Orientation and Role Transition

Ineffective role transition from clinical expert to clinical nurse educator leads to faculty attrition (Owens, 2018; Wenner & Hakim, 2019). The placement of poorly trained clinical faculty undermines nursing students' clinical competency attainment (Merrill, 2019; Rodger, 2019). Faculty retention can be improved through effective clinical nurse educator development which, according to Phillips et al. (2019), promotes orientation and role transition. Using a qualitative phenomenological design, Wenner and Hakim (2019) explored the lived experience of 14 novice clinical nurse educators in their role transition from clinical care practice to academia. Subjects were registered nurses working simultaneously in academic and client care capacities. The participants stated feeling they experienced uncertainty and overwhelming stress during the initial phase of role transition. Wenner and Hakim suggested lack of clinical pedagogy training and inconsistent guidance from full-time academic faculty were added stressors, concurring with Owens (2018).

The lack of effective training for the clinical instructor role demonstrates the need for transformational leadership to guide and inspire new faculty orientation programming. Through transformational leadership, novice clinical instructors' individual orientation and role transition needs may be met (Rafii et al., 2019; Suratno et al., 2018). Ineffective role transition and faculty attrition compound the nation's nursing shortage crisis, resulting in an adverse effect on the health and well-being of community stakeholders (Dunker & Manning, 2018). Phillips et al.

(2019) agreed with Dunker and Manning (2018) and Wenner and Hakim (2019) regarding the interrelationship of the nursing workforce shortage, nursing faculty shortage, nursing faculty attrition, and ineffective novice adjunct clinical faculty orientation. The lack of clinical educator pedagogy preparation hinders student progress through ineffective instruction and evaluation, ultimately having a negative impact on client outcomes (Dunker et al., 2021; Dunker & Manning, 2018; Gcawu et al., 2021; Reising et al., 2018; Rodger, 2019).

Orientation and Role Transition Professional Development Design

Online Learning

Phillips et al. (2019) identified the lack of a theoretical framework to guide program development as a contributing factor to the ineffective orientation of novice nurse educators. Shellenbarger (2019) agreed with Phillips et al. about the importance of including role-specific competencies in novice clinical educator training. Christensen and Simmons (2020) agreed with Shellenbarger that specialty practice competencies support meaningful collaboration with nursing program leaders during orientation and role transition.

Phillips et al. (2019) designed an asynchronous eLearning course for their mixed methods study of clinical faculty development. The eLearning modules were developed using NLN CNE competencies (Christensen & Simmons, 2020). Phillips et al. referenced novice to expert learning theory and transformational leadership's creative and reflective principles to describe their eLearning course design. Data collection focused on the effectiveness of eLearning courses helping faculty acquire the knowledge, skills, and attitudes needed for clinical instruction.

Researchers reported results demonstrating a moderate impact on knowledge, moderate impact on skills, and slight impact on attitude following their eLearning course participation (Phillips et al., 2019). It is unknown how these results may have differed if CNEC were used for

the eLearning course rather than CNE competencies (Shellenbarger, 2019). A limitation to the study was the inclusion of novice and experienced clinical educator subjects, and it is unclear how quantitative and qualitative conclusions may have differed if results were provided separately for novice and experienced subjects. Despite the limited improvement for orientation and role transition, Phillips et al. (2019) helped fill the gap in the scholarly literature by providing information about the lived experiences and perceived orientation and role transition needs of novice clinical nurse educators.

Mentoring with Clinical Judgment Model

Rodger (2019) reported on a mentoring approach for the orientation of novice clinical nurse educators using Tanner's *clinical judgment model* (2006). A master's-prepared clinical instructor worked as a mentor to four novice clinical nurse educators during a 6-week clinical rotation. Collaboration and mentoring occurred in remote and in-person formats to apply noticing, interpreting, responding, and reflecting student learning strategies to the role of clinical nurse educator. Novice clinical educators in Rodger's study stated they gained a deeper understanding of the clinical educator role through the encouraging, positive mentor-mentee relationship. Rodger's results confirm Wenner and Hakim's (2019) findings that mentoring was a key component of optimal role transition for novice clinical nurse educators. The mentoring results of Rodger, and Wenner and Hakim, were consistent with transformational leadership results such as employee retention, greater engagement and productivity, and ethical behavior enhancement (Ross et al., 2014; Suratno et al., 2018).

Competency-Based Orientation

Dunker et al. (2021) and Dunker and Manning (2018) agreed with Phillips et al. (2019) that a competency-based orientation plan for novice clinical nurse educators is needed to provide

effective orientation and role transition. Dunker et al. reported on a competency-based simulation learning course for novice clinical nurse educators. The simulation learning project incorporated Quality and Safety Education for Nurses (QSEN) competencies in the course design. Of the 15 participants, 80% found the simulation course helpful for orientation and transitioning to the clinical nurse educator role. Competency-based learning is supported by the novice to expert theoretical framework as the learner progresses in competency development along a continuum (Ozdemir, 2019).

Effective Clinical Instruction

The NLN formalized CNEC to recognize and clarify the specialized clinical nurse educator's knowledge, skills, and attitudes constituting effective nursing clinical instruction (Shellenbarger, 2019). A cornerstone of successful undergraduate nursing education, clinical instruction bridges the gap between didactic learning and the clinical setting by integrating theory with client care (Beiranvand et al., 2021; Gcawu et al., 2021; Labrague et al., 2020; Reising et al., 2018). The subjects of clinical instruction encompass student supervision, teaching and mentoring students, and the evaluation of student progress (Docherty, 2018; Gcawu et al., 2021; Hoffman & Daniels, 2020; Labrague et al., 2020; Rafii et al., 2019; Reising et al., 2018). Characteristics of effective clinical instruction found in the literature were as follows: using various level-appropriate teaching and evaluation strategies; promoting a culture of safety, enthusiasm and motivation for learning, and collegiality; and role modeling professional nursing and interdisciplinary health care team relationship development.

Using a Variety of Teaching and Evaluation Strategies

Nursing clinical pedagogy is a complex, specialized practice area for which few novice clinical educators are prepared when entering academia (Gcawu et al., 2021; Labrague et al.,

2020; Shellenbarger, 2019). Gcawu et al. (2021) examined the teaching practices of 68 clinical nurse educators across five campuses. Although bridging the gap between theory and client care is a crucial component of clinical pedagogy, Gcawu et al. concluded fewer than half of the study subjects had received sufficient orientation for teaching and evaluation strategies. Hoffman and Daniels (2020) concurred with Gcawu et al. and Labrague et al. (2020) that a key component to clinical instruction is bridging the theory-practice gap in a live client care setting.

Beiranvand et al. (2021) conducted an integrated review of the scholarly literature from 2008–2018 to identify clinical educator characteristics and competencies. Teaching and evaluation were captured in themes one and two generated from the literature study. Labrague et al. (2020) conducted a similar integrative literature review but focused on clinical educator characteristics from the student's perspectives. The review conducted by Labrague et al. included scholarly nursing literature published between 2001 and 2017. Labrague et al. found the most desirable clinical nurse educator characteristics were current clinical competence, communication and interpersonal relationship skills, and effective clinical pedagogy application.

Using novice to expert nursing education theory is foundational to promoting effective teaching and evaluation in the clinical setting (Gcawu et al., 2021; Karlstrom et al., 2019). Novice to expert theory provides a scaffolding framework through which nursing theory and clinical education practice are built according to the student's scope of practice and competency level. Karlstrom et al. (2019) described the novice to expert education process as incrementally challenging nursing students to develop clinical judgment and reasoning. The effective clinical educator begins instruction by assessing the student's competency level, which is an example of using novice to expert learning theory in the clinical setting (Rafii et al., 2019). Gcawu et al.

(2021) described clinical nurse educators' competence levels using Benner's novice to expert system.

Valiee et al. (2016) used a descriptive cross-sectional study design to investigate nursing students' perspectives of clinical educators' effective teaching strategies. The 158 participants were studying midwifery at a university in Iran. A similar study was conducted in the American Midwest by Reising et al. (2018) using a descriptive exploratory design with 384 nursing student participants. Valiee et al. and Reising et al. agreed the clinical nurse educator's current clinical expertise, pedagogy knowledge and application, and authentic evaluative feedback were integral to providing quality clinical education. Subjects in Valiee et al.'s study added effective clinical educators should be knowledgeable about course content. Rafii et al. (2019) supported Valiee et al., finding effective clinical educators can competently communicate curricular strengths and weaknesses to the academic institution.

Clinical teaching practices from the perspective of the clinical nurse educator were studied by Gcawu et al. (2021) using a quantitative design. Kantar (2021) and Hoffman and Daniels (2020) conducted studies similar in purpose to Gcawu et al. but using a qualitative design. Gcawu et al. and Hoffman and Daniels' studies were conducted in Africa, and Kantar's study was conducted in Lebanon. Gcawu et al.'s data focused on clinical teaching practice frequencies. Hoffman and Daniels explored clinical educators' perceptions of their level of teaching preparation. Gcawu et al. agreed with Hoffman and Daniels that teaching standardization is often lacking in clinical nursing education and that clinical educators should possess current clinical practice skills to be effective. Gcawu et al. added highly qualified instructors use student-centered, active teaching strategies. Hoffman and Daniels added accurate evaluation and documentation of student progress are characteristics of an effective clinical

educator. Labrague et al.'s (2020) literature review findings concurred with those of Gcawu et al. and Hoffman and Daniels.

Kantar's (2021) study participants' responses suggested there are four clinical nursing education practice domains: creating partnerships, building competence, nurturing, and making meaning. Kantar agreed with Gcawu et al. (2021) and Hoffman and Daniels (2020) that a standardized pedagogical framework should be the foundation of clinical nursing education. However, unlike Gcawu et al. and Hoffman and Daniels, Kantar concluded providing a safe and nurturing learning environment was the most important facet of effective student competency building.

Using qualitative case study design, Docherty (2018) examined the effectiveness of clinical nurse educators' evaluations of student nurse competency in the clinical setting. Findings confirmed the need for enhanced standardized nursing pedagogy for novice clinical instructors to prepare them for clinical instruction and student nurse competency evaluations. Competency six of CNEC states the best practices parameters for assessment and evaluation to determine the effectiveness of clinical instruction, supportive of Docherty's findings (Shellenbarger, 2019).

The evaluation of student clinical competence should be outcome-driven and based on a set of level-appropriate standards, according to Shellenbarger (2019) and Rafii et al. (2019). Rafii et al. suggested one purpose of an evaluation is to identify student strengths and areas for improvement to remove barriers to advancement. In Beiranvand et al.'s (2021) study of clinical educator competencies, theme one featured the evaluation of students. Hoffman and Daniels (2020) concurred with Rafii et al. that a key goal of providing constructive evaluative feedback to students is to prepare them to provide excellent, safe nursing care. Karlstrom et al. (2019) focused on unsafe student clinical behaviors using a Delphi technique mixed methods study. A

panel of 17 expert clinical nurse educators from two British Columbia, Canada, nursing schools ranked 55 behaviors as *unsafe for patients* and *unsafe for others*. Karlstrom et al. explained study results could provide a valuable theoretical knowledge resource for clinical educator orientation, in-service development, and clinical assignment preparation, which supported Hoffman and Daniels' findings.

Promoting a Culture of Safety, Enthusiasm and Motivation, and Collegiality

An integrative literature review on nursing and health science leadership was conducted by Carrara et al. (2017). Their findings pointed to transformational leadership as the most frequently mentioned leadership style in nursing and healthcare. Transformational leadership concepts promote a culture of student and client safety through inspiration and loyalty, motivation and enthusiasm for quality nursing care in the learning environment, and collegial interpersonal relationships. Transformational nursing leadership concepts are found throughout the literature (Beiranvand et al., 2021; Karlstrom et al., 2019; Labrague et al., 2020; Rafii et al., 2019; Suratno et al., 2018).

Safety

Hoffman and Daniels (2020) and Karlstrom et al. (2019) highlighted the importance of educating undergraduate nurses to provide excellent safe client care. Rafii et al. (2019) added the goal of clinical education is ultimately to produce graduate nurses with the ability to provide quality care. Docherty (2018) agreed with Hoffman and Daniels, and Karlstrom that nursing education quality is directly related to community health and safety. Docherty concluded clinical nurse educators must have specific training to teach competent nursing care. In this way, they protect the public from unsafe and unqualified graduate nurses entering the workforce. Novice

clinical educator orientation should include solid clinical pedagogy preparation for students' competency evaluation.

Kantar (2021) described the acquisition of nursing skills predicated on client safety as foundational to clinical instruction. Kavanagh and Szweda (2017) agreed with Kantar, adding a rationale for more effectively preparing novice clinical nurse educators to protect public safety is the explosion of medical knowledge and complex client diagnoses. Building on the public safety theme, Karlstrom et al. (2019) used the illustration of novice to expert nursing education theory when discussing a dangerous scenario in which a novice clinical educator incorrectly evaluated the competency progress of a beginning nursing student.

Enthusiasm and Motivation

Creating a positive, inclusive, and safe learning environment is foundational to the clinical learning process (Beiranvand et al., 2021; Gcawu et al., 2021; Reising et al., 2018). Reising et al. (2018) conducted a quantitative study with 384 nursing student participants from which four themes of effective clinical educators emerged. One theme encompassed the transformational leadership facets of caring, passion, enthusiasm, and motivation. Labrague et al. (2020) concurred with Reising et al. (2018) regarding the importance of clinical educator enthusiasm and passion are motivating factors for students. Labrague et al. found common themes of effective clinical instruction found in the literature were interpersonal skills demonstrated through caring, respect, openness, and supportiveness. A literature review conducted by Beiranvand et al. (2021) found that establishing an atmosphere of mutual respect in the clinical setting positively affected student motivation for learning. Beiranvand et al. concurred with Labrague et al. there was a strong positive relationship between clinical educator enthusiasm for teaching and clinical pedagogy expertise.

Collegiality

Gaining competence in collegiality is foundational to student nurse preparation for professional practice, as outlined in CNECs three and five. Collegiality development in student nurses is similar to collegiality and collaboration skills developed during clinical nurse educator role transition (Shellenbarger, 2019). Collegiality development in clinical nurse educators follows the novice to expert theory of learning. Clinical educator professional communication and collegiality positively affect student nurse clinical learning (Beiranvand et al., 2021). Kantar (2021) used the term *partnership* to describe the clinical nurse educator teaching domain through which an educational relationship between students and instructors develops. Nurturing partnership between students and educators supports the learning process by creating a culture of collegiality. Learning to act with professionalism and collegiality may assist students in translating these skills to future workplace relationships. Agreeing with Kantar, Hoffman and Daniels (2020) added a culture of collegiality builds trust and cohesion, promotes effective communication, and improves productivity.

Role Modeling Professional Relationship Development

As novice members of an interdisciplinary health care team, student nurses benefit from clinical educators mentoring them in professional relationship development (Rafii et al., 2019; Shellenbarger, 2019). Educator role modeling of organization, punctuality, honesty, efficiency, and patience are assistive to student development of professional relationships (Reising et al., 2018). Strong interprofessional relationships promote effective client care and organizational loyalty, which lead to employee retention. When combined with transformational leadership skills, these professional relationships, improve organizational effectiveness (Rafii et al., 2019; Suratno et al., 2018).

Collaboration between students and clinical educators leads to future collaborative professional healthcare relationships (Dunker & Manning, 2018; Labrague et al., 2020). A similar collaborative relationship occurs when expert clinical educators act as role models for novice clinical educators (Merrill, 2019). Labrague et al. (2020) found congruence between the relational aspects of holistic education and clinical instruction focused on communication skills, the development of self-confidence, and independence, as key elements of effective clinical nursing education.

Clinical Judgment

Preparing undergraduate nursing students to provide safe, competent care requires helping them develop problem-solving, critical thinking, and clinical reasoning skills. Nursing clinical judgment is discussed in the literature as client-centered problem-solving, critical thinking, and clinical reasoning. (Labrague et al., 2020; Rafii et al., 2019; Rodger, 2019). Kavanagh and Szweda (2017) added *critical action* to clinical judgment to emphasize the importance of transforming knowledge into timely action to ensure best outcomes for the client. The clinical nurse educator's role in creating opportunities for students to develop clinical judgment while assisting them in translating didactic knowledge to clinical judgment skills is referenced in CNECs one, two, and four (Shellenbarger, 2019). Seminal work by Tanner (2006) provided evidence-based practice guidelines for academic and clinical nurse educators to guide students in developing clinical judgment.

The effectiveness of utilizing Tanner's nursing student clinical judgment development model (2006) to guide the orientation of newly hired adjunct clinical instructors was investigated by Rodger (2019). Rodger adapted Tanner's model so it was applicable to clinical educators, predicting novice clinical educators acquire pedagogy skills much like undergraduate nursing

students acquire clinical judgment skills. The qualitative study included the orientation and mentorship of four novice clinical instructors. Mentoring activities were conducted remotely and in person over a 6-week medical-surgical clinical rotation in which the subjects were employed as clinical faculty.

Rodger (2019) found parallels between the thought processes of developing nursing students and those of novice clinical nurse educators during role transition (Quinn, 2020). Novice clinical nurse educators learn to notice student learning needs, interpret patterns and actions relevant to course competencies, respond appropriately to enhance student learning, and reflect on meanings for the evaluation of student and educator performance. Tanner's model of clinical judgment acquisition is compatible with the novice to expert theory of nursing education. The clinical judgment model's cyclical design allows for the guidance, documentation, and evaluation of clinical judgment development.

Delivering high-quality nursing care in the context of the rapid evolution of fast-paced globalized technology requires expert clinical instruction for undergraduate students (Kavanagh & Szweda, 2017). Their study of more than 5000 new grad nurses found 23% demonstrated entry-level nursing competency. Kavanagh and Szweda (2017) concluded a crisis in clinical nursing education related to clinical judgment and the application of critical thinking to client care scenarios. Lack of clinical judgment competency in nurses entering the workforce places the health and well-being of the public at risk (Beiranvand et al., 2021; Caputi & Kavanagh, 2018; Karlstrom et al., 2019; Rafii et al., 2019).

Rafii et al. (2019) agreed with Kavanagh and Szweda (2017) regarding the importance of undergraduate nursing students developing clinical judgment, linking clinical judgment competence with the provision of highly skilled quality nursing care. Rafii et al. designed and

implemented a clinical competency evaluation tool for their quantitative cross-sectional study. The validity and reliability of the evaluation tool system was examined after being used to evaluate student clinical performance in an 18-day rotation. Docherty (2018) agreed with Rafii et al. on the importance of providing an accurate evaluation of nursing students' clinical judgment, adding clinical nurse educators must have the requisite clinical pedagogical skills to assess student progress accurately. Kantar (2021) agreed with Docherty and Rafii et al. that to safeguard the public, clinical educators must be competent in clinical judgment use to accurately evaluate student progress. Citing public safety, Karlstrom et al. (2019) argued it was imperative for clinical educators to assess students' client care expertise development and provide authentic clinical evaluation regarding student problem-solving, critical thinking, and clinical reasoning skills.

Faculty Development and Mentoring

Regard for faculty professional development is widely known as a component of nursing higher education. CNEC four and six list faculty development as an NLN clinical nurse educator standard (Shellenbarger, 2019), and CNEC five describes the standards of mentoring and role modeling. The NLN position regarding professional development and continuing education for all nursing faculty is stated in *Ethical Principles for Nursing Education* (National League for Nursing, 2012). The code of excellence calls for nursing programs and nurse educators to demonstrate excellence through scholarship, ongoing professional growth, and transformative leadership (Christensen & Simmons, 2020). According to Foster and Hill (2019), the Institute of Medicine recommended increasing numbers of graduate prepared clinical and academic practice nurses to meet the needs of an increasingly complex and technologically-based health care

marketplace. To meet the demand of nurse scholars and improve employee retention, Foster and Hill argued for the increased use of professional mentoring relationships.

Reising et al. (2018) and Dunker and Manning (2018) studied faculty development programs and mentoring to determine their effectiveness in promoting role development in clinical nurse educators. The effective role development of novice educators was shown to promote nursing faculty retention (Harris, 2019). Harris described the tension among academic funding for professional development, faculty attrition versus retention, and national initiatives by professional nursing education authorities. According to Harris, mentoring relationships formed between expert nursing faculty and novice faculty lead to improved retention and opportunities for professional development.

Dunker and Manning (2018), Roman (2018), and Horner (2021) put the NLN call for excellence into action by designing and implementing nursing faculty professional development programs. The nursing faculty professional development programs were designed to promote the expertise of clinical education at their academic institutions. Dunker and Manning, Harris (2019), and Horner related the benefits of professional development to address the nurse educator shortage. Dunker and Manning, and Horner studied in person professional development projects, while Roman used an online delivery format.

An 8-module continuing education program in a live setting, including discussion and mentoring, was piloted by Dunker and Manning (2018). The purpose of the study was to evaluate the effectiveness of mentoring for clinical educators. Participants included 84 clinical nurse educators with varying levels of experience. Dunker and Manning concluded a strong positive response to the format and content, particularly for the opportunity to collaborate with faculty from other nursing schools. Harris (2019) and Merrill (2019) agreed with Dunker and

Manning novice nursing faculty professional development and retention are promoted through mentoring provided by experienced clinical faculty. Phillips et al. (2019) pointed out, similar to how nursing students benefit from mentoring by clinical educators, novice clinical faculty development is improved by mentoring from experienced clinical faculty. Shellenbarger (2019) added mentoring can promote clinical pedagogy competence for the multifaceted complex set of skills required for providing effective clinical instruction.

Roman (2018) studied the use of an online professional learning community to meet the pedagogy development needs of novice and expert clinical nurse educators. The study had 37 participants who were currently practicing as clinical nurse educators. Evidence-based research about general education and nursing pedagogy themes formed the basis of the asynchronous online learning modules used in the study. Mentoring occurred through post-module completion discussion boards. Subjects reported an increase in the effectiveness of clinical nursing pedagogy at the end of the study. Novice clinical educators described the benefit of sharing needs with, and receiving guidance from, experienced clinical educators. Mentoring was facilitated by the professional learning community design incorporated into the modules. Dunker and Manning (2018) conducted a live study on mentoring that was similar in purpose to Roman's study. Participants suggested additional mentoring from experienced faculty would be beneficial, and they recommended an extended online delivery. Roman concluded mentoring using an open access online platform for clinical nurse educators would promote professional development. Phillips et al. (2019) agreed with Dunker and Manning, and Roman about the valuable role online learning played in creating opportunities for clinical nursing faculty development.

Mentoring and shared vision are key components of transformational leadership (Suratno et al., 2018). Horner (2021) and Foster and Hill (2019) examined the relationship between career

satisfaction and mentoring in nursing. Results from both studies confirmed mentoring's positive effects. Horner and Foster and Hill concurred with Harris (2019) and Merrill (2019) that improved career satisfaction promotes faculty retention, which can help reduce the nurse educator shortage. Horner reported on a live clinical nurse educator professional development course offered by the Colorado Center for Nursing Excellence. The professional development course, Clinical Scholars, spanned five days and utilized competencies congruent with CNEC. Participants were from a wide variety of nursing backgrounds, and included hospital staff nurses interested in becoming clinical nurse educators, experienced clinical educators, classroom educators, and deans of nursing programs.

Foster and Hill (2019) utilized a descriptive correlational design to study mentoring's effect on career satisfaction. Their findings indicated experienced nurses must mentor the next generation to promote professional development and continue nursing practice standards. Rodger (2019) argued mentoring is important but framed the rationale differently from Foster and Hill. Rodger agreed that mentoring assists nursing faculty professional role development but argued that faculty retention is an additional need addressed by mentoring. Foster and Hill reported a significant positive psychosocial benefit in the relationship between mentor and mentee, pointing out the importance of coaching and role modeling in nursing professional development. Rodger concluded a significant benefit of the mentoring relationship is coaching the mentee on reflective pedagogy practices.

Leadership

CNEC three and six relate directly to the clinical nurse educator's leadership role. Leadership is demonstrated in the clinical environment through effective management, fostering a shared learning community, and using consistent performance standards for student assessment

and evaluation (Shellenbarger, 2019). Transformational leadership themes were strongly evident in the literature (Quinn, 2020). Clinical nursing education scholars commonly used transformational leadership themes such as motivation, encouragement, inspiration, change agent, loyalty, ethical behaviors, trust, and personal growth (Quinn, 2020; Suratno et al., 2018).

Professional practice nurses are familiar with leadership in their role as healthcare providers and client health facilitators in clinical practice (Quinn, 2020). As clinical nurse educators, these expert clinicians assume leadership roles with the responsibility to supervise, guide, and evaluate undergraduate nursing students (Hoffman & Daniels, 2020; Labrague et al., 2020). Clinical nurse educators demonstrate leadership in the clinical environment by fostering authentic professional relationships among the interdisciplinary healthcare team members. When clinical nurse educators teach and demonstrate self-care and reflective practices, they model leadership skills for students (Kantar, 2021). As academic leaders, clinical nurse educators expertly connect didactic nursing theory to real-world client care scenarios using evidence-based practice teaching strategies (Reising et al., 2018).

Qualitative exploratory design was used by Hoffman and Daniels (2020) in their study of the core functions of 12 undergraduate clinical nurse educators. Hoffman and Daniels agreed with Labrague et al. (2020) and Reising et al. (2018) regarding the importance of role modeling leadership as part of effective clinical nursing education pedagogy. Reising et al. discussed leadership in terms of setting clear expectations for clinical nursing students and monitoring their ability to function with less supervision over time. Reising et al. further agreed with Labrague et al. and Hoffman and Daniels about the importance of interpersonal skills of dedication, caring, and enthusiasm related to clinical educator leadership. Labrague et al. provided information on resources for measuring educator characteristics. It is unclear how nursing schools are

implementing evaluation standards for clinical educator leadership. Additional research on leadership development and evaluation for clinical nurse educators may be helpful to support growth from novice to expert clinical education leader (Quinn, 2020; Reising et al., 2018).

Effective clinical educators mentor students to help them envision their academic and professional goals, transferring goal identification skills nursing care. The clinical educator helps students make the association of goal identification to client care, informing plans for goal-oriented nursing interventions (Reising et al., 2018; Shellenbarger, 2019). Docherty (2018) examined the lack of effective supervisory and evaluative leadership by clinical nurse educators who failed to fail nursing students for providing unsafe client care. Without directly referring to student clinical evaluations, Hoffman and Daniels (2020) suggested poor clinical supervisory skills impact student competency attainment, and jeopardize the health and safety of the public. Karlstrom et al. (2019) agreed with Hoffman and Daniels that skilled leadership is imperative to protecting public safety. Karlstrom et al. added effective clinical leadership involves the identification of student knowledge deficits based on educator values of honesty and precision.

Clinical nurse educators work with diverse members of the interdisciplinary care team, to foster a shared learning community. Learning opportunities for clinical nursing students are identified and enhanced through collaboration about student unit assignments (Horner, 2021; Shellenbarger, 2019). According to Gcawu et al. (2021), effective clinical education leadership includes providing students clear learning objectives, making effective facility placements, continual rounding and monitoring, and creating a positive learning environment. Kantar (2021) concurred with Gcawu et al. that effective clinical leaders create a positive learning environment. Kantar used terms such as mutual trust, learning relationship, nurturing, and reflective meaning-making to describe effective clinical leadership.

The reduction of student stress by clinical educators communicating clearly defined roles and responsibilities, and explaining clinical facility policy and procedure guidelines, was discussed by Kantar (2021) and Hoffman and Daniels (2020). Shellenbarger (2019) expanded on the importance of collaboration between clinical nurse educators and facility personnel, noting healthcare is a team effort comprising multiple disciplines. The clinical educator functions as the liaison between academia and clinical practice partners. Instilling confidence in doing the right thing, fostering an environment of respect and civility, and rewarding teamwork are elements of nursing leadership (Shellenbarger, 2019). The mutual respect and shared vision necessary for liaison leadership are also consistent with transformational leadership theory (Suratno et al., 2018).

Potential Counterarguments to the Research

The problem was a lack of understanding of how undergraduate nursing program leaders in Arizona implemented the CNEC and to what degree their implementation improved the orientation and evaluation of clinical nurse educators. There is a gap in the literature regarding the use of established clinical nurse educator competencies to guide the orientation and evaluation of professionals in this specialized practice area (Phillips et al., 2019; Roman, 2018). Hoffman and Daniels (2020) and Beiranvand et al. (2021) agreed that clinical instructors must be expertly prepared to provide clinical nursing pedagogy, describing the need for orientation and training, but did not offer a solution. The literature is widely supportive of the need for a structured framework to guide the orientation of novice clinical nurse educators but offers little guidance on creating a standardized plan (Dunker et al., 2021; Sousa & Resha, 2019). Some scholars described using competencies to guide orientation, while others did not. It is unclear how nursing education leaders design evaluation tools specific to the clinical nurse educator role.

The subject of a standardized competency-based evaluation for clinical nurse educators needs further study by nursing education scholars.

Competencies Used

Dunker and Manning (2018) conducted a qualitative study on clinical faculty orientation using mentoring in a competency-based online program but did not provide information about the learner competencies. Study participants expressed the need for standardized orientation to clinical pedagogy. Horner (2021) reported results from a week-long competency-based clinical nurse educator orientation program. Dunker and Manning, and Horner cited the importance of using competencies to guide clinical nurse educator orientation and professional development programs. Horner reported using competencies closely aligned with CNEC, utilizing the novice to expert learning theory. Dunker et al. (2021) presented a plan for novice clinical nurse educator orientation using simulation. The simulation training was designed using QSEN nursing student competencies rather than competencies focused on the skills and behaviors of the professional clinical nurse educator.

Competencies Not Used

Hoffman and Daniels (2020) conducted their qualitative study in a university setting. The university nursing program used several processes to orient novice clinical educators, such as attending meetings and shadowing experienced clinical instructors. Using competencies for orientation or evaluation was not mentioned by Hoffman and Daniels. Although Rodger (2019) agreed novice clinical instructors needed specific orientation for the clinical nurse educator role, Rodger did not mention using competencies. Like Rodger, Roman (2018) advocated for providing professional development and mentoring to orient novice clinical instructors. Using

competencies to design the asynchronous modules in Roman's study is not included in the article.

Labrague et al. (2020) agreed with Roman that mentoring for orientation and role transition was useful and stressed the importance of having a structured plan. Labrague et al. also mentioned the contributions of NLN CNE competencies to clinical instruction. However, they did not find evidence that nursing program leaders used CNEC despite the publication of Labrague et al.'s article two years after CNEC was established. Sousa and Resha (2019) concluded the need for a formalized structured orientation to the clinical nurse educator role with ongoing role transition support. Despite publication one year after CNEC, Sousa and Resha did not mention nursing program leaders' using CNEC for orientation or evaluation. Rather, Sousa and Resha suggested using results from an orientation-needs survey would help develop orientation programs for novice clinical instructors.

Gap in the Literature

Clinical nurse educators play a crucial role in educating undergraduate nursing students and promoting community health and well-being (Kantar, 2021; Reising et al., 2018). Scholarly nursing education literature evidences the need for structured orientation and evaluation programs for novice clinical nurse educators. NLN, the global authority on nursing education, published a set of specialized practice competencies for the clinical educator role (Shellenbarger, 2019). Despite the vital role of the clinical nurse educator, a paucity of scholarly work exists to guide the orientation and evaluation of nurses entering this specialized field of practice (Phillips et al., 2019; Roman, 2018). Findings from this qualitative study will contribute to the body of knowledge about how nursing education leaders in Arizona implemented CNEC and how their implementation improved the orientation and evaluation of novice clinical nursing educators.

Study findings addressed the literature gap and may be useful globally for informing future development and standardization of orientation programs and evaluation tools for clinical nurse educators.

Chapter Summary

Several themes related to clinical nursing faculty orientation and evaluation emerged from the literature review: orientation and role transition, effective clinical instruction, clinical judgment, faculty development and mentoring, and leadership. The specialized role of nursing clinical instructors with a unique skill set is discussed by scholars presented in the literature review (Horner, 2021; Owens, 2018; Sousa & Resha, 2019). The need for a formalized orientation framework for nurses entering clinical pedagogy roles was widely recognized in the literature (Beiranvand et al., 2021).

Ineffective role transition negatively affecting clinical nurse educator performance, student outcomes, and faculty retention was also widely recognized and discussed (Wenner & Hakim, 2019). A paucity of research is available about how CNEC is being used in nursing education, particularly in qualitative research. This demonstrates a gap in the body of knowledge and research design for the specialty practice field of clinical nurse educator (Christensen & Simmons, 2019; Ross & Dunker, 2019). Scholarly works reviewed demonstrated agreement on the need for formalized orientation for the unique role of adjunct clinical nurse educator and detrimental results when role transition was not adequately supported. Nursing scholars agree additional research is needed to understand best practices for orienting novice clinical nurse educators. Agreement among nursing pedagogy scholars supports the dissertation study (Phillips et al., 2019; Rodger, 2019; Shellenbarger, 2019; Sousa & Resha, 2019; Wenner & Hakim, 2019).

Transformational leadership theory (Ross et al., 2014) and novice to expert nursing education leadership theory (Benner et al., 2010) provided the theoretical framework for the study. Transformational and novice to expert nursing education leadership theories supported the literature review findings regarding the need for formalized orientation, role transition, and evaluation guidelines for clinical nurse educators. Although clinical nursing education scholarly studies demonstrated the need for standardized orientation competencies, it was not until the NLN published CNEC in 2018 that a set of competencies suitable for orientation and evaluation of clinical nurse educators was available from an authoritative source (Christensen & Simmons, 2019; Shellenbarger, 2019). In the next chapter are found the research method, design, procedures, and data analysis for the qualitative study about CNEC implementation by nursing program leaders in Arizona and the degree to which their implementation improved the orientation and evaluation of clinical nurse educators.

Chapter 3: Methodology

The purpose of this qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. Undergraduate nursing programs deliver education through didactic and clinical learning experiences. In the clinical setting, students are supervised and mentored by clinical instructors who are most often adjunct faculty with little or no nursing pedagogy preparation (Ross & Dunker, 2019). Published in 2018, the use of competencies for the advanced specialty area of clinical nurse educator are not considered in many scholarly research articles (Christensen & Simmons, 2019). The problem was a lack of understanding of how undergraduate nursing program leaders in Arizona implemented the CNEC (Shellenbarger, 2019) and to what degree their implementation improved the orientation and evaluation of clinical nurse educators. The following research questions guided the study:

Research Question 1: How are CNECs used to inform the orientation of novice clinical nurse educators?

Research Question 2: How are CNECs used to inform the evaluation of clinical nurse educators?

Research Question 3: What improvement in orientation and evaluation processes for clinical nurse educators in Arizona resulted from the implementation of CNEC?

Six major sections comprise chapter organization to describe and provide a rationale for the study methodology: research methodology, design, and rationale; role of the researcher; research procedures; data analysis; reliability and validity; and ethical procedures. The chapter summary includes a discussion of the major chapter components and a preview of the next

chapter. Careful consideration of study methodology and research design yielded alignment with the study purpose and problem (Polit & Beck, 2012; Raskind et al., 2019).

Research Methodology, Design, and Rationale

Qualitative research methodology's flexibility and exploratory nature allow innovative inquiry suitable for studies focused on healthcare topics (Raskind et al., 2019). The selection of a qualitative methodology for the study allowed for a deeper understanding of participants' experiences implementing CNEC, perceptions about the implementation process, and meanings of CNEC implementation for the orientation and evaluation needs of clinical nurse educators (Creswell & Creswell, 2018). According to Bellamy et al. (2016), research in health care is often best served through a generic qualitative design because this approach invites multiple components of qualitative research that can be modified to meet the study's purpose. A basic qualitative design selection promoted the flexibility of approach necessary to gain evolving information about participants' experiences implementing the CNEC during data collection and their beliefs and perspectives on how CNEC implementation improved the orientation and evaluation of clinical nurse educators.

Qualitative Methodology

This dissertation answers the general research question of how nursing program leaders implemented CNEC and how their implementation improved the orientation and evaluation of clinical nurse educators. Gaining an understanding of how nursing program leaders implemented CNEC and their opinions about the processes and results of implementing CNEC led to the selection of a qualitative methodology. Arghode (2012) explained a research methodology can be thought of as the logic behind how research is conducted. By nature, a qualitative research methodology is exploratory and inductive. When the subjects share their stories, their lived

experiences unfold, providing rich data that may reveal information to address the study problem and purpose (Bansal, 2012). With open-ended questions, exploratory discussions, interviews, and field observations, qualitative researchers gain insight into the personal perspectives of subjects, who recount how they understood their life experiences (Creswell & Creswell, 2018). Using a qualitative methodology promoted exploration into how nursing education leaders, such as nursing program directors or clinical coordinators, used CNEC to orient and evaluate clinical nurse educators in their undergraduate programs.

Published in 2018, nursing education program leaders have had only a few years to incorporate CNEC into their orientation and evaluation processes for clinical nurse education faculty (Christensen & Simmons, 2020). Using an open-ended questionnaire with follow-up semi-structured interviews was best suited to gain information about the process of CNEC implementation. A qualitative methodology supported further exploration of subjects' stories about effective and ineffective implementation plans, how those plans evolved, and what improvements in clinical education delivery resulted from CNEC implementation (Merriam, 2009).

Basic Qualitative Design

A basic qualitative study design provides a flexible and holistic approach to subject inquiry that fit the study's purpose (Bellamy et al., 2016; Merriam, 2009). Data collected to address the study purpose and questions were more scientific than socio-emotional in nature, leading to the selection of a study design with maximum flexibility to understand leadership processes and opinions related to CNEC implementation (Ritchie et al., 2014). Other qualitative designs, including phenomenology, case study, narrative analysis, and grounded theory, were not as well suited to address the study's purpose. A phenomenology design leads the researcher to

discover inherent underlying meanings and subjective interpretations, which was inconsistent with the development of knowledge, skills, and attitudes paradigm of clinical nursing education (Chan et al., 2013). Case study design was not appropriate because the design calls for a large amount of descriptive data examining relationships and trends over time. Case studies often require conducting a detailed study over a longer time than was feasible for the current qualitative study. Although it is useful for gathering story data, narrative analysis does not generally involve collecting data through questionnaires, which was an important precursor to the semi-structured interviews. Grounded theory design was not selected because this study did not include post-data collection theory generation (Polit & Beck, 2012). Because the target population of nursing education leaders covered the state of Arizona, selecting a study design appropriate for online and telephonic data collection was important to remain consistent with the available study resources.

Role of the Researcher

Qualitative researchers collect data using various processes and are an integral part of the data collection process. At times in the process, a researcher may choose to pursue a certain line of inquiry based on subject responses (Polit & Beck, 2012). The fluid nature of qualitative inquiry results in researcher involvement with, rather than detachment from, participant observation and interview (Arghode, 2012). For the study, researcher-created open-ended instrument questions provided a vehicle for data collection. Instrument creation utilized verbiage correlated directly to the research study questions. The online questionnaires and follow-up semi-structured interviews employed these researcher-created instruments.

As a leader in Arizona clinical nursing education, the researcher's prior knowledge of the subject assisted in understanding participant responses and determining the need for additional

inquiry. An aspect of the role of the researcher is using bracketing, which allows for the identification of personal biases related to a familiarity with the topic before beginning the research process (Ward et al., 2018). Bracketed notes documented the researcher's preconceived ideas or professional biases. Research authenticity and deliberate reduction of bias effect resulted from reflectively using bracketed notes during data collection and analysis (Baksh, 2018).

Participants were nursing education leaders from undergraduate programs across the state of Arizona. None of the participants had employment at the researcher's workplace, nor was there any personal or supervisory relationship between the participants and the researcher. The ethical researcher strives to eliminate conflict of interest through personal or work relationships with participants (Polit & Beck, 2012). Therefore, participants in the study understood they were volunteering with no offer of participation incentives. Participants had the opportunity to remove themselves from the study at any time, could choose to answer or not answer any written or verbal questions, and were assured the privacy and confidentiality of their responses would be maintained (Chenail, 2011). Information gathered from participants was processed with reflexivity and other measures to limit personal bias or interpretation (Ramani & Mann, 2016).

Research Procedures

This section explains procedures to recruit participants, research instrumentation, and data collection. A basic qualitative research design provided a vehicle for guiding procedures to gain insight into and an understanding of the practices and experiences of undergraduate nursing program leaders as they implemented CNEC (Ramani & Mann, 2016). The population selected aligned with the study purpose to ensure valid, reliable data (Polit & Beck, 2012). Using a systematic approach to plan and execute research procedures for the study provided a framework for ongoing decision-making during recruitment, participant and instrumentation selection, and

data collection (Daniel, 2019). A description of the method and rationale for population selection, sampling and sample size, site permission, potential subject recruitment, informed consent management, instrumentation, and data collection follows.

Population and Sample Selection

Public information about undergraduate nursing programs in Arizona provided information to identify the target population for the study. According to the Arizona State Board of Nursing, 37 undergraduate nursing programs offering registered nurse or practical nurse courses operated in the state at the time of population consideration. Academic institutions offering nursing programs at multiple sites had site-specific program administrators, which provided an adequate total population for the 15-20 people appropriate for a qualitative study. The Arizona Board of Nursing website listed undergraduate nursing program administrators' names and contact information for approved programs (Arizona State Board of Nursing, 2021). For the study, leaders from the 37 nursing programs constituted the target population because they had the institutional authority to implement and evaluate professional development for clinical nurse educators employed by their academic institutions. The resultant 16 study participants, identified based on qualification and availability, ensured adequate research data.

Purposeful sampling with snowballing allowed study participants to identify and invite additional qualified nursing education leaders to participate in the study. Within larger nursing programs, the authority to implement CNEC to orient and evaluate clinical nurse educator faculty may be delegated to clinical coordinators by the nursing program administrator. Snowball sampling allowed nursing program administrators to refer other administrative faculty with authority to implement CNEC to participate in the study (Polit & Beck, 2012). The sampling method was consistent with the population intended to benefit from knowledge and insights

gained from the study because the study focused on the specialized area of clinical nursing educator orientation and evaluation (Suhonen et al., 2015).

For clarity and replicability, researchers further explain eligibility criteria for subject selection in terms of inclusion and exclusion (Polit & Beck, 2012). Inclusion criteria were Arizona undergraduate nursing program administrators whose programs had State Board of Nursing approval status. According to Polit and Beck, exclusion criteria may be characteristics that disqualify potential participants due to vulnerability or inability to provide appropriate responses consistent with the study purpose. Excluded from the study were nursing program administrators whose programs the Arizona State Board of Nursing identified having an active decree of censure or consent for probation. Exclusion criteria were determined to minimize bias and ensure the integrity of data relevance (Creswell & Creswell, 2018).

Recruitment and research commenced following written approval from the American College of Education Institutional Review Board (IRB) (see Appendix A) and site permissions from the nursing program leaders' academic institutions (see Appendices B and C). Prospective participants who met the inclusion criteria received emailed recruitment information and an invitation to participate in the study (Dilmi, 2012). Contact information for undergraduate nursing program administrators was publicly available (Arizona State Board of Nursing, 2021). The Invitation to Participate recruitment letter (see Appendix D) included communication regarding research procedures, subject privacy and anonymity, security and disposal of data, and the ability to opt out of participation at any time. Demographic data recorded included participant names and their academic institutions. Prospective participants who did not respond to the emailed invitation to participate received a phone call inviting them to participate in the study, using the same script as the emailed invitation.

Persons agreeing to participate in the study received emailed informed consent information, including a detailed description of the study procedure (see Appendix E). Processes to secure informed consent adhered to established ethical standards in the Belmont Report (Department of Health, Education, and Welfare, 1979). Each participant candidate received an email offer to discuss the informed consent contents: opt-out options; time commitment for participation; data collection methods and instruments; the voluntary basis of participation; data storage, processing, and destruction; and the opportunity to ask questions prior to signing the informed consent document. Willing candidates signed and returned the informed consent document electronically, retaining a copy for their records. Signed informed consent documents returned via email were securely stored electronically with other study documents under password protection.

Data Instruments

Qualitative research methods allow for in-depth exploration of subject experiences and perceptions. In qualitative studies, the researcher is the primary instrument, functioning as data collector and analyst, necessitating a carefully planned data collection protocol to minimize the effect of bias (Birt et al., 2016). An interview is a common form of data collection as part of a methodology used to collect qualitative data (Polit & Beck, 2012).

The study's qualitative data collection employed two forms of questioning: an online open-ended questionnaire (see Appendix F) and a formal semi-structured telephone interview with a protocol (See Appendices G and H). Live semi-structured interviews were audio-recorded using digital technology. Barrett and Twycross (2018) explained qualitative questionnaires and interviews provide insight into participants' beliefs, decision-making processes, and interventions. The context, research questions, and data types should inform and align with

instrumentation selection (Raskind et al., 2019). For the study, researcher-created open-ended questions informed the composition of the online questionnaire and semi-structured interview questions.

Research instrument development followed a framework to align the study purpose, research questions, and instrument questions (Castillo-Montoya, 2016). According to Rubin and Rubin (2012) and Castillo-Montoya (2016), researcher-created questions provide a unique data collection tool specific to the study because they demonstrate a congruence and authenticity superior to standardized formats. Following an interview protocol assisted process organization to guide subjects through communicating their unique stories and perceptions (Butina, 2015).

Online Questionnaire

An online questionnaire with questions identical to those used for live semi-structured interviews formed the foundation for subjects' reflection on their experiences implementing CNEC (Castillo-Montoya, 2016). The online vehicle selected to provide participants access to the questionnaire was Google Forms. Researcher-created open-ended questions comprised the online six-item questionnaire. Using a unique set of questions was important to establish a direct relationship to the study purpose, research questions, and CNEC verbiage. Polit and Beck (2012) and Merriam (2009) supported researcher-created questions for basic qualitative study. Open-ended questions are assistive in reducing bias because they do not set an expected response, allowing the subject to reflect on a wide avenue of response options.

Semi-Structured Interview and Protocol

Live semi-structured private interviews with each participant followed their receipt and review of online questionnaire responses. Questions used for the online questionnaire were identical to core questions for the live semi-structured interviews. Prior online interaction with

the open-ended questions facilitated live telephone interview conversations between researcher and participants (Castillo-Montoya, 2016). Protocol for the semi-structured interviews followed a three-step planning process, including alignment of study questions with semi-structured interview questions, ensuring a rich, open-ended question format with opportunity for probing and deeper conversation based on initial participant responses, and incorporation of subject matter expert feedback during interview question formulation for clarity and understandability (Merriam & Tisdell, 2016).

Individual participant interviews occurred by telephone on a date and time selected by each participant (Merriam & Tisdell, 2016). An email reminder was sent one week before the arranged interview date, with a follow-up reminder sent three days prior. The interview reminder emails reiterated the interview would be digitally recorded and contain the semi-structured interview questions with CNEC verbiage for prior review by participants. An introductory script used to commence the telephone interviews reviewed the purpose of the study, the expected interview duration of 20-30 minutes, provided a statement about digitally recording the interview, and the opportunity to provide consent. Next, participants had an opportunity to give neutral descriptive information and background information about their area of nursing education. This created the foundation to introduce the CNEC and questions, then begin with the first interview question.

During the live interview, subjects had additional opportunities to expand on their experiences and perceptions beyond their Google Forms questionnaire responses. Dilmi (2012) described the blending of objective and subjective perceptions as the person begins to further interpret and assign meaning to their own story. Adjustments to the interview corresponded to the nature of participant response, using probe techniques of silence, clarification request, and

asking for more detail as the interview organically unfolded (Merriam & Tisdell, 2016). The closing script contained statements thanking participants for their involvement, providing information about member checking follow-up and total data collection time-frame, and allowing participants to ask questions.

Subject Matter Experts

For maximum congruency with the study purpose, researcher-created questions comprised the content of the online questionnaire and live semi-structured interview questions (Castillo-Montoya, 2016). An open-ended question format supported the basic qualitative design because subjects' answers were not limited to a defined numeric or scripted response set. The first step in question creation was intentionally aligning question verbiage with the research questions and CNEC language. Polit and Beck (2012) advised using clear, unambiguous wording for study questions to ensure each question presents minimal bias and contains considerate, respectful, and professionally appropriate wording.

The instrument was field tested by three undergraduate nursing education SMEs to establish content validity. Three SMEs not affiliated with American College of Education contributed to the field test. All were nursing education residential faculty, each having a minimum of five years of participating in didactic and clinical instruction management. Recruitment of SMEs included clarifying their role as content and style reviewers and that they would not respond directly to instrument questions (Zamanzadeh et al., 2015). Email correspondence from SMEs agreeing to the protocol and purpose of field testing the study instrument resides with study documents. SME feedback formed the basis for instrument modification and improvement.

Data Collection

Data collected for the basic qualitative study utilized online Google Forms and digital audio recorded live semi-structured private telephone interviews. Because qualitative data are non-numeric and focus on communication between the researcher and participants, study data sources were open-ended responses to online questionnaires and semi-structured telephone interviews (Merriam, 2009). An identical set of six questions comprised the online questionnaire and live semi-structured interview questions. Before data collection, each site provided permission for the study, and the IRB provided written study approval (see Appendices A and C). Data collection occurred over six weeks.

The Google Forms document contained the six-item open-ended question instrument with space for paragraph responses. Each subject received an email with the internet study link to the Google Forms document. Permission to view subject responses resided solely with the researcher to ensure privacy. Options for responding to the questionnaire included using a web browser on a smartphone, laptop, or personal computer, establishing ease of use. Participants did not need to have a Google account to submit questionnaire responses. The expected time commitment to complete the online questionnaire was 10 minutes, dependent on the participant's level of response detail. Participants completed the online questionnaire once and submitted responses, providing raw study data. Davies et al. (2020) found data collected using an online format often lacks the richer contextual content afforded through live interview processes. For this reason, data collection employed live telephonic interviews to bolster and enrich understanding of participants' experiences using CNEC.

Participants and researcher communicated via email to set up live semi-structured interviews. Participants had the opportunity to select a convenient date and time for their semi-structured telephone interview. An interview confirmation email contained written interview

questions, providing participants an opportunity to reflect and prepare for the interview. The confirmation email reiterated the expected interview duration of 20–30 minutes and included a reminder about the audio recording of their personal telephone interviews. During qualitative research, the interviewer participates in data collection through impression and reflection on the need for further exploration and follow-up to subjects' initial responses, lending flexibility to the expected interview duration (Barrett & Twycross, 2018; Davies et al., 2020).

Dedoose online software facilitated the integration of the written questionnaire responses and the audio recorded interview transcriptions. Participants' interview responses to the open-ended questions with follow-up discussion constituted a second raw data set. Upon completing the online questionnaire and private semi-structured live interviews, participants entered the debriefing portion of the study, during which they had an opportunity to ask questions and express concerns or complaints about research-related matters. Debriefing demonstrates respect for study participants and communicates concern for their well-being (Polit & Beck, 2012).

Data Analysis

Collected data were secured on a password-protected device and stored in electronic and hard copy formats in a secured safe. Before data analysis, the raw data were prepared and organized according to subject response categories. In this phase, data sets were labeled with numeric pseudonyms to protect participant privacy in preparation for interface with Dedoose software. Raw data from the Google Forms questionnaire responses were processed and synthesized with transcribed live interview audio data. Each respective participant received an emailed copy of their synthesized questionnaire and interview responses with instructions for member checking. Member checking is a process whereby study participants validate and verify

researcher-provided study response documents accurately represent their intended responses (Birt et al., 2016).

Data Analysis Model

Data analysis utilized Braun and Clarke's (2006) six-step thematic analysis model. Braun and Clarke's model was a good fit because themes capturing nursing education leaders' opinions, knowledge, and experiences comprised research data. Researchers often apply thematic analysis to transcribed text from interviews and questionnaire responses. Following data deconstruction, concepts and themes from qualitative data emerged and were coded for organization and analysis. Themes were defined and named according to the study purpose and research questions (Polit & Beck, 2012). Dedoose software assisted with categorizing and collapsing codes to develop themes. Color-coding themes assisted in the identification of unique data chunks. Using distinct markings for secondary data not directly correlated to the study purpose and research questions expedited the organization process. The data analysis focused on consistently emerging data chunks. Open and axial coding promoted clarification of relationships among themes to understand subjects' perspectives on their experiences implementing CNEC (Sutton & Austin, 2015). A researcher-created matrix facilitated the exploration of causal pathways for nursing education leaders' implementation of CNEC and their assessments of the perceived benefits of CNEC use for the orientation and evaluation of clinical nurse educators (Raskind et al., 2019).

Reliability and Validity

Reliable research design and procedures allow future studies to produce similar results consistently. The ability to generate consistent, accurate results over time is a hallmark of reliable research. Scholars often refer to trustworthiness when describing reliability in qualitative research. Validity in qualitative research is often referred to as believability, accomplished when

a study's methods and procedures measure what is intended for measurement so predictions about future results are plausible. Believability promotes the transferability of findings to extended populations (Polit & Beck, 2012). To accomplish reliability and validity in qualitative research, elements of credibility, dependability, transferability, and trustworthiness should be evident in the study design, methodology, and execution (Bloomberg & Volpe, 2019).

Credibility

Believability and trustworthiness measures increased the study rigor and enhanced the credibility of and confidence in the study results. Reflexivity and journaling further assisted awareness of how participant responses and personal biases may simultaneously affect the study process. Reflections on bracketed notes during data collection minimized researcher bias, improving study rigor and believability (Baksh, 2018). Triangulation through multiple data sources and methods provided a comprehensive perspective on participant responses, assisting in validating research findings. Validation strategies for the basic qualitative study included data triangulation with multiple sources, member checking, and SME field-testing of instrument questions (Noble & Heale, 2019).

Dependability

Dependability, also known as reliability, refers to consistency over time or a study design that allows researchers to produce similar results if repeated (Merriam & Tisdell, 2016). For the study, peer examination through SME's review of and input into the instrumentation development promoted dependability. Clear documentation of the data collection plans, implementation, and results enhanced the stability of findings and promoted duplicability. Reflecting on and articulating personal perspectives and biases acknowledged why biases exist and how they may influence data interpretation (Sutton & Austin, 2015).

Transferability

Transferability refers to how study understandings and knowledge may be utilized for related situations and settings (Bloomberg & Volpe, 2019). Understanding how nursing program leaders implemented CNEC and the related effects on faculty orientation and evaluation processes may have broad applicability among nurse assistant, practical nursing, and registered nursing programs. Data sources and methods for the study included collecting the experiences and perspectives of numerous nursing education leaders through an online questionnaire and semi-structured interviews with member checking. Follow-up semi-structured interviews allowed deeper exploration into subject experiences and perceptions, providing thick, rich descriptive data, and improving transferability (Barrett & Twycross, 2018).

Trustworthiness

Seminal scholars highlighted the importance of trustworthiness in qualitative studies, mentioning key attributes of value and significance (Guba & Lincoln, 1982). Methods to increase trustworthiness reduce bias, improving connection with reality, according to Merriam and Tisdell (2016). Transparency of study design, data collection, and data analysis methods promoted trustworthiness through vigilant exposure of subjective perspectives. Objectivity was not claimed; rather, an open consciousness of and engagement with one's own biases systematically challenged methodological processes throughout the study (Bloomberg & Volpe, 2019).

Ethical Procedures

The ethical researcher makes the well-being of subjects their primary consideration when planning and conducting research. Principles from the Belmont Report, respect for persons, beneficence, and justice, guided the study (Department of Health, Education, and Welfare,

1979). To avoid ethical violations and conflicts of interest, the study participants came from outside nursing programs, and no participants were peers or personal workplace reports. Because the study utilized human subjects as data sources, guidance and approval from the IRB formed boundaries for ethical practice (Hatcher, 2011).

Respect for Persons

Arrangements to demonstrate respect for nursing program leaders used as study participants included voluntary participation protocol and informed consent documentation prior to participation (see Appendix E). The participant invitation included information about informed consent procedures, including voluntary participation without compensation and the ability to opt out at any time at the participant's discretion. Informed consent procedures and options were reiterated and enlarged upon in the consent processes, stated in writing on the informed consent document, and discussed orally before live telephone interviews (see Appendix G) (Walton, 2016). Participants' relationships with their workplaces will remain anonymous in all reports and publications of the study to eliminate exploitation. No position of authority over participants was implied or held (Department of Health, Education, and Welfare, 1979).

Beneficence

Privacy relates to a person's ability to self-determine which personal information is collected and how the information is used (Bloomberg & Volpe, 2019). Participant confidentiality procedures demonstrated beneficence by replacing names with numeric codes and storing data on password-protected devices and a secured safe. Access to encrypted, password-protected, and locked study materials is held solely by the principal investigator. Coded subject information with no identifiable correlation to personal information further demonstrated the

element of beneficence. Destruction of digital audio recordings, researcher notes, and transcripts will occur after three years. (Department of Health, Education, and Welfare, 1979).

Justice

Making the dissertation widely available through publication demonstrates justice. Regardless of class or status, all persons may access published dissertations (Department of Health, Education, and Welfare, 1979). Participants' receipt of their interview transcript during member checking also demonstrated a fair distribution of information. Following the study's conclusion, each participant will receive an electronic copy of the final dissertation report. Findings are expected to be published in the *Arizona State Board of Nursing Regulatory Journal*, a quarterly publication. The completed manuscript will be made available widely through academic and professional nursing publications (Bloomberg & Volpe, 2019).

Chapter Summary

A detailed presentation of the study methodology provides an understanding of how study plans facilitated the investigation of how Arizona nursing program leaders implemented CNEC and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. Basic qualitative research design and rationale guided the study methodology, providing the foundation for population identification and subject sampling. The study purpose and research questions informed researcher-created study instruments, validated by three SMEs through field testing. Lastly, a discussion of ethical considerations for respect of persons, beneficence, and justice demonstrated their careful inclusion in each research plan phase. Presentation and discussion of research findings and data analysis results follow in the next chapter.

Chapter 4: Research Findings and Data Analysis Results

Undergraduate nursing programs deliver education through didactic and clinical learning experiences. In the clinical setting, students are supervised and mentored by clinical instructors who are most often adjunct faculty with little or no nursing pedagogy preparation (Ross & Dunker, 2019). Published in 2018, the use of competencies for the advanced specialty area of clinical nurse educator do not appear in many scholarly research articles (Christensen & Simmons, 2019). The problem was a lack of understanding of how undergraduate nursing program leaders in Arizona implemented the CNEC (Shellenbarger, 2019) and to what degree their implementation improved the orientation and evaluation of clinical nurse educators. The purpose of this qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. Data collection, data analysis and results, and reliability and validity comprise the three major chapter sections. Three research questions guided the study:

Research Question 1: How are CNECs used to inform the orientation of novice clinical nurse educators?

Research Question 2: How are CNECs used to inform the evaluation of clinical nurse educators?

Research Question 3: What improvement in orientation and evaluation processes for clinical nurse educators in Arizona resulted from the implementation of CNEC?

Data Collection

Study participants were nursing program leaders in Arizona with institutional authority to implement and evaluate professional development for clinical nurse educators employed by their

academic institutions. Nursing program administrators whose programs the Arizona State Board of Nursing identified as having an active decree of censure or consent for probation were excluded from invitation to participate in the study for purposes of study clarity and replicability. Upon receiving written approval from the American College of Education IRB on February 25, 2022, recruitment for the study commenced.

Recruitment and Informed Consent

Recruitment emails containing an invitation to participate in the study were sent to the 28 Arizona nursing program leaders meeting the inclusion criteria for participation (See Appendix D). Prospective participants who did not respond to the emailed invitation to participate received a follow-up phone call invitation to participate in the study. Of the 28 prospective participants, 19 responded they were interested in study participation. Nursing education leaders interested in participating were emailed an informed consent document through DocuSign encrypted e-signature service. The informed consent contained information regarding research procedures, the audio recorded telephone interview portion of the study, the opportunity to ask questions before providing consent, participant privacy and anonymity, security and disposal of data, and the ability to opt out of participation at any time (See Appendix E).

Participants returned their signed and dated informed consent documents electronically via DocuSign. The completed informed consent documents were downloaded and stored electronically on a password protected computer under randomly assigned numeric identifiers replacing participant names. Collection of informed consent occurred between March 2 and March 29, 2022. Following receipt of their completed informed consent, participants were eligible to engage in data collection activities. Sixteen nursing education leaders returned completed informed consents and entered the data collection phase of the study. Hennink and

Kaiser (2022) reported participant quantity saturation in qualitative research may be attained using sample sizes ranging from nine to 17. Participants' employment and responsibilities commonality supported the determination of sample size saturation.

Data Collection Procedures

In qualitative studies, the researcher is the primary instrument, functioning as data collector and analyst, necessitating a carefully planned data collection protocol to minimize the effect of bias (Birt et al., 2016). Qualitative data were collected through an online questionnaire and live semi-structured audio recorded telephone interviews. The same six open-ended questions were used for the online questionnaire and the live telephone interviews (See Appendices F and H). Data collection occurred between March 4 and April 21, 2022. All 16 participants completed the online questionnaire and the live telephone interview, yielding a 100% completed response rate. Data collection demonstrated saturation through repeating themes emerging among the rich, thick qualitative responses throughout the data. (Creswell & Creswell, 2018).

Google Forms was the vehicle for data collection of participant responses to the online six-item questionnaire. Upon receiving informed consent, each participant entered the data collection phase of the study. The first data collection phase was to complete the Google Forms online questionnaire. Participants accessed their blank Google Forms study questionnaire through the autogenerated link in their unique invitation email. Due to the online accessibility of the Google Forms questionnaire, participants could choose from multiple internet-capable devices and any time of day to submit their responses. Four of the 16 participants did not access the Google Forms questionnaire within one week of their invitation, prompting a follow-up reminder effective to elicit online questionnaire completion. Each participant accessed the online

questionnaire once and provided responses to all six questionnaire items. Access to Google Forms participant responses was restricted to the principal investigator through password protection. Each participant's questionnaire responses were transferred to a data response table document with side-by-side columns for online questionnaire and telephone interview responses.

After completing the Google Forms online questionnaire, participants received an emailed invitation to select a date and time of their convenience for a private audio recorded telephone interview. An investigator-created interview protocol guided the semi-structured telephone interview conversations to maintain consistency and reliability (See Appendix G). Prior interaction with the open-ended questions facilitated live telephone interview conversations (Castillo-Montoya, 2016). During the telephone interview, participants provided verbal consent to be recorded prior to and immediately upon audio recording initiation. The open-ended interview format allowed for rich conversation and opportunity for probing based on initial participant responses.

Raw data from each audio recording were prepared for transcription by participant deidentification and selection of segments containing only their responses to the six study questions. Removal of participants' personal comments and name statements preserved their confidentiality, promoting privacy and anonymity. The resultant shortened audio recording, labeled with the participant's numeric code identifier, comprised the data unit for transcription. Rev.com, a secure password-protected and encrypted online service, transcribed the shortened data sets to text documents. Participant responses from the online questionnaire and shortened interview data set populated individual data response tables, stored electronically on a password protected computer file under the participant's numeric code identifier.

The data response table, populated with a participant's responses to the online questionnaire and their shortened telephone interview transcription, were emailed to the participant for member checking. Member checking provides a mechanism whereby participants verify and validate their intended responses to study questions (Birt et al., 2016). Participants were asked to review their responses for accuracy and provide corrections or clarification as needed via return email. During the telephone interview, an explanation of the email communication process for reviewing their data response table allowed participants the opportunity to ask questions and receive clarifications about member checking. Editable data response tables for individual participants were attached to an emailed message containing directions to indicate desired corrections or clarification to their responses by either highlighting or typing their edits in colored font. Participants either responded that no corrections or clarifications were needed or provided their edited data response table documents via email, completing the member checking process. Four of the 16 participants returned an edited version of their responses. Edits made by three participants were grammatical in nature; one participant provided verbiage clarification where the audio recording was unclear or inaudible to the transcriptionist. The resultant member-checked responses were transferred to separate documents for each participant in preparation for review and initial coding.

Data collection and member checking activities followed the plan presented in Chapter 3. There were no significant or unusual circumstances encountered during data collection. Data from responses to the online questionnaire and from telephone interview transcripts were populated to investigator-created coding forms to prepare for data analysis. Each participant's data were compiled on a unique coding form document labeled with their identification code.

Data Analysis and Results

Preparation for data analysis and display of results commenced with several readings of participant responses for the online questionnaire and telephone interview transcripts. Bloomberg and Volpe (2019) suggested analysis is an ongoing process in qualitative research, inherent to each research phase and the writing process. Multiple data readings facilitated the organization of raw data into documents for various collection and analysis functions: data response tables for member checking, coding response forms, and specific data compilation forms used in Dedoose computer assisted qualitative data analysis software. Systematic readings of participant response data in electronic and hard copy formats multiple times provided a fresh outlook and promoted clarity of understanding of participant response themes and experiential meanings. The fruit of multiple data reading was the emergence of patterns and themes from initial and secondary codes, which formed the evolution of study results (Ritchie et al., 2014). Dedoose software assisted in organizing and categorizing data for analysis and providing visual cues for collapsing codes among data chunks to refine themes.

Data Analysis

Qualitative data are non-numeric and non-linear, requiring an inductive approach to analysis (Bloomberg & Volpe, 2019). Nursing program leaders' opinions, knowledge, and experiences comprised the thick, rich descriptive data from which inductive data-driven patterns emerged. A systematic approach to working through the data assisted progressive identification of key topics and integration of initial codes to higher-order themes (Ritchie et al., 2014). Maintaining a reflective attitude through journaling assisted bias identification and promoted a deeper understanding of emergent themes and patterns in participant data (Bloomberg & Volpe, 2019).

Transformational leadership theory (Ross et al., 2014), blended with Benner's novice to expert theory (Benner et al., 2010), supported the purpose of the study by providing a structural and motivational framework to guide data analysis. Transformational nursing education leaders inspire and guide their reports to innovate orientation and evaluation processes by including current evidence-based CNEC. Novice clinical nurse educator role development through orientation and evaluation processes aligns with Benner's five knowledge and skill acquisition stages in nursing education.

Braun and Clarke's (2006) six-step thematic analysis model guided the analysis of data from the two data collection instruments: online questionnaire and recorded telephone interviews. The six steps of Braun and Clarke's thematic analysis are: familiarize oneself with the data, generate initial codes, search for themes, review themes, define and name themes, and report the analysis (Braun & Clarke, 2006). Although the two data collection instruments contained identical study questions, response data from each instrument were initially reviewed and coded separately. Once a clear pattern of consistency for responses among both instruments emerged, data from both instruments were populated to a three-column combined data analysis form demonstrating each participant's combined questionnaire and telephone interview responses to each of the six study questions.

Columns on the data analysis form provided space for the study question, participant responses to the online questionnaire followed by transcribed telephone interview responses, and a blank column for coding notes. Data from the online questionnaire utilized a different font than data from the telephone interview, promoting visual clarity for each data collection source. Developing a refined data analysis tool containing research question connections within the

study questions in column one enabled a visual cue promoting deeper levels of analysis and theme identification.

Following the six thematic analysis steps systematically provided the necessary structure for qualitative data analysis. Through multiple readings of the huge volume of data, which at first seemed overwhelming, a pathway cleared for understanding participant experiences related to the research questions. Color coding of data chunks specific to each research question facilitated the identification of core ideas and patterns of nursing education leaders' experiences implementing CNEC in orientation and evaluation processes. Color-based coding of data chunks through Dedoose's secure, web-based platform provided a data organization and management mechanism. Open and axial coding promoted reflection to clarify relationships among themes. These relationships led to understanding the subjects' perspectives on their experiences implementing CNEC (Sutton & Austin, 2015). As themes emerged from the data, correlation to the study purpose and guiding research questions facilitated data display design to report findings. Table 1 shows Braun and Clarke's six-step thematic analysis implementation, yielding a combined approach to data analysis for responses to the six identical questions used for both data instruments.

Table 1

Implementation of Braun and Clarke's Six-Step Thematic Analysis

Thematic analysis steps	Implementation process
Step one: familiarize oneself with the data	Multiple data readings; electronic and printed formats Creation of individual participant data forms
Step two: generate initial codes	Identification and coding of core ideas and patterns Consistency between online questionnaire and telephone interview data identified Migration to combined individual participant data forms

Thematic analysis steps	Implementation process
Step three: search for themes	Refined coding analysis form developed Re-coding and initial theme identification
Step four: review themes	Comparison of initial themes to the study purpose and research questions Themes combined or revised to minimize repetition
Step five: define and name themes	Codes collapsed; emergent themes refined Relationships categorized, themes defined and named
Step six: report the analysis	Description of the coding process and results prepared for inclusion in dissertation study report

Results

Thematic analysis of study data resulted in 83 initial open codes, condensed to 17 refined codes through axial coding. Broader concepts from the data resulted in five emergent themes to describe participant experiences and opinions regarding the implementation of CNEC aligned with the three research questions. According to Bloomberg and Volpe (2019), themes resulting from immersion in qualitative data capture and illuminate participants' meanings of lived experiences. Reflexive journal notes and sidebar memos assisted the process of interpretive theme development as a complement to data analysis software use.

An example of theme development from initial open coding was the seeming inability of some participants to remain on topic for certain study question responses. Notations and open codes identified off-subject responses for the online questionnaire and telephone interview data. Further investigation and reflection revealed a deeper understanding of the participants' perceived intimate connections between the orientation of novice clinical nurse educators and evaluation of their performance and role development progress. The initial code related to unknowingly using CNEC was compressed with similar codes, resulting in the theme of CNEC used informally to inform orientation and evaluation. Five themes emerged to describe

participants' answers addressing the research questions: lack of pedagogy preparation; role transition/role development; CNEC used informally; orientation and evaluation inconsistency; and support for CNEC use.

Emergent Themes

Lack of Pedagogy Preparation. Consistent with literature review findings (Dunker & Manning, 2018; Rodger, 2019), Arizona nursing education leaders expressed unanimous concern about novice clinical nurse educators' lack of pedagogy preparation. Participants expressed concern novice clinical educators do not know pedagogy verbiage and often have little or no experience assessing and evaluating student performance outcomes. Bridging the didactic to practice gap through effective teaching strategies is a foreign concept to the majority of newly hired adjunct clinical faculty.

Role Transition/Role Development. The transition to academia from clinical practice for adjunct faculty is multifaceted and stressful. Nursing education leaders stated recognition for the considerable stress experienced by novice clinical educators learning to function in the academic environment yet operating functionally distant from their full-time residential faculty peers. Most study participants attributed the high clinical educator attrition rate and increased leadership workload to role transition stress. Participants perceived a lack of institutional understanding and resource allocation exacerbated role transition and development challenges.

CNEC Used Informally. Several participants stated they became familiar with CNEC verbiage through study participation, although they had prior knowledge of CNEC existence. Rather than using CNEC verbatim to guide the orientation and evaluation of clinical educators, participants voiced informal inclusion of CNEC concepts in their program practices. The most consistently referred to CNECs were related to role transition and clinical nursing pedagogy.

Orientation and Evaluation Inconsistency. Data revealed a lack of consistency in orientation and evaluation practices of nursing programs across Arizona. Some nursing education leaders described an all-faculty meeting at the beginning of each semester to orient and update faculty. Others stated their program has no formal orientation process for novice clinical nurse educators. Orientation methodologies included online, in-person, needs-based, and informal mentoring. Most nursing education leaders described using a standard evaluation form to conduct regularly scheduled clinical nurse educator performance evaluations. The evaluation forms described varied widely among reflective, generic to institution faculty, or specific to the nursing faculty role.

Support for CNEC Use. Participants responded with overwhelming support for CNEC use for orientation and evaluation of novice clinical nurse educators. Many expressed the desire for collaboration among Arizona nursing education leaders to develop orientation and evaluation frameworks embedded with CNEC. A recurring perception among participants was the need for CNEC to be the standard set of guidelines defining the role of clinical nurse educator. The rationale often stated for using CNEC was adherence to evidence-based standards set by the NLN.

Through multiple reflective readings of the data and condensing codes, communication patterns emerged, revealing emergent themes of nursing program leaders' use of CNEC in orientation and evaluation of undergraduate clinical nurse education faculty. The deeply felt interest in improving orientation and evaluation processes was evident in participant statements. Table 2 shows the relationship between emergent themes, participant experiential meanings, and related quotes.

Table 2

Emergent Themes and Related Participant Quotes

Emergent themes	Definitions/meanings	Related quotes
Lack of pedagogy preparation	• Expert clinicians • Novice educators	"So, we know that our clinical faculty are such amazing clinical experts, but growing them into the educator role takes a little bit of time" (Participant 1017). "A concern that I have is that the instructors lack the experience needed for teaching after only one day of orientation" (Participant 1014). "We discussed pre-conference and post-conference because it's almost like you're teaching new concepts to an educator that they kind of have no idea what you're talking about" (Participant 2002).
Role transition/role development	• Stress • Faculty attrition • Lack of resources	"So being able to bring people on board and continue to develop them is a very big concern to me. The longevity, it becomes exhausting for our teams to try to stay at that high level…" (Participant 1015). "That is probably my biggest challenge and everything else falls underneath it. We don't have the time, or the resources, or the money" (Participant 2006).
CNECs used informally	• Limited or no knowledge of CNEC • CNEC concepts used	"And in glancing at them, we hit all of them, but they haven't necessarily been intentionally designed that way" (Participant 1005). "I don't think we necessarily use the core competencies per se in any direct way…" (Participant 1017). "I'm not sure that all of the competencies are fully captured directly in the evaluation. Yeah, it's more about being a positive role model to the students" (Participant 1008).
Orientation and evaluation inconsistency	• Formal processes • Informal processes	"The week before classes, we have a clinical orientation that we invite new and returning clinical faculty to. Topic areas include roles of the clinical faculty member, formative/summative evaluation for the students, and professional agency" (Participant 1005). "There is no formal orientation program" (Participant 2013).

Emergent themes	Definitions/meanings	Related quotes
		"We write an evaluation of the faculty for their annual review and other than that it is typically just informal verbal feedback…" (Participant 3009). "The form has some, but definitely not all of the concepts needed to evaluate faculty" (Participant 2012).
Support for CNEC use	• Dissatisfaction with current practices • Use as guideline, framework • Promote collaboration • National standard	"So, to add these competencies into the orientation, for me would just further impress upon them that this is what we're looking for. Our students deserve to have nothing but the best, in my opinion" (Participant 1010). "I think we need more structure to both, because I think that, unfortunately, a lot of what our instructors learn is kind of as they go…" (Participant 1007). "…if we can frame the clinical education role according to those competencies…I think that they are really the gold standard" (Participant 1004).

Note. CNEC = Clinical Nurse Educator Competencies

CNEC Used to Inform Orientation

The first two study questions stimulated participant dialogue about their experiences planning and implementing orientation activities for novice clinical nurse educators. Research Question 1 asked, "How are CNECs used to inform the orientation of novice clinical nurse educators?" A lack of pedagogical preparation formed the chief rationale for needing to communicate role expectations to new hires effectively. Participants recounted their experiences, weaving in references to CNEC throughout their responses. CNECs represented the most strongly in participant responses related to the importance of the academic-healthcare relationship in nursing education, student learning and socialization to nursing, and student assessment and evaluation functions. Emergent themes helping to answer Research Question 1

were lack of pedagogy preparation, role transition/role development, and CNEC used informally. The answer to Research Question 1 is Arizona nursing education leaders use CNEC concepts to inform the orientation of novice clinical nurse educators in the areas of transition to academia, facilitating student clinical learning, and preparation for student assessment and evaluation.

CNEC Used to Inform Evaluation

Study questions three and four asked participants to discuss their experiences planning and implementing evaluation activities for novice clinical nurse educators. Research Question 2 asked, "How are CNECs used to inform the evaluation of clinical nurse educators?" A recurrent frustration about evaluation practices was the lack of an evaluation tool specific to nursing faculty. Some nursing education leaders stated they used reflective evaluations, informal meetings, or had no structured evaluation process to meet this challenge. They stated understanding of the relationship of CNEC to the evaluation of clinical nurse educator performance, often verbalizing CNEC concepts utilized to inform clinical faculty evaluations. The CNEC concepts most often used during clinical educator evaluation related to the academic role, clinical teaching and learning skills, and learner socialization to nursing. Emergent themes helping to answer Research Question 2 were role transition/role development, and CNEC used informally. The answer to Research Question 2 is Arizona nursing education leaders use CNEC concepts to inform the evaluation of clinical nurse educators in the areas of transition to academia, facilitating student clinical learning and development, and preparation for student assessment and evaluation.

Improvement in Orientation and Evaluation Processes

A final data collection question inquired about nursing education leaders' perceptions of how the use of CNEC improved orientation and evaluation processes. The question, designed to

stimulate deeper exploration of orientation and evaluation concerns, followed responses on how nursing program leaders used CNEC to inform orientation and evaluation practices (Ritchie et al., 2014). Enthusiastic and hopeful telephone conversations provided rich, thick data to explore forward-thinking ideas to innovate orientation and evaluation processes. Although participants recognized the need for improvement in their programs, they expressed interest in seeking solutions through statewide collaboration.

Common perceptions and concerns about orientation and evaluation practices voiced by nursing program leaders were: lack of pedagogical preparation in novice clinical nurse educators; lack of academic institution recognition of and provision of resources for orientation and evaluation alignment with CNEC; nursing program leaders' respect for the advice and input of the NLN regarding clinical nursing education expertise; and belief that better prepared clinical nurse educators would better facilitate the preparation of competent graduates for nursing workforce entry.

Discussing orientation and evaluation concerns provided a natural cognitive pathway for participants to provide data to answer Research Question 3, "What improvement in orientation and evaluation processes for clinical nurse educators in Arizona resulted from the implementation of CNEC?" The answer to Research Question 3 is Arizona nursing education leaders believe implementation of CNEC will provide a much-needed set of guidelines and a framework for process improvement for orientation and evaluation of novice clinical nurse educators. Table 3 shows the relationship between emergent themes, research question answers, and nursing program practices.

Table 3

Emergent Themes Related to Research Question Answers

Emergent themes	Research Question	Nursing education practice or planned practice
Lack of pedagogy preparation	1	• Familiarize with course curriculum • Demonstrate teaching and assessment strategies • Explain required paperwork
Role transition/role development	1 & 2	• Share legal and ethical guidelines for educators • Mentor in lab, simulation, and clinical shadowing • Explain performance duties and expectations • Mentor in collegial relationship development with academic and facility partners
CNECs used informally	1 & 2	• Concepts recognized but not intentionally used • Concepts loosely threaded throughout orientation and evaluation practices
Orientation and evaluation inconsistency	3	• No recognized framework for orientation of clinical nurse educators in Arizona • No recognized framework for evaluation of clinical nurse educators in Arizona
Support for CNEC use	3	• Would provide guidelines or a framework for orientation and evaluation processes • Set expectations for role transition • Provide structure for ongoing professional role development • Collaboration among leaders would promote consistency in clinical education across Arizona

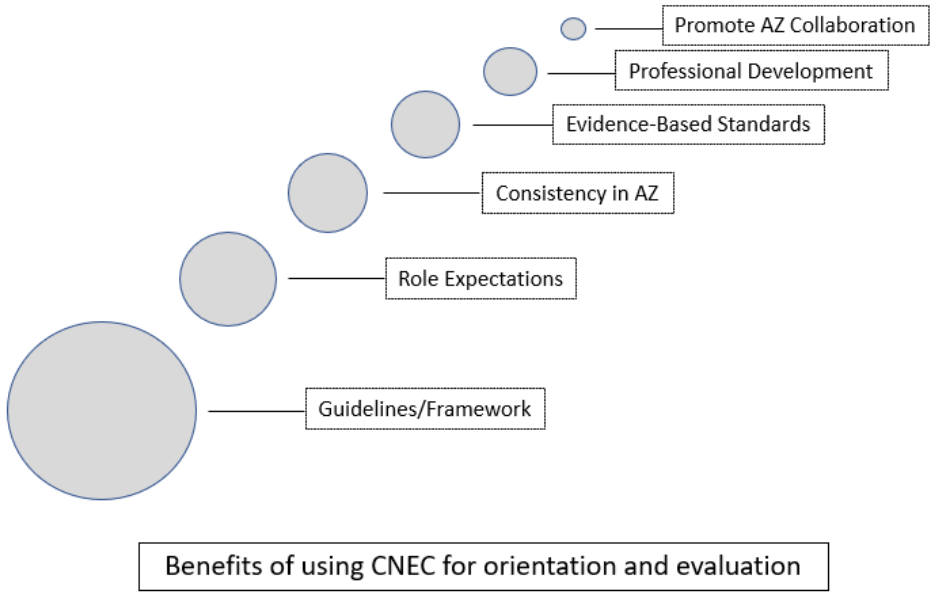
Note. CNEC = Clinical Nurse Educator Competencies

Participants expressed respect for the CNEC as best practices guidelines for orientation and evaluation provided by the NLN while voicing the need for a template or standardized format to guide the use of CNEC in their programs. Although discussing multiple concerns about the efficacy of current orientation and evaluation practices, nursing education leaders were

optimistic about the future intentional use of CNEC for their programs and across Arizona. Participants' experiences and perceptions about CNEC implementation for orientation and evaluation naturally led to creative ideas for collaboration among Arizona nursing education leaders. They voiced strong support for using CNEC as a guideline or framework for orientation and evaluation, stating CNEC could be used to define role expectations. According to participants, the use of CNEC would improve communication of role expectations for novice clinical nurse educators and provide consistency across nursing programs in Arizona. Figure 1 displays bubbles representing frequently stated benefits of CNEC use for orientation and evaluation processes. Bubble size correlates to the perceived benefit statement frequency as nursing education leaders discussed CNEC use.

Figure 1

Frequently Stated Benefits of CNEC Use for Orientation and Evaluation Processes



Note. CNEC = Clinical Nurse Educator Competencies

Reliability and Validity

The ability to produce consistent, accurate results over time is a hallmark of reliable research. Consistency in research procedures results in the ability of other researchers to obtain similar results when following the study design, demonstrating dependability. Dependability may be referred to as reliability in qualitative research. Trustworthiness is often referred to when describing reliability in qualitative research (Merriam & Tisdell, 2016). Validity in qualitative research is often referred to as believability, accomplished when study methods and procedures measure what is intended for measurement so predictions about future results are plausible. Transferability refers to the ways study results and understandings may be utilized for related situations and settings (Bloomberg & Volpe, 2019). Believability promotes the transferability of findings to extended populations (Polit & Beck, 2012). To accomplish reliability and validity in qualitative research, elements of credibility, dependability, transferability, and trustworthiness are evident in the study design, methodology, and execution (Bloomberg & Volpe, 2019).

Reflexivity and journaling using bracketed notes throughout the data collection and analysis processes increased study rigor and bias minimization, enhancing credibility (Baksh, 2018). Triangulation through multiple data sources and methods provided a comprehensive perspective on participant responses, assisting validation of research findings. SME peer review during instrument development promoted dependability. Verification of intended responses by participants through member checking, and consistent use of designated forms and data collection procedures, further enhanced study credibility and dependability (Noble & Heale, 2019).

The study's purpose and design demonstrate transferability to undergraduate nursing education. Understanding how nursing program leaders implement CNEC and the related effects

on faculty orientation and evaluation processes may have broad applicability among nurse assistant, practical nursing, and registered nursing programs. Study participants voiced interest in a more robust application of CNEC for their nursing programs, demonstrating a connection with professional reality is a hallmark of trustworthiness (Merriam & Tisdell, 2016). Open consciousness of and engagement with inherent biases, managed through reflexivity and journaling, increased study trustworthiness (Bloomberg & Volpe, 2019).

Chapter Summary

The focus of Chapter 4 was data collection, analysis, and study results. Responses from the 16 nursing education leader participants to identical questions used for the online questionnaire and recorded telephone interview provided data to inform answers to the three research questions. Data analysis followed Braun and Clarke's (2006) thematic analysis model. Careful, systematic data coding with reflexivity and journaling assisted identification of emergent themes in the experiences of nursing program leaders' experiences using CNEC to inform orientation and evaluation of novice clinical nurse educators and participant perceptions of how the implementation of CNEC may improve orientation and evaluation processes. The emergent themes guided further data analysis to uncover answers to the research questions.

Answers to research questions one and two emerged from participant response data regarding how CNEC were used to inform orientation and evaluation. The answer to Research Question 1 is Arizona nursing education leaders use CNEC concepts to inform the orientation of novice clinical nurse educators in the areas of transition to academia, facilitating student clinical learning, and preparation for student assessment and evaluation. Research Question 2's answer is Arizona nursing education leaders use CNEC concepts to inform the evaluation of novice clinical nurse educators in the areas of transition to academia, facilitating student clinical

learning and development, and preparation for student assessment and evaluation. According to participants' responses, the answer to Research Question 3 is Arizona nursing education leaders believe implementation of CNEC will provide a much-needed set of guidelines and a framework for process improvement for orientation and evaluation of novice clinical nurse educators.

Data indicate strong support for using CNEC as a guideline or framework for orientation and evaluation. The use of CNEC was also expected to improve communication of role expectations for novice clinical nurse educators and provide consistency across nursing programs in Arizona. Study findings, interpretations, conclusions, limitations, recommendations, and implications for leadership follow in the next chapter.

Chapter 5: Discussion and Conclusion

Undergraduate nursing programs deliver education through didactic and clinical learning experiences. In the clinical setting, students are supervised and mentored by clinical educators who are often adjunct faculty with little or no nursing pedagogy preparation. A gap in scholarly literature exists for CNEC implementation in undergraduate nursing programs. The problem was a lack of understanding of how undergraduate nursing program leaders in Arizona implemented CNEC and to what degree their implementation improved the orientation and evaluation of clinical nurse educators. The purpose of this basic qualitative study was to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators.

Data collected and analyzed from the 16 study participants' responses revealed five emergent themes: lack of pedagogy preparation; role transition/role development; informal use of CNEC; orientation and evaluation inconsistency; and support for CNEC use. Uncovering answers to the three research questions followed further analysis of emergent themes. Participants' responses to instrument questions regarding how CNECs were used to inform orientation and evaluation guided the answers to research questions one and two.

According to participants' responses, the answer to Research Question 1 is Arizona nursing education leaders use CNEC concepts to inform the orientation of novice clinical nurse educators in transition to academia, facilitating student clinical learning, and preparation for student assessment and evaluation. The answer to Research Question 2 is Arizona nursing education leaders use CNEC concepts to inform the evaluation of novice clinical nurse educators in the areas of transition to academia, facilitating student clinical learning and development, and

preparation for student assessment and evaluation. Research Question 3, a natural extension of thought processes comprising the former two research questions, focused on how CNEC use might improve the orientation and evaluation processes for clinical educators in their nursing programs. The answer to Research Question 3 is Arizona nursing education leaders believe implementation of CNEC will provide a much-needed set of guidelines and a framework for process improvement for orientation and evaluation of novice clinical nurse educators. Sections containing study findings, interpretations, conclusions, limitations, recommendations, and implications for leadership follow.

Findings, Interpretations, and Conclusions

Five emergent themes resulted from the analysis of qualitative data from this study. For the first and second research questions, data analysis revealed participants' perceptions of inconsistent and informal use of CNECs to guide the orientation and evaluation of adjunct clinical educators in their undergraduate nursing programs. Program leaders voiced deep concern regarding the lack of pedagogy preparation of novice clinical educators and the lack of resources to promote role development through effective CNEC use. Participants expressed respect for the NLN evidence-based standards embodied in CNEC and hopeful feelings that CNEC use in the future could be more intentional and effective. Findings related to the third research question revealed strong support for using CNEC as a guideline for communicating role expectations in orientation and evaluation processes. Participants observed the lack of a standardized framework to guide Arizona nursing program leaders' pedagogy development for their clinical educators. The desire for collaboration among Arizona program leaders to facilitate CNEC guideline development for orientation and evaluation processes indicates a willingness to share resources to promote best practices in nursing education across the state.

Findings Related to Scholarly Literature

A search of peer-reviewed literature revealed a knowledge gap related to CNEC implementation for the orientation and evaluation of novice clinical educators. Using basic qualitative study design facilitated exploration of the perceptions of how nursing program leaders implemented CNEC and the resulting benefit of CNEC implementation to orientation and evaluation processes for undergraduate nursing education. The literature search presented in Chapter 2 disclosed five themes related to clinical nursing faculty orientation and evaluation: orientation and role transition, effective clinical instruction, clinical judgment, faculty development and mentoring, and leadership. Study findings confirmed and extended knowledge of the five clinical education themes found in the literature. A comparison of extant literature and study data themes follows.

Orientation and Role Transition

Owens (2018) as well as Wenner and Hakim (2019) discussed the challenges of teacher preparation for adjunct clinical nursing faculty, most of whom approach teaching with little or no clinical pedagogy background (Dunker et al., 2021). Study results confirmed and supported considerable clinical educator role transition challenges, including a lack of financial and staffing resource support by higher education organizational administration. Nursing program leaders expressed considerable stress from balancing novice clinical educators' orientation and role transition needs with immediate teaching needs resulting from clinical faculty attrition. Findings agreed with the literature regarding the connection between ineffective role transition and clinical faculty attrition (Phillips et al., 2019; Wenner & Hakim, 2019). Study participants expressed strong support for the benefit of using a CNEC template or framework to guide orientation and role transition mentoring for novice clinical nurse educators.

Effective Clinical Instruction

Effective clinical educators use a variety of instructional and assessment strategies to guide nursing student learning in the clinical environment (Gcawu et al., 2021; Labrague et al., 2020). Results of the study corroborated the importance of using CNEC as a framework to guide new hires' preparation for pedagogy implementation and effective use of clinical teaching strategies. CNECs outline components of effective clinical nursing education and student-centered teaching strategies, but little scholarly literature describes the use of CNECs to promote effective clinical pedagogy in novice clinical educators. Results of the study are assistive in reducing the literature gap through participants' descriptions of current CNEC use and how CNEC use could further enhance educator clinical pedagogy expertise through intentional inclusion of CNEC in orientation and evaluation processes.

Clinical Judgment

Student nursing clinical judgment development is imperative for providing safe, client-centered, competent care in situations requiring sound clinical reasoning and problem solving (Labrague et al., 2020; Rafii et al., 2019). Study results confirm the clinical educator uses clinical judgment and problem-solving skills to determine the best methods of instruction and intervention to promote learning among a diverse cohort of nursing students in the clinical environment (Shellenbarger, 2019). Data confirmed novice clinical educators require assistance to develop educator judgment because, although they are experts in their fields of client care, they are inexperienced in clinical nursing pedagogy. Study findings demonstrated support for using CNEC to provide a supportive framework from which Arizona nursing program leaders could introduce and expand upon clinical pedagogy judgment for novice clinical educators.

Faculty Development and Mentoring

Effective faculty development processes, including consistent mentoring by seasoned clinical faculty, facilitate the role transition of novice clinical educators. The professional relationships fostered through collaborative leadership benefit all experiential levels of clinical education faculty, promoting organizational effectiveness (Rafii et al., 2019; Suratno et al., 2018). Participants unanimously expressed support for CNEC use as a framework for role development, mentoring, and ongoing faculty development programming.

Findings added to the body of knowledge regarding using competencies to guide the orientation and evaluation of clinical educators through professional development and mentoring strategies. Although most participants knew the existence of CNEC, intentional use of CNEC was often a future goal rather than a regular practice in their nursing programs. The use of CNEC to guide mentoring processes during faculty evaluation exercises comprised the reflections of many participants during the telephone interview portion of data collection. Study results confirmed the importance of ongoing faculty development and mentoring of clinical educators, yet many nursing program leaders expressed feeling a lack of support from their organization's administration. Lack of support and resources for expanding and improving professional development was the cause of frustration for several leaders concerned about faculty turnover, agreeing with Harris (2019) that effective professional development promotes faculty retention.

Leadership

The orientation and evaluation of adjunct nursing faculty are functions of nursing program leadership (Reising et al., 2018). During teaching assignments, clinical nurse educators act as leaders and supervisors of undergraduate nursing students, promoting leadership development through role modeling (Hoffman & Daniels, 2020; Labrague et al., 2020). Study

results corroborated with extant literature regarding the development of nursing leadership qualities in educators and undergraduate students in the clinical environment. Findings extended scholarly knowledge by revealing ways CNEC could more effectively be used to develop leadership through orientation and evaluation processes and how thorough CNEC implementation could promote collaborative standardization of practices across Arizona.

Findings Related to Theoretical Framework

A blend of transformational leadership theory (Ross et al., 2014) and Benner's five-level scaffolded novice to expert theory of nursing education (Benner et al., 2010) provided the theoretical framework for the study. Data demonstrated nursing program leaders employ transformational leadership to guide orientation and evaluation processes. Creative, visionary strategies for future CNEC implementation resonated through many leaders' responses. Participants demonstrated a reflective approach to their roles as nursing program leaders as they described new insights and meanings resulting from study participation. Benner's novice to expert scaffolding formed participants' understanding of role development for newly hired clinical nurse educators. Implementing CNEC would ideally follow the path of novice to expert as newly hired clinical educators gain proficiency in clinical pedagogy over time.

Throughout the telephone interviews, participants expressed deep feelings of loyalty to nursing education improvement via more effective leadership of their clinical education faculty. Data confirmed affinity for transformational leadership methods to guide orientation and evaluation processes and an understanding of the benefits of using CNEC to promote novice to expert role development for clinical nurse educators. Participants recognized their program's CNEC use was often inconsistent and lacked intention, expressing gratitude for the opportunity to participate in the study because it afforded a space to reflect on ways to improve their clinical

educator role development processes. Findings demonstrate participants understood their position as novices at CNEC implementation, expressing the desire for a state-wide collaborative effort to develop CNEC orientation and evaluation templates. Participants expressed equally strong sentiments regarding frustration at the lack of financial, time, and staffing resources available to realize their goals of robust CNEC implementation. Collaboration among Arizona nursing program leaders was viewed as a method to enhance their role development as advocates for the resources needed to implement CNEC more thoroughly and intentionally in their undergraduate programs.

Conclusions

This qualitative research encompassed a narrow scope of inquiry specific to clinical nursing education. Interpretations and conclusions are focused on the impressions of undergraduate nursing education leaders in Arizona regarding the implementation of CNEC for novice clinical educator orientation and evaluation processes. Findings indicated most nursing program leaders perceive an ongoing need for clinical educator orientation and evaluation using CNEC yet lack the resources and intentionality to do so effectively and thoroughly.

According to participant responses, most nursing programs in Arizona use only a portion of the six CNECs for orientation and evaluation processes for their novice clinical nurse educators. The remaining CNEC content constitutes important role definitions for the specialty area of clinical nurse educator yet is not largely represented in Arizona nursing program orientation and evaluation processes (Shellenbarger, 2019). A lack of thorough use of all CNEC content suggests incomplete preparation for state-of-the-art evidence-based practice for the orientation and evaluation of clinical nurse educators in Arizona undergraduate nursing programs.

Viewed through the lens of the extant literature and theoretical framework, study results point to informal sporadic CNEC use to guide orientation and evaluation processes. Participants felt focused collaboration among nursing program leaders across Arizona would result in a framework for CNEC implementation. Robust intentional CNEC implementation across Arizona undergraduate nursing programs would foster inter-program clinical nurse educator pedagogy consistency, produce better prepared graduate nurses, improve faculty retention, and promote community health and well-being.

Limitations

The potential for researcher bias is a significant limitation of any qualitative study (Bloomberg & Volpe, 2019). Reflexivity and journaling promoted awareness of personal biases and allowed the opportunity for bracketing throughout data collection and analysis. These processes, along with triangulation and SME participation in data collection instrument creation, contributed to study credibility and dependability. A second limitation of the study was data came solely from nursing program leaders' responses. Additional information from the perspective of clinical nurse educators could provide a wider understanding of the mechanisms and effectiveness of orientation and evaluation processes across nursing programs in Arizona, improving confirmability. The context of competency use for clinical education orientation and evaluation processes may apply widely across other health care education programs such as occupational therapy and physician assistant (Bierwas et al., 2017; Preston, 2020).

Transferability relates to a degree of external validity allowing for the application to similar relevant contexts (Bloomberg & Volpe, 2019). The participant population of the study represented nearly half of the approved undergraduate nursing programs in Arizona. It is reasonable to apply study findings to similar undergraduate nursing programs in Arizona.

Similarities in undergraduate clinical nurse educator role development and practice challenges across the US, identified in the literature review, point to the potential transferability of study results across nursing programs nationally. The gap in scholarly literature regarding CNEC use and the recommendations for novice clinical educator orientation guidelines indicate study findings may be transferable across many nursing programs.

Recommendations

Study results provided insight into how Arizona undergraduate nursing program leaders implemented CNEC in orientation and evaluation processes and to what degree CNEC implementation improved orientation and evaluation processes. Because full intentional CNEC content use is not standard practice, the primary recommendation is intentional robust inclusion of CNEC in the orientation processes for novice clinical nurse educators and the ongoing evaluation processes for all clinical nurse educators in Arizona undergraduate nursing programs. A mechanism to inform and assist nursing program leaders regarding the necessity and scope of CNEC use is to update the current Arizona Board of Nursing Advisory Opinion, *The Role of the Clinical Instructor,* to include verbiage regarding the implementation of CNEC in orientation and evaluation processes (Arizona State Board of Nursing, 2016). Advisory opinion drafting and updating are functions of a sub-committee of the Arizona State Board of Nursing. The Advisory Opinion Committee should update the current policy opinion regarding the orientation and evaluation of clinical nurse educators.

Due to the implications for nursing student preparation and community health, a further recommendation is nursing program leaders should begin an internal assessment of CNEC use in their programs. Internal assessments should identify how each of the six CNECs are currently

used or CNEC use gaps. As CNEC use gaps are identified, steps should be formulated to include CNEC standards for the orientation and evaluation of clinical nurse educators.

Based on study results, Arizona nursing program leaders are interested in state-wide leadership collaboration to produce a guideline or framework for CNEC implementation for orientation and evaluation processes in their nursing programs. Participants stated understanding of CNEC existence but felt they lacked resources for thorough CNEC implementation without collaborative peer support. An Arizona nursing education leader from the community college district or a state university nursing program director should follow through with interest expressed in formulating an exploratory committee to create CNEC implementation guidelines. Several participants voiced interest in participating in an Arizona CNEC implementation guidelines committee. These participants should communicate with their Arizona nursing education peers for follow-up.

Recommendations for further research are twofold. First, adding the opinions and perspectives of adjunct clinical nurse educator faculty regarding CNEC use would expand the body of knowledge and promote understanding of CNEC implementation effectiveness. A feedback loop between the presenter, nursing program leadership, and clinical nurse educators would promote continuous process improvement for orientation and evaluation processes. Research including clinical nurse educator participants will broaden understanding and promote a feedback loop to improve orientation and evaluation processes.

For example, a replicated study with adjunct clinical educator participants from Arizona undergraduate nursing programs should be conducted to augment findings from nursing program leaders' perspectives. Results from the replicated study should be compared to this study's findings to determine patterns of need for CNEC implementation. Data from the replicated study

should be widely shared in a dual report format with this study's findings. The appropriate publication for report sharing is the Arizona State Board of Nursing's Quarterly Regulatory Journal. Similar studies should be conducted nationwide to determine clinical educators' perspectives regarding CNEC implementation needs and the benefits of CNEC use.

Second, future research should include replication of the study following CNEC guidelines implementation across Arizona undergraduate nursing programs. A replicated study would demonstrate the degree of effectiveness of a CNEC guidelines tool, adding to the body of knowledge of evidence-based nursing education practice in Arizona. Results from the replicated study would be assistive in guiding ongoing nursing program modification and process improvement for CNEC use in orientation and evaluation processes.

The first step in developing a plan to replicate the study is CNEC implementation guideline development by Arizona nursing program leaders. Next, the replicated study should be conducted following robust CNEC implementation for two to three years. Results of the replicated study should be compared with this study's results to determine the effectiveness of CNEC implementation in improving clinical nurse educator orientation and evaluation processes. A focused CNEC use needs assessment of ongoing orientation and evaluation processes should inform study interpretations and implications.

Implications for Leadership

Study results combined with information from extant literature provide insight into implications for nursing program leadership. Scholarly literature emphasized the connection between robust orientation and role development of clinical nurse educators, citing links with student enrollment, faculty retention, and community health and well-being. The participant pool represented approximately half of all Board of Nursing-approved Arizona undergraduate nursing

program leaders, who overwhelmingly expressed support for CNEC use and a sense of frustration by the lack of administrative and resource support for CNEC implementation. Study participants should take the opportunity to promote policy and organizational culture change through collaboration with peers and administration leadership. Failure to act will result in clinical nurse educator role stagnation, leading to poor student nurse program outcomes and a diminished quality of nursing care for community members served by graduate nurses.

An ad hoc committee to begin Arizona CNEC implementation guidelines development should be formed within two months of this study's release. As a body of nursing education leaders in Arizona, an inter-program collaboration by the ad hoc committee should work to determine best practices to address specific study findings related to CNEC implementation for orientation and evaluation processes. The committee's goals should focus on collaboration to promote CNEC use for clinical educator role development consistency, the use of evidence-based standards, and improvement of professional development programs. Within their organizations, committee members should advocate for the necessary financial, staffing, and time resources for robust CNEC implementation in their clinical nurse educator orientation and evaluation processes. Monthly progress communications should be disseminated across Arizona undergraduate nursing program leadership using established communication methods, including the Arizona State Board of Nursing and the Arizona Clinical Education Collaborative (AzCEC).

Arizona nursing education leaders are known across the country for spearheading collaborative efforts in clinical coordination through the AzCEC. Nursing education leaders and stakeholders should use the AzCEC platform to facilitate professional change through advocating for additional resources to implement CNEC thoroughly and robustly. Leveraging the AzCEC platform, nursing program leaders should communicate the need for resources to

robustly implement CNEC to higher education organizational administration and the Arizona State Board of Nursing. Communicating CNEC guidelines development and implementation progress to facilitate consistency in undergraduate nursing education across Arizona is imperative to promote evidence-based collaboration.

By leading the way for a deeper understanding of the connection between organizational effectiveness, nursing program accreditation, and community health, nursing program leaders may effect social change benefiting the wider community of stakeholders served by their organizations. Thorough, consistent implementation of CNEC across undergraduate nursing programs in Arizona would promote positive social change through educational equity for undergraduate nursing students among university, community college, and privately funded nursing programs.

Conclusion

This basic qualitative study aimed to understand how nursing program leaders implemented CNEC in undergraduate nursing programs in Arizona and to what degree their implementation informed and improved the orientation and evaluation of clinical nurse educators. A key finding of the study is although largely aware of CNECs and their importance in clinical nurse educator orientation and evaluation processes, nursing program leaders' implementation of CNECs lacks intentionality and thoroughness. Study participants recognized the lack of intentional robust implementation of CNEC in their programs and expressed feelings of frustration at the lack of organizational resources for effective CNEC implementation. Where CNECs were used to inform orientation and evaluation processes, participants recounted the benefits to clinical educator role development and student learning processes. Data analysis revealed a strong desire among Arizona nursing program leaders to collaborate on developing

CNEC implementation guidelines. The predominant sentiment expressed in the data was hopefulness that intentional robust CNEC implementation would result in clinical nurse educator pedagogy consistency, produce better prepared graduate nurses, improve faculty retention, and promote community health and well-being.

Implications for nursing education leadership are the call to action for collaboration rising from peer participant leaders. Results of the study produced new knowledge of feelings of ineffective leadership regarding CNEC implementation among Arizona undergraduate nursing programs that could be addressed through collaborative action. Inconsistent, sporadic CNEC implementation results in educational inequity for undergraduate nursing students across Arizona programs. Inter-program collaboration among nursing program leaders would effect positive social change by promoting educational equity resulting from consistently prepared clinical nurse educators across Arizona. As a collaborative body, Arizona nursing program leaders should begin dialogue toward formulating CNEC implementation guidelines to inform orientation and evaluation processes for clinical nurse educators in their undergraduate programs. Future research focused on CNEC implementation from the perspective of clinical nurse educators could provide a wider understanding of current implementation effectiveness and identify gaps in CNEC implementation for orientation and evaluation processes. A replicated study following the introduction of CNEC implementation guidelines across Arizona undergraduate nursing programs would be assistive in determining the effectiveness of a newly drafted CNEC protocol.

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Appendix A

IRB Approval Letter

February 25, 2022

To : Marie Rozell
Kevin Grant, Dissertation Committee Chair

From : Institutional Review Board
American College of Education

Re: IRB Approval

"Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona"

The American College of Education IRB has reviewed your application, proposal, and any related materials. We have determined that your research provides sufficient protection of human subjects.

Your research is therefore approved to proceed. The expiration date for this IRB approval is one year from the date of review completion, February 25, 2023. If you would like to continue your research beyond this point, including data collection and/or analysis of private data, you must submit a renewal request to the IRB.

Candidates are prohibited from collecting data or interacting with participants if they are not actively enrolled in a dissertation sequence course (RES6521, RES6531, RES6541, RES6551, RES6561, RES6302) and under the supervision of their dissertation chair.

Our best to you as you continue your studies.

Sincerely,

Tiffany Hamlett
Chair, Institutional Review Board
American College of Education

Appendix B

Site Permission Email to Academic Institutions

Date [ ]

[Person to Whom You are Writing}

[Title]:

Dear [ ] :

My name is Marie Rozell and I am a doctoral candidate at American College of Education (ACE) writing to request permission to interview undergraduate nursing education leaders from your institution. This information will be used for my dissertation research related to *Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona*.

The purpose of the basic qualitative study will be to understand how nursing program leaders implement the National League for Nursing Clinical Nursing Educator Competencies in undergraduate nursing programs in Arizona and to what degree their implementation informs and improves the orientation and evaluation of clinical nurse educators. Research study instruments will include a questionnaire and follow-up telephone semi-structured interviews.

Important Contacts for this study include:

Principal Investigator: Marie Rozell E-mail: marie.rozell0910@my.ace.edu

Phone: [redacted]

Dissertation Chair: Dr. Kevin Grant E-mail: kevin.grant@ace.edu

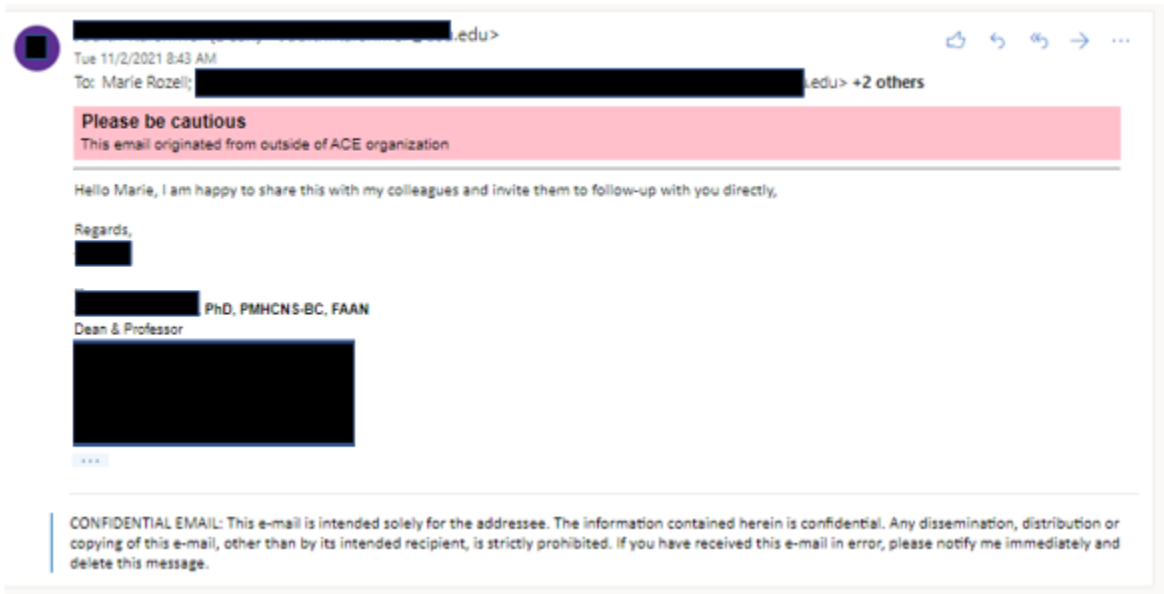
Thank you for your attention to this issue and prompt response. I appreciate your time and consideration of my request.

Regards,

Marie Rozell

Appendix C

Site Permission Approval



[redacted].edu>
Tue 11/2/2021 8:43 AM
To: Marie Rozell; [redacted].edu> +2 others

Please be cautious
This email originated from outside of ACE organization

Hello Marie, I am happy to share this with my colleagues and invite them to follow-up with you directly,

Regards,
[redacted]

[redacted] PhD, PMHCNS-BC, FAAN
Dean & Professor
[redacted]

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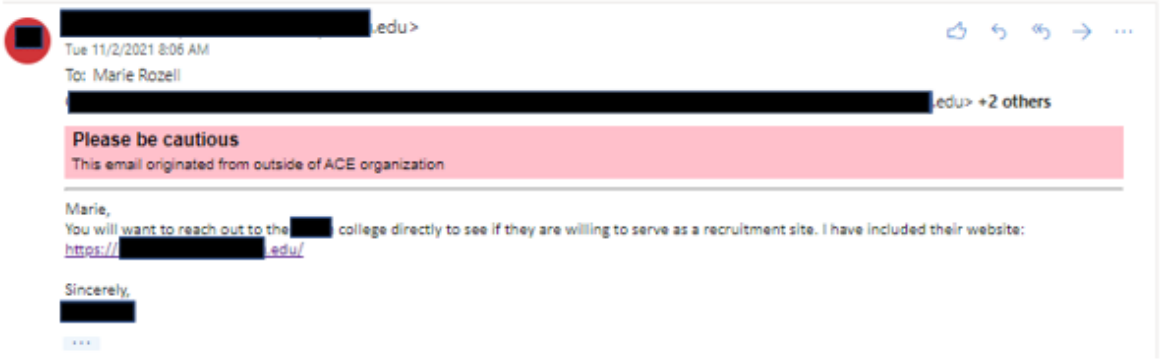
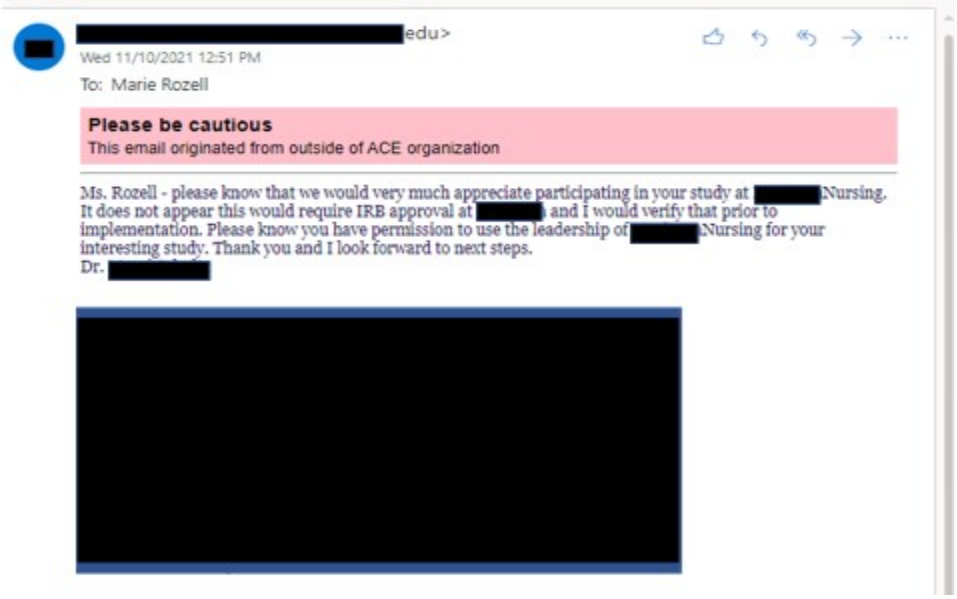


[redacted].edu>
Tue 11/2/2021 8:06 AM
To: Marie Rozell
[redacted].edu> +2 others

Please be cautious
This email originated from outside of ACE organization

Marie,
You will want to reach out to the [redacted] college directly to see if they are willing to serve as a recruitment site. I have included their website:
https://[redacted].edu/

Sincerely,
[redacted]



[redacted]edu>

Wed 11/10/2021 12:51 PM

To: Marie Rozell

Please be cautious

This email originated from outside of ACE organization

Ms. Rozell - please know that we would very much appreciate participating in your study at [redacted] Nursing. It does not appear this would require IRB approval at [redacted] and I would verify that prior to implementation. Please know you have permission to use the leadership of [redacted] Nursing for your interesting study. Thank you and I look forward to next steps.

Dr. [redacted]

[redacted]

[redacted] Site Authorization (PI Marie Rozell)

[redacted].edu>
Thu 11/18/2021 3:08 PM
To: Marie Rozell
Cc: [redacted].edu>

Please be cautious
This email originated from outside of ACE organization

[Please
see the updated list of colleges that approved your study below.]

Dear Marie Rozell,

I am pleased to inform you that your
request for Institutional Approval (or Site Authorization) for your referenced study at [redacted] Colleges has been granted by the following colleges, and only these colleges:

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]

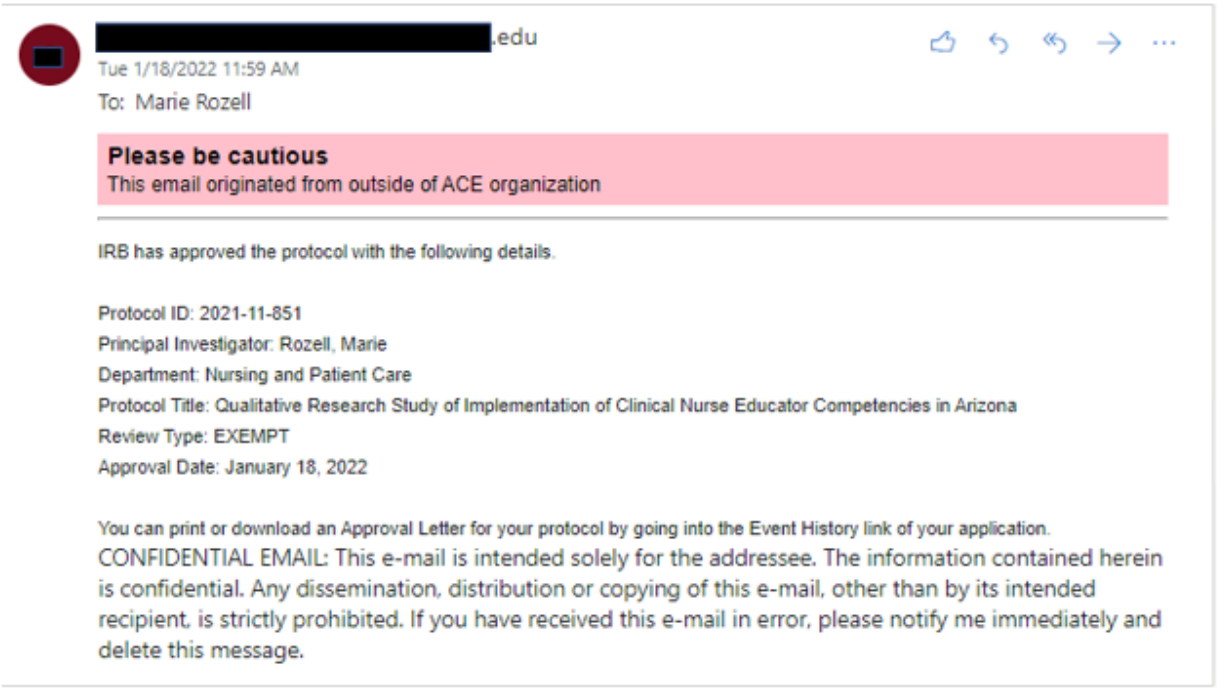
Be advised
College did [redacted]

Now that you have institutional approval
at the colleges indicated above, you can continue to the next step of the IRB application process at [redacted]

By
continuing the IRB application process, you acknowledge and accept the following:

1. This approval does not commit [redacted] to provide resources or data collection for the investigators;
2. IRB approval does not commit the [redacted] to participate in the project or to provide resources or data collection for the investigators; and
3. If the IRB disapproves the study, the investigators cannot conduct the study, but they may revise and resubmit their proposal to the IRB.

Best
wishes,
[redacted]



[redacted].edu

Tue 1/18/2022 11:59 AM

To: Marie Rozell

Please be cautious
This email originated from outside of ACE organization

IRB has approved the protocol with the following details.

Protocol ID: 2021-11-851
Principal Investigator: Rozell, Marie
Department: Nursing and Patient Care
Protocol Title: Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona
Review Type: EXEMPT
Approval Date: January 18, 2022

You can print or download an Approval Letter for your protocol by going into the Event History link of your application.

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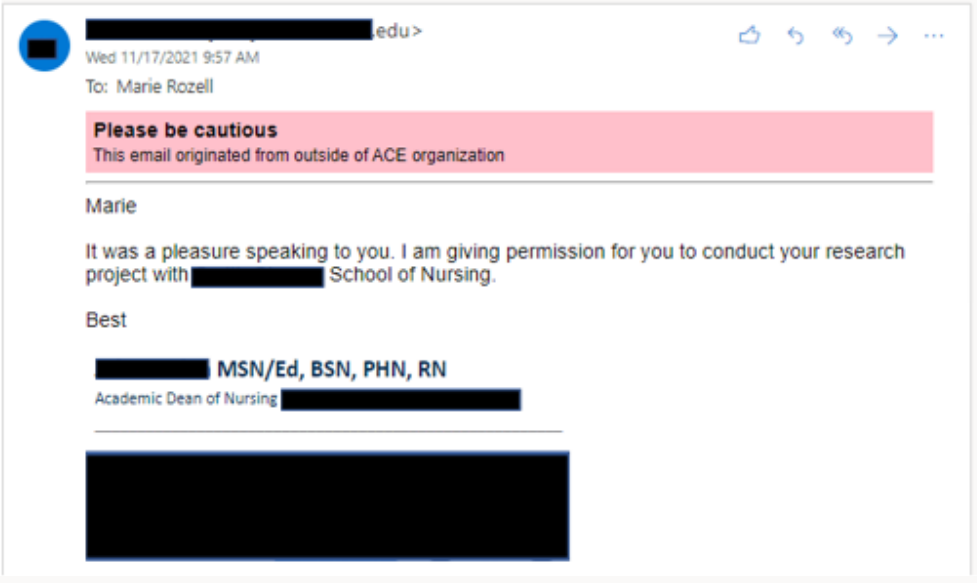


[redacted].edu>

Wed 11/17/2021 9:57 AM

To: Marie Rozell

Please be cautious
This email originated from outside of ACE organization

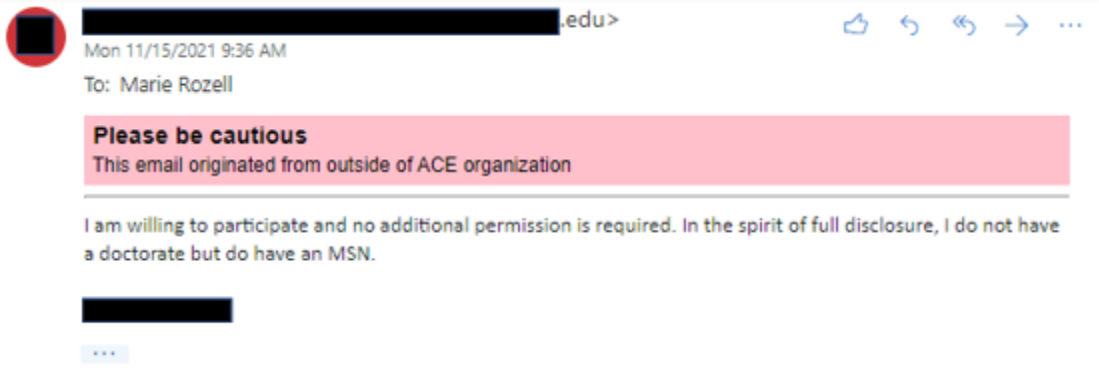
Marie

It was a pleasure speaking to you. I am giving permission for you to conduct your research project with [redacted] School of Nursing.

Best

[redacted] **MSN/Ed, BSN, PHN, RN**
Academic Dean of Nursing [redacted]

[redacted]



[redacted].edu>

Mon 11/15/2021 9:36 AM

To: Marie Rozell

Please be cautious
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I am willing to participate and no additional permission is required. In the spirit of full disclosure, I do not have a doctorate but do have an MSN.

[redacted]

Appendix D

Recruitment Email

Date [ ]

Dear Nursing Education Leader,

My name is Marie Rozell and I am a doctoral student at American College of Education. I am writing to let you know about an opportunity to participate in a dissertation research study. You are asked to participate in the study because of your experience as a leader in undergraduate nursing education in Arizona, serving either as a nursing program director, division chair, or nursing clinical coordinator. Please forward this invitation to other nursing education directors, program chairs, and clinical coordinators who may wish to participate in the study.

The purpose of the study is to understand how nursing program leaders implement NLN Clinical Nurse Educator Competencies (CNEC) in undergraduate nursing programs in Arizona and to what degree their implementation informs and improves the orientation and evaluation of clinical nurse educators. The study will use basic qualitative design.

Your participation in the study would be voluntary and no compensation is offered for participation. Research participation will involve answering a six-item online questionnaire and follow-up telephone interview. The anticipated total time commitment is 30-40 minutes. It is not anticipated that any risk of harm exists for participants. At any time during the study, you may choose to withdraw from the research and notify me by email of your intent to withdraw. Participant identity will be kept confidential, names being replaced with numeric identifiers. Neither your name nor academic institution of employment will be identified in any research documentation or resultant publication. Demographic information and data collected from the study will only be used to understand how CNEC are implemented and how their implementation informs and improves the orientation and evaluation of clinical nurse educators.

If you are interested in participating in this study and would like to be included in the participant selection pool, please indicate your interest by replying to this email. Upon receipt of your interest, you will be sent informed consent information for your review and acceptance.

Contact Information:

You may contact me at marie.rozell0910@my.ace.edu or [redacted]

The Dissertation Chair is Dr. Kevin Grant. The Chair may be reached at kevin.grant@ace.edu

Thank you for considering the opportunity to participate in this dissertation research study.

Kind regards,
Marie Rozell
Principal Investigator

Appendix E

Informed Consent Form

Prospective Research Participant: Read this consent form carefully and ask as many questions as you like before deciding to participate in this research study. You are free to ask questions at any time before, during, or after your participation in this research.

Project Information

Project Title: Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona

Researcher: Marie Rozell

Organization: American College of Education

Email: marie.rozell0910@my.ace.edu **Telephone:** [redacted]

Date of IRB Approval:

Please note that this research study has been approved by the American College of Education Institutional review Board. The IRB approved this study on ___. A copy of the approval letter will be provided upon request.

Researcher's Dissertation Chair: Dr. Kevin Grant

Organization and Position: American College of Education, Faculty

Email: kevin.grant@ace.edu

Introduction

I am Marie Rozell, and I am a doctoral candidate student at American College of Education. I am doing research under the guidance and supervision of my Chair, Dr. Kevin Grant. I will give you some information about the project and invite you to be part of this research. Before you decide, you can talk to anyone you feel comfortable with about the research. If you have questions, ask me to stop as we go through the information and I will explain. If you have questions later, feel free to ask me then.

Purpose of the Research

The purpose of this qualitative study is to understand how nursing program leaders implement Clinical Nurse Educator Competencies (CNEC) in undergraduate nursing programs in Arizona and to what degree their implementation informs and improves the orientation and evaluation of clinical nurse educators. You are being asked to participate in a research study which will assist

with understanding how nursing program leaders implemented clinical nurse educator competencies and to what extend implementation improved the orientation and evaluation of clinical nurse educators. Conducting this qualitative study will add to the knowledge base of how CNEC are used in undergraduate nursing programs and identification of best practices in clinical nurse educator orientation and evaluation processes.

Research Design and Procedures

The study will use a qualitative methodology and basic qualitative research design. A letter of invitation will be disseminated to specific participants in Arizona, in the United States. The study will comprise 15-20 participants who will participate in online questionnaire and private semi-structured interviews. The study will involve 15-20 participants, to be conducted at a time most convenient for participants. After data are gathered, a debrief session will occur. Participants will be given a copy of their synthesized study responses transcript and asked to review the transcript for accuracy. Opportunity will be provided for participants to clarify, make changes, or add notations within 14 days of the interviews.

Participant Selection

You are being invited to take part in this research because of your experience as an undergraduate nursing program leader with institutional authority to implement and evaluate professional development for clinical nurse educators employed by your academic institution. Participation selection criteria: Undergraduate nursing program directors, division chairs, or nursing clinical coordinators serving programs approved by the Arizona State Board of Nursing without an active decree of censure or consent for probation.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate. If you choose not to participate, there will be no punitive repercussions.

Right to Refuse or Withdraw

Participation is voluntary. If at any time you wish to end your participation in the research study, you may do so by sending me an email explaining you are opting out of the study. There will be no repercussions for leaving the study.

Procedures

We are inviting you to participate in this research study. If you agree, you will be asked to fill out an online questionnaire and participate in a private semi-structured telephone interview. The

type of questions asked will range from a demographical perspective to direct inquiries about the topic of CNEC implementation and its effect on the orientation and evaluation of clinical nurse educators. Telephone interviews will be audio recorded.

Duration

The online questionnaire portion of the study will take approximately 10 minutes to complete. The interview portion of the study will require approximately 20-30 minutes to complete. If you are chosen to be a participant, the telephone interview will be conducted on a date and time of your convenience. Prior to the interview, you will be asked to provide permission to have the interview audio recorded for the sake of having an accurate transcript for data. A follow-up debriefing session will take no more than 10 minutes.

Risks

The researcher will ask you to share personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not to have to answer any question or take part in the discussion if you don't wish to do so. You do not have to give any reason for not responding to any question.

Benefits

While there will be no direct financial benefit to you, your participation is likely to help us find out more about how CNEC are implemented in undergraduate nursing programs and how their implementation may benefit the orientation and evaluation of clinical nurse educators.

Confidentiality

I will not share information about you or anything you say to anyone outside of the researcher. During the defense of the doctoral dissertation, data collected will be presented to the dissertation committee. The data collected will be kept in a locked file cabinet or encrypted computer file. Any information about you will be coded and will not have a direct correlation, which directly identifies you as the participant. Only I will know what your number is, and I will secure your information on a password protected computer.

Sharing the Results

At the end of the research study, the results will be available for each participant. It is anticipated to publish the results so other interested people may learn from the research.

Questions About the Study

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me at marie.rozell0910@my.ace.edu. The research has been reviewed and approved by the Institutional Review Board of American College of Education. This is a committee whose role is to make sure research participants are protected from harm. If you wish to ask questions of this group, email IRB@ace.edu.

Certificate of Consent

I have read the information about this study, or it has been read to me. I acknowledge why I have been asked to be a participant the research study. I have been provided the opportunity to ask questions about the study, and any questions have been answered to my satisfaction. I certify I am at least 18 years of age. I consent voluntarily to this study including the audio recording of my telephone interview.

Print or Type Name of Participant:_____

Signature of Participant:_____

Date:_____

I confirm that the participant was given an opportunity to ask questions about the study, and all the question asked by the participant have been answered to the best of my ability. I confirm that the individual has not been coerced into giving consent and the consent has been given freely and voluntarily. A copy of this Consent Form has been provided to the participant.

Print or Type Name of Principal Investigator: Marie Rozell

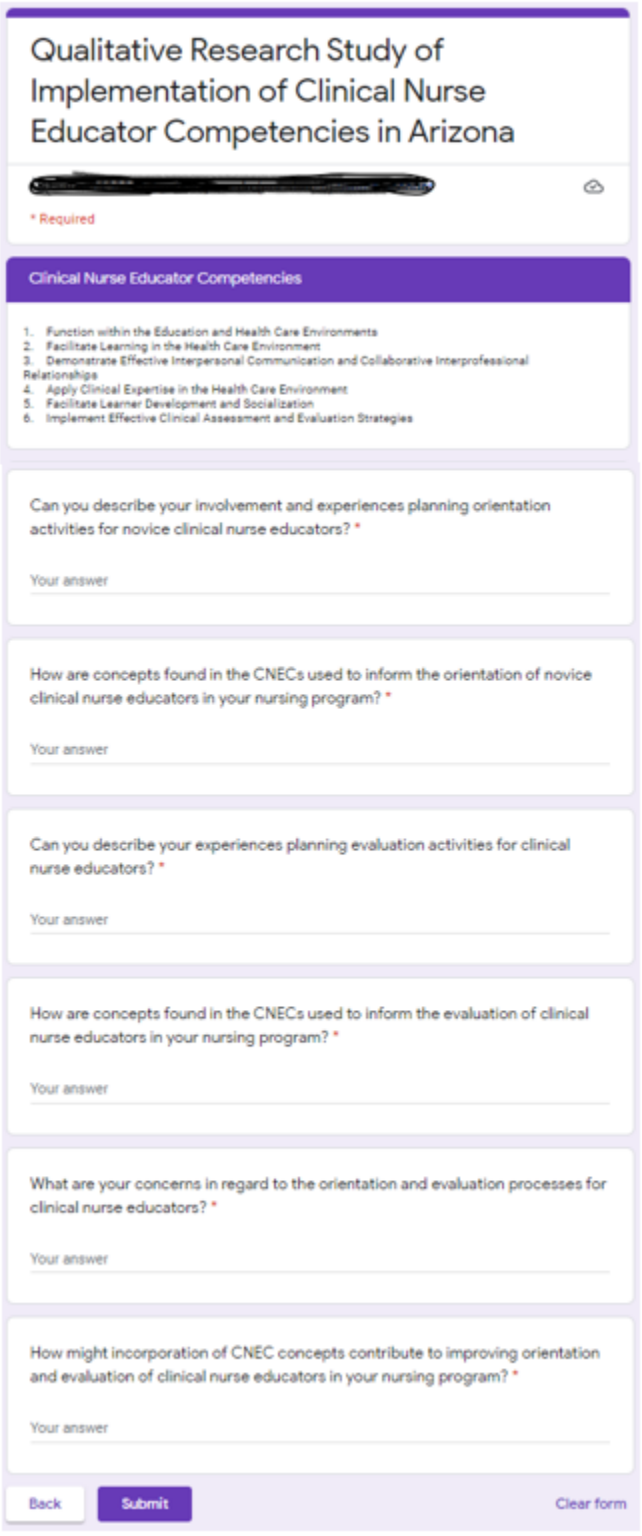
Signature of Principal Investigator: _____

Date: _____

PLEASE KEEP THIS INFORMED CONSENT FORM FOR YOUR RECORDS

Appendix F

Research Instrument Items: Google Forms Online Questionnaire



Qualitative Research Study of Implementation of Clinical Nurse Educator Competencies in Arizona

[redacted]

* Required

Clinical Nurse Educator Competencies

1. Function within the Education and Health Care Environments
2. Facilitate Learning in the Health Care Environment
3. Demonstrate Effective Interpersonal Communication and Collaborative Interprofessional Relationships
4. Apply Clinical Expertise in the Health Care Environment
5. Facilitate Learner Development and Socialization
6. Implement Effective Clinical Assessment and Evaluation Strategies

Can you describe your involvement and experiences planning orientation activities for novice clinical nurse educators? *

Your answer

How are concepts found in the CNECs used to inform the orientation of novice clinical nurse educators in your nursing program? *

Your answer

Can you describe your experiences planning evaluation activities for clinical nurse educators? *

Your answer

How are concepts found in the CNECs used to inform the evaluation of clinical nurse educators in your nursing program? *

Your answer

What are your concerns in regard to the orientation and evaluation processes for clinical nurse educators? *

Your answer

How might incorporation of CNEC concepts contribute to improving orientation and evaluation of clinical nurse educators in your nursing program? *

Your answer

Back Submit Clear form

Appendix G

Research Instrument: Interview Protocol

Greeting Script
"Hello _____, this is Marie Rozell. I hope your day is going well. As you recall, I am a doctoral candidate with American College of Education, conducting my dissertation research study. Thank you for agreeing to participate in my study."

Verification of Consent to Record
"Our conversation today will be recorded. Although you already provided written consent for recording, will you please now give verbal consent for the conversation to be recorded? Thank you. I have started the recording. _____, for the recording, please again affirm your consent to be recorded so that your consent is captured on the recording. Do you have any questions about the consent before we begin the recorded interview? The interview should take from 20-30 minutes of your time."

Introduction to the Study and Interview
"Let me tell you briefly about my study. Participants are leaders in nursing education with authority to implement the National League for Nursing Clinical Nurse Educator Competencies. The purpose of the study is to understand how nursing program leaders implement Clinical Nurse Educator Competencies (CNEC) in undergraduate nursing programs in Arizona and to what degree their implementation informs and improves the orientation and evaluation of clinical nurse educators."
"Before we begin with the specific interview questions, could you please tell me a little about yourself and your role in nursing education?"
"You have already provided answers to the six research study questions through the online questionnaire. During our recorded interview today, we will revisit those same six questions. You will have opportunity to expand on your responses or discuss the question topics as desired. Your responses from the online questionnaire and your responses from this live interview will be synthesized and emailed to you for review and accuracy validation. You will have opportunity to clarify or correct any of your synthesized responses and return them to me via email. This process is used to ensure your responses are recorded accurately according to your intended answers to the six study questions."

Interview Questions
"We are ready to begin the formal interview portion now. I will read the CNEC to you, then each of the six study questions verbatim. Following reading of each study question you will have opportunity to answer and discuss as you see fit."
[CNEC and Questions read verbatim; Responses and Discussion]

Ending Script and Debriefing
"That concludes the interview question and answer session. Is there anything more you would like to share regarding the study or our interview today?"
"Do you have any other questions or any concerns about the study process or your role as a participant?"

“I will email your synthesized responses from the online questionnaire and our interview today. Following review of your responses, please email me any clarifications or corrections so that I have an accurate set of your responses. If you have any questions, I can be reached by email or phone as provided on the consent form. My contact information will be included in the email containing your synthesized responses for review. Thank you for participating in my dissertation study. Goodbye.”

[Recording Ended]

Appendix H

Research Instrument Items: Semi-Structured Interview

Semi-Structured Interview Guide

Introduction: Refer to the six National League for Nursing's *Clinical Nurse Educator Competencies* (shown below) when considering your response for each question.

Clinical Nurse Educator Competencies

1. Function within the Education and Health Care Environments
2. Facilitate Learning in the Health Care Environment
3. Demonstrate Effective Interpersonal Communication and Collaborative Interprofessional Relationships
4. Apply Clinical Expertise in the Health Care Environment
5. Facilitate Learner Development and Socialization
6. Implement Effective Clinical Assessment and Evaluation Strategies

Open-Ended Questions	Probe Notes
A. Can you describe your involvement and experiences planning orientation activities for novice clinical nurse educators?	
B. How are concepts found in the CNECs used to inform the orientation of novice clinical nurse educators in your nursing program?	
C. Can you describe your experiences planning evaluation activities for clinical nurse educators?	
D. How are concepts found in the CNECs used to inform the evaluation of clinical nurse educators in your nursing program?	
E. What are your concerns in regard to the orientation and evaluation processes for clinical nurse educators?	
F. How might incorporation of CNEC concepts contribute to improving orientation and evaluation of clinical nurse educators in your nursing program?	