

School of Nursing and Midwifery
Centre for Cardiovascular and Chronic Care

The role of the nurse educator
in acute care hospitals Australia

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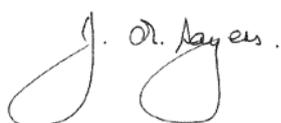
This thesis is presented for the Degree of
Doctor of Philosophy
of
Curtin University

November 2013

Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material, which has been accepted for the award of any other degree or diploma in any university.

A handwritten signature in black ink, appearing to read "J. M. Sayers". The signature is written in a cursive style with a large initial "J" and "M".

Jan Maree Sayers

Date 28th November, 2013

Abstract

The health of our society is dependent upon continually developing and sustaining a knowledgeable nursing workforce. The challenges of educating nurses within the tertiary sector in Australia to meet immediate and future workforce needs are well understood. Conversely, the nurse educator role in continuing nurse education and professional development in acute care hospitals is relatively unknown. Implicit in the development of nursing workforce education models in the acute care sector is an understanding of the role and scope of practice of the nurse education workforce. Within the current health workforce reform agenda clinical education and continuing professional development have high priority, as do opportunities for role and scope of practice redesign. This mandate has provided the impetus for this study.

The nurse educator position is an advanced nursing role integral to continuing professional education and development. Nurse educators provide clinical leadership within the acute care environment. Role ambiguity may impede their work and influence nurse educator identity, visibility and contribution when nursing roles are being challenged by health and workforce reform.

The Nurse Educators in Acute Care Hospitals (NEACH) study has explored the role, scope of practice and performance standards of nurse educators in acute care hospitals in Australia. The NEACH study examined social, policy and organisational barriers nurse educators face enacting their roles facilitating clinical and professional education to nurses in hospitals.

Role theory and symbolic interactionism underpinned the NEACH study, design, methods and interpretation of the data. A mixed method research design was chosen for this study to allow the investigation of multidimensional facets of the nurse educator role, and to incorporate the socio-cultural context of the contemporary hospital environment. The methodological approaches included a group interview with key stakeholders, a questionnaire with embedded validated psychometric measures, as well as investigator developed items appropriate to the Australian context and research questions.

Item generation for the questionnaire was informed by a comprehensive review of the published literature, policy documents and key informant consultations. The researcher developed the Activities and Competencies of Nurse Educator (ACONE) scale which provides a framework for future role development and performance criteria as well as a legitimate tool for self-assessment of nurse educator performance.

The survey was administered by snowball and targeted sampling. The completion rate was 95% (n = 425 completed all items). Of those who reported having a postgraduate education qualification only 21.9% (n= 93) had this qualification at a Masters level; 65.1% (n=274) had participated in performance review within the preceding twelve months and 69.6% (n=272) reported their role was not linked to clinical or outcome indicators.

Qualitative data revealed role ambiguity and confusion were identified as impacting on nurse educator role expectations and responsibilities, as well as role visibility, role overload and stress.

Whilst some educators perceive they were valued in the workplace, a greater number expressed that the role is devalued within their organisation. Logistic regression analysis was undertaken and a model for higher nurse educator regard of the practice environment emerged. This model demonstrates that nurse educators who have a Masters qualification, have their professional development and learning needs identified and have regular meetings with their line manager, are more likely to have a more favourable view of their workplace and perform intended domains of the nurse educator roles. Issues in sampling and responder bias need to be considered in interpreting these data.

Changing dynamics in professional education require nurse educators to actively drive the transformation of workforce education. Through engaging in policy and debate to develop dynamic, innovative models of continuing education and professional development it is likely that there will be improvements in patient outcomes and safety. As workforce is one of the critical issues in health care service reform it is important to ensure that the nurse educator role is well defined and clarified in the Australian health care system. A national, standardised approach to role description and scope of practice for nurse educators is required to achieve this. Without validation

and support, nurse educators may disengage from their roles and workplaces or perform inadequately.

Further research to elucidate the impact of the role of the nurse educator on education, practice change and patient outcomes is essential. It is acknowledged that nurse academics and professional nursing alliances may be influential in providing opportunities for nurse educators to define and redesign their role and advance specialty development.

This thesis has focussed on the role and contribution of nurse educators to nurse education in acute care hospitals in Australia. The study has highlighted role ambiguity, conflict and erosion and practice limitations. The competencies (ACONE scale) for role development and use as a tool for self-assessment of performance by nurse educators, has been developed and tested. The identification of these anomalies and implementation of the ACONe tool may enable nurse educators individually and collectively and the nursing profession, to have a broader perspective of the nurse educator role in hospitals and contextually within nursing education and healthcare.

Dedication

This thesis is dedicated to my family.

To my husband Peter, (who sadly passed away before the outcome of my studies was known) for his generous spirit and heartfelt love supporting my endeavours at every stage of this journey.

- May He Rest in Peace -

To my son Daniel and my daughter Laura - I could not have attempted nor completed this work without your unfailing love and encouragement.

Acknowledgments

‘To go quickly is to go alone.

To go far, go together.’

An African Proverb.

I have not walked this journey alone but have been pleased to be supported by some inspirational role models along the way.

I would like to acknowledge Professor Patricia Davidson, my principal supervisor, who introduced me to the world of possibilities that embarking on my PhD would provide. To Dr. Michelle Di Giacomo, my co-supervisor, thank you for believing in me, for your unfailing good humour and words of wisdom.

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To my fellow students, Hui, Jane, Jo, and Vix, it has been a privilege to know you and work alongside you during our respective PhD journeys. I am indebted to you all for your friendship and unfailing support.

Publications Arising from this Thesis

Based on Chapter	Status / Permissions*	Publication
One	Published. /Permission granted to use paper in thesis. *	Sayers, J., Di Giacomo, M. (2010). The nurse educator role in Australian Hospitals: Implications for policy. <i>Collegian</i> , 17,(2), July. 77-84.
Two	Published. /Permission granted to use paper in thesis.*	Sayers, J., Di Giacomo, M. and Davidson, P.M. (2011). The nurse educator role in the acute care setting in Australia: important but poorly understood. <i>Australian Journal of Advanced Nursing</i> . 28,(4), 44-51.

* Refer to Appendix 9 for permission documents.

Conference Presentations

Arising from this Thesis

Peer Reviewed

Nurse Educators in Acute Care Hospitals, Australia (Poster Presentation), Conference, Malta, May, 2011.

State of the Nation: Nurse Educator Practice in Australia, International Nurse Education Conference (NETNEP), Sydney, April, 2010

Birds on the Wire - Lessons from the Field - Utilising the Web Based Survey as a qualitative tool in nursing research. International Networking for Education in Healthcare Conference, Cambridge, England. September, 2009.

The Nurse Educator role in Australian Hospitals: Implications for health policy. International Networking for Education in Healthcare Conference, Cambridge, England. September, 2009.

A Brave New World - from Chaos to Leadership Challenge, 13th National Nurse Education Conference, Sydney, September, 2008.

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Abbreviations

ABBREVIATION	FULL TERM
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANCI	Australian Nursing Council Incorporated
ANTS	Australian Nurse Teachers Society
CE	Continuing Education
CINAHL	Cumulative Index Nursing Allied Health Library
CNE	Clinical Nurse Educator
CPD	Continuing Professional Development
CNC	Clinical Nurse Consultant
CONN	Council of Deans Nursing and Midwifery
HREC	Human Research Ethics Committee
NE	Nurse Educator
NHHRC	National Health and Hospitals Reform Commission
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board, Australia
NRI	Nurse Retention Index
PPE	Professional Practice Environment
RCNA	Royal College of Nursing, Australia
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organisation

Glossary

Term	Definition
Clinical education	Clinical education refers to the clinical component of student or health practitioner education that allows the learner to apply theoretical knowledge to practice within health care or health-related settings [1].
Continuing education	Education post-registration through to retirement [2].
Continuing professional development	Professional development addressing learner needs and practice competency [2].
Nurse educator	A nurse educator is a registered nurse and professional expert whose primary responsibility is to provide education to undergraduate and postgraduate nursing students, graduate nurses and other occupational groups within a hospital setting [3].
Role	Role is a term used to describe a position [4].
Role expectations	Role expectations may be defined as attributes that other staff and the organisation believe an individual assumes in their job [5].
Role performance	Role performance is the individual's understanding of how other staff and the organisation view their role [5].

Glossary References

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Chapter 1 – Introduction

1.1 Introduction

Promoting health care quality and safety is dependent upon sustaining a knowledgeable nursing workforce [1]. Nurses assume a critical position in acute hospital care and the nurse educator role is fundamental to achieving this goal [2]. Nurse education is a pivotal element of the registered nurse role and articulated in competencies nationally and internationally [3,4]. The purpose of this chapter is to provide an overview of the Nurse Educators in Acute Care Hospitals (NEACH) study. Specifically, this chapter: outlines the influences and interface between the Australian healthcare system; explains the characteristics of the health and nursing workforce, education and funding; depicts the role of the nurse educator in acute care hospitals; outlines study methodology and significance and presents the organization of the thesis.

Health care systems internationally and in Australia are under stress. Increasing demands, fiscal pressures and workforce issues underscore the importance of supporting nurses in the clinical practice setting [2,5]. Explicit in the development of nursing workforce education models in the acute care sector is an understanding of the role of the nurse education workforce. To date, there has been limited investigation of the nurse educator role in acute care hospitals in Australia [2]. This thesis has sought to address this gap.

Clinical education and continuing professional development have high priority in the Australian health workforce reform agenda, as do opportunities for role and scope of practice redesign [6]. The study design focused on identifying and critically examining factors influencing the nurse educator role and their scope of practice in the acute care hospital.

Shifting societal demands have provided the incentive for developing and sustaining an educated and competent health workforce to ensure safe patient care from pre-registration through to career long continuing education [7]. Although the role of the nurse as a teacher is strongly endorsed, nurses may not always be equipped with the knowledge and competence to provide optimal teaching and learning opportunities [2].

In Australia, health workforce reform initiatives have directed significant resources towards developing changes in education in clinical practice [8]. The focus of these reforms includes undergraduate clinical placements, new graduate supervision and medical education [8]. Undeniably, these are strategic imperatives in addressing healthcare system challenges arising from increased patient acuity, skill mix and adverse events including patient mortality [8]. An associated imperative is the continuing professional education and development of nurses, the largest professional group within the health workforce and the group who spend more time with patients [5]. Health Workforce Australia, established by the Council of Australian Governments, has overarching responsibility for overseeing health workforce recruitment, planning and education [6].

Despite proposed reforms in health care and developing new or expanded nursing roles, the position of the nurse educator in continuing education in the hospital sector is not well described nor clearly articulated [2,9]. For the purposes of this discussion, a nurse educator is defined as a registered nurse and professional expert whose primary responsibility is to provide education to undergraduate and postgraduate nursing students, graduate nurses and other occupational groups within a hospital setting [2]. This broad definition embraces a range of titles for nurse educators (e.g. nurse educator, clinical nurse educator, staff development nurse) employed within hospitals across Australia assuming responsibility for educating the groups cited above.

The recent introduction of mandated continuing professional development for nursing registration in Australia focuses on identification of knowledge gaps, development of competence and expertise and a commitment to lifelong learning [10]. The nurse educator role is fundamental to nurses achieving these goals through the formal and informal education programs they provide within hospitals. Nurse educators also provide an important role in facilitating programs and providing assistance with professional development [11].

Notwithstanding the importance of workplace education, Australian acute care nurse educators remain 'invisible' within the health education reform agenda and do not have a strong voice in policy development. Notably, blurring and ambiguity across nursing roles that provide education further compound the nurse educator position and the influence of nurse educators in achieving reform in policy and practice [2, 9, 12].

1.2 Study aims

This study aimed to:

- Describe the existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care hospitals in Australia.
- Describe the contribution of nurse educators to nursing and interdisciplinary education.
- Develop competency standards to guide nurse educator practice in acute care hospitals.

1.3 Background to the study

Australia has a world class health system strengthened by the current health and workforce reform agenda where nurses play an indisputable role implementing best practice initiatives [8]. Nursing roles are influenced by population health needs, the healthcare system and legislation [13]. A culture of continuous learning within the health system equips nurses with the knowledge and skills necessary to address changing health needs and professional practice [13].

Nurse educators collaborate with organizational leadership to determine nursing practice priorities [13]. In partnership with the leadership team, they plan and manage education and professional development initiatives to address these priorities. Many nurses have taken pivotal roles in leadership and policy development. The inclusion of education and professional development programs within strategic and business plans in health care settings acknowledges organizational commitment to learning [13]. Nurse educators facilitate and implement these programs, engaging nurses in education and learning experiences in clinical practice [12,13]. These programs develop and inform the critical thinking and decision-making skills of nurses to provide optimal patient care [2]. The nurse educator role in acute care hospitals is integral to achieving the National Health and Hospitals Reform Commission initiatives of strengthening and developing a skilled and competent health workforce [8]. These goals are achieved by influencing policy and practice as an expert, role model, educator and clinical leader.

1.3.1 The Australian healthcare system

Both government and private sectors provide healthcare in Australia across a diverse range of metropolitan, rural, remote and regional settings [14]. Strategic health policy, leadership and funding around core health areas are provided by the Commonwealth government while the States and Territories currently assume responsibility for the delivery of acute care and some community based public health services. The public health system provides the majority of acute healthcare services to Australian residents. Nurse educators work in both the public and private healthcare sectors [15].

1.3.2 Health demographics of the Australian population

The ageing population, escalating healthcare costs and health workforce shortages will significantly impact the health status of Australian society during the next half century. Chronic illness, disability and co-morbidities associated with asthma, cancer, heart disease, arthritis and musculoskeletal conditions, osteoporosis, diabetes, mental health, obesity and dementia are the national priorities for prevention and care strategies. The scope and burden of these issues is apparent with over one million people currently requiring daily assistance with self-care, mobility and communication as a consequence of severe disability. The burden of chronic disease and disability is evident in communities across Australia [16]. Aboriginal and Torres Strait Islander health is worse than that of non-indigenous Australians, for example, with high admission rates to acute care [16]. Addressing the health needs of our society is complex and costly and is largely dependent on a competent, responsive and sustainable health workforce [6].

1.3.3 Health funding

Although the focus of care is increasingly moving into the community in response to an ageing population, chronic illness and spiraling healthcare costs, hospitals remain an important focus of care [17]. Australia supports a system of universal healthcare coverage, where employees pay a tax levy to support government funding of public healthcare. In turn, all Australians are entitled to receive free public hospital care [18].

This funding is administered through a complex and layered system of Commonwealth, State and Local governments and public and private providers. Within this funding system healthcare providers can be both government

employees and private providers and there is a coexistence of private insurance, co-payment – where private health insurance pays part of the service costs and the patient pays the remainder – and universal coverage [18].

1.3.4 Health workforce funding

Funding for the health workforce, including nurse educator positions in acute care hospitals, is provided through the Commonwealth and State governments described above [19]. Although there has been substantial funding between 2008 and 2011 for infrastructure to support undergraduate clinical education at the local level [20] there has been no specific government allocation for nurse educator positions to provide clinical education and professional development programs in acute care hospitals [2]. To date, there is no strategic planning for postgraduate nursing education in Australia, perhaps with the exception of funding incentives for aged care. However, emerging policy initiatives from Health Workforce Australia provide some direction [6].

In view of the requirement for continuing professional development as specified within the registered nurse competency standards [3] and the mandated requirement for continuing professional development for ongoing professional registration this is an important consideration in health workforce planning [10]. Currently, there is no evidence of a unified agenda for postgraduate nurse qualifications in Australia [14]. Qualifications are currently obtained through both post-graduate diploma as well as masters level programs. Also in some jurisdictions there has been a demand for certificate level courses [11].

There has been an increasing shift in focus requiring registered nurses to provide clinical education [11]. Although this is a requirement of the registered nurse role, their ability to provide education is often constrained by their primary role of providing care and their skills and competency in providing clinical education [13]. Increasing health care costs, an ageing population and chronicity significantly impact care services amid pressures to diminish length of hospital stay [19]. These factors have significant implications for the role and function of nurse educators to facilitate skill and competency development within healthcare environments characterized by diverse skill mix [2].

1.3.5 Scholarship funding to support professional education

Registered nurses employed in clinical roles seeking professional education or continuing professional development are eligible for various scholarships provided by the Commonwealth and State governments [21]. Professional nursing organizations and some State authorities offer scholarships, that both registered nurses working in clinical contexts and nurse educators are eligible for [21]. However, nurse educator awareness, uptake and the adequacy of these scholarships to engage in continuing education and professional development is unknown. It is likely that the majority of professional development beyond formal academic programs is as a consequence of conference attendance, workplace education and activities of professional societies.

1.3.6 Health care and workforce challenges

Providing care to a culturally diverse society all with specific complex care needs, coupled with diminishing workforce participation, is challenging workforce capability to meet service demands. If these needs are to be addressed, nurse educators need to be conversant with changing population demographics and cultural practices, and informed of the specific health needs, service delivery models and specialty nursing practices to provide relevant, affordable, timely, accessible education to nurses working in hospitals serving these communities [22]. These challenges are not unique to Australia, [23] but to achieve health reforms they must be considered within the local policy environment and health system funding.

1.3.7 Changing models of care

As the demand for health services change, models of care and the development of nursing and interdisciplinary workforce patterns have evolved [17]. In acute care, new models of care have arisen in response to decreasing lengths of stay, fewer acute care beds, increasing patient acuity and associated co-morbidities, and an unprecedented growth in day surgery [19]. Nurses need to have an understanding of these models of care and their appropriateness given the changing contexts of their work and the divergent skill mix among staff providing care in the multidisciplinary team [24].

It is within this milieu that nurses and other health care workers may be led and influenced by the nurse educator assuming clinical leadership and fostering interdisciplinary education, knowledge and skill development [9].

1.3.8 Australia's health workforce

Nurses comprise 52% of the health workforce with 29.8% of registered nurses, aged over 50 years. As 50% of this cohort retires over the coming decades [25] their ranks will include highly qualified and knowledgeable nurse educators leaving specialty deficits. Increasing recruitment to undergraduate and graduate places at universities and colleges has been presented as a solution to addressing nursing shortages [26]. This strategy of increasing nursing graduates has been marred by a reduction in available new graduate positions in some hospitals due to budgetary restraints. This has compromised recruitment in acute care hospitals, leaving a workforce with a markedly depleted knowledge and skills base [23].

Another response to workforce shortfalls has been workforce diversification through the initiation of health worker training courses (e.g. personal care assistant) at the college level [22]. While a workforce of greater skill diversity may provide short term relief to staffing deficits, the potential exists for the varying knowledge, skills and expertise of these workers to negatively impact quality patient outcomes [23]. These new health worker roles influence the registered nurse role and the capabilities required, as the scope of practice for nurses and other health workers changes [22]. In this environment, the registered nurse may be responsible for delegating and supervising care rather than being the direct care provider [22]. The ability of the healthcare system to provide safe and effective care is reliant on a sufficient and skilled workforce working within service models that optimize staff performance [27]. In a workforce characterized by variable knowledge, skills and expertise, clinical education is essential to achieve this [22]. This workforce diversification underscores the importance of supervision, mentorship and coordinated professional education [22,23].

1.4 The role of the nurse educator in the health workforce

In Australia, the nurse educator role in acute hospitals, qualifications and scope of practice vary considerably and are subject to the context of practice [22]. The Australian role is varied and complex; some have primary responsibility for

organization-wide programs such as mentorship courses, while others work within a specialty such as surgical nursing, providing specialty education [9]. Conway and Elwin (2007) argue that the nurse educator role in acute care hospitals is unclear and poorly described and that there is blurring across various categories of nurses providing education in the practice environment [9]. As long as this ambiguity persists, role description and enactment may be adversely impacted leading to role erosion and role conflict [9]. Accordingly, the success of educational initiatives with nurses within the reform agenda may also be affected, as stress arising from confusion regarding role boundaries and role erosion may result in communication breakdown and interprofessional rivalry [2,28]. In the context of these issues and a growing concern regarding the sustainability of nurse educator positions (positions not directly responsible for patient care), it is timely to consider the role within the Australian healthcare system [2,9].

1.4.1 Historical perspectives of the nurse educator role in Australia

Historical perspectives provide an understanding of some influences on the nurse educator role. Nursing and nurse education in Australia, Canada and Malta have been modeled on the United Kingdom (UK) system as a consequence of discovery, settlement and initial development as colonies [29]. Over time, the nurse educator role in each of these countries has also developed along similar lines to the role in the UK, although this changed significantly with the integration of nurse education into the university sector [9,30].

Nurse educators in Australia primarily work in acute care hospitals [9]. In comparison, nurse educators in the UK and the United States of America (USA) may work in academia and the clinical environment or in academia alone [9,30]. The role in Australia is focused on the continuing education and development of nurses, maintaining practice standards and managing and facilitating clinical education and competency [9,12,31].

Over the past 10 years, nurse education in Australia has been under the spotlight through the National Review of Nurse Education (2001) and the establishment of the National Nursing and Nurse Education Taskforce (2003), in response to growing concerns about nursing shortages, undergraduate clinical training places and new graduate programs [15,21]. The underlying premise for the National Review of Nurse Education and the establishment of the National Nursing and Nurse

Education Taskforce was that nursing is a practice-based discipline and therefore nurse education needed to be considered in the context of practice and the broader health setting [15,21].

Recognition of the impact of education on the workforce and patient outcomes is increasingly recognized as demonstrated by initiatives, such as Magnet programs seeking to maximize internal organizational factors to improve patient outcomes and nurses' workplace satisfaction [5]. This underscores the importance of activities to assess the impact of workforce configuration and educational programs. The pressure for outcome focused practice, the need for ongoing professional development, the high turnover rates of new graduate nurses, [28] and the introduction of new levels of health care workers, [22] are some of the issues nurse educators may encounter in contemporary hospital settings.

Unlike some nursing roles in Australia, such as the nurse practitioner [32] the literature on nurse educators in hospitals is sparse [2]. As a consequence, the professional profile, development and power base of nurse educators is impeded, as is their role in policy decisions [12]. The introduction of other nursing roles with responsibility for education has culminated in the duplication and fragmentation of nurse education services as well as the potential for role ambiguity and conflict [9]. Describing the nurse educator role and factors enhancing and constraining practice is essential to inform the development of contemporary models of nurse education in the acute care sector [2].

In considering the role of nurse educators, it is also important to consider issues in workplace education more broadly [6]. Workplace education programs build upon the workers existing qualifications and skills to enable them to undertake their jobs more effectively and efficiently [33,34]. Moreover, many of these activities also address occupational health and safety issues [34]. Regulatory frameworks, executive support and provision of resources often influence the impact of these programs. Considering nurse educators in the context of workplace education is of increasing importance [5,35].

1.5 Policy in support of nurse educator practice

The establishment of the Nursing and Midwifery Board of Australia (2010) has unified registration and mandated continuing professional development

requirements for nurses [10]. Nursing policy supporting professional development programs at the local level is important to ensure nurses have a certain level of skills and competence, to instill a culture of lifelong learning, and to facilitate continuing education for better clinical practice. As health workforce reform gains momentum, policy supporting the development of the nurse educator specialty is an important consideration. Importantly, as advanced practice nursing roles emerge, it is opportune for nurse educators to exercise leadership in developing a vision for their specialty role to further influence nursing and the broader health workforce, education and practice.

1.6 Study method

To further understand the nurse educator role in hospitals, a mixed method approach was undertaken. The study described problems and issues, investigated these problems and provided solutions. Role theory [36] and symbolic interactionism [37] provided an overarching framework for the study design and interpretation of data. This strategy enabled nurse educators in hospitals to describe their perceptions of their role and practice within their workplace [37].

Role theory considers how ‘actors’ or people may perform in certain circumstances [36]. Role theory is used to facilitate both the individual and the organization to better understand and predict individual behavior and how someone may feel and perform in socially constructed events [36]. As individuals are challenged to adapt to change, perceptions of their ability to engage in change and associated expectations may result in the person coping well or feeling stressed. For example, if a new nurse educator was asked to initiate a research study, their perceptions regarding their ability to successfully conduct the study or their role as study leader may be influenced by prior leadership and research experiences and previous relationships. Role theory describes socialization processes as a role is enacted, providing a framework for interpreting role related actions and behaviors [36].

Symbolic interactionism [38] is based on three premises:

- Humans act towards things as a consequence of the meanings these things hold for them
- Meanings arise through the process of communication
- Interpretation modifies the meanings

Meaning is central to symbolic interactionism, whereas human behavior and interactions are considered through symbols and the meanings people have for them [37]. As humans, we don't simply respond to events we encounter; our thought processes allow us to consider and give meaning to events. Our actions in response to an event occur as a consequence of the meaning the event holds for us [37].

The application of these approaches has allowed consideration and interpretation of role interactions within nursing and nurse education services in acute care hospitals.

1.7 Thesis organisation

An overview of each of the chapters within the thesis follows. References are provided at the end of each chapter and appendices located at the end of the thesis.

Chapter 1 – Introduction to the Nurse Educators in Acute Care Hospitals Study

This chapter provides a rationale for the research investigation and an overview of study aims and methodology. It summarizes the contextual issues relating to the study.

Chapter 2 –Integrative Review of the Literature

An integrative literature review of the nurse educator role in the Australian context is presented in this chapter. The chapter commences with a brief overview of health and health workforce reform. A discussion on clinical education and continuing professional education and competency to practice then follows. An explanation of the integrative literature review method and its application to

the study is identified. The findings of the review are presented, clarifying the role of the nurse educator in the healthcare system, their contribution to nursing and interprofessional education and impact on patient outcomes. The literature review subsequently identifies and addresses key issues arising from the review: role identity, ambiguity and conflict; educational preparation; professional development; career pathways and contemporary issues in nurse education. This chapter also summarizes issues in work-based education.

Chapter 3 – Role Theory and Symbolic Interactionism: A Framework for Exploring the Nurse Educator Role

This chapter provides a discussion of the elements of role theory and symbolic interactionism. This framework underscores that nurse educators work in dynamic environments and are both receptive and responsive to the external milieu. These theoretical perspectives have driven the design of the study, interpretation of data and recommendations for future research.

Chapter 4 – Method

This chapter describes the methodological approach to the study. An explanation is given of the philosophical underpinnings of the research and rationale for using a mixed method design. The chapter then reports on development of an online survey. A detailed description of the process for instrument development, data generation and analysis strategies are explained. Ethical issues and quality considerations are also addressed. The survey developed as part of this study encapsulated specific domains of the nurse educator role.

Chapter 5 – Results Part 1

Chapter 5 presents the qualitative results from the group interview and survey of nurse educators in acute care hospitals in Australia. Qualitative data analysis arising from the group interview identified three central themes: challenges in enacting the role; education; and policy and funding.

Qualitative data were also collected via one open-ended item within the nurse educator survey. The three themes that emerged from survey data relating to the role were: expectations and responsibilities; ambiguity, overload and role stress; and organizational culture devaluing the role. Within these themes, respondent issues pertaining to role ambiguity, role conflict, and role identity, scope of practice and role criteria as well as role satisfaction and dissatisfaction are described.

Chapter 6 – Results Part 2

This chapter provides the quantitative results from the survey of nurse educators in acute care hospitals in Australia. It reports the findings of the eight specific survey sections: socio-demographic and educational characteristics; reporting and performance; competencies; career intentions; professional practice environment; workplace issues; self-appraisal of performance; and role enactment. Finally, the integrated data are discussed highlighting differences and similarities between the data sets. A hypothetical model is presented that is derived from the study findings to explain factors contributing to decreasing role conflict and ambiguity and workplace satisfaction of nurse educators in the acute hospital setting.

Chapter 7 – Discussion

Chapter 7 provides discussion of the quantitative and qualitative data. The relationship between these findings and the literature are provided as well as strengths and limitations of the study.

Chapter 8 – Summary and Conclusions

This chapter provides a summary of the study's findings and provides recommendations for policy, practice and research for further development of the role, education and practice of nurse educators in acute care hospitals.

1.8 Significance

The nurse educator role in acute care hospitals has evolved over time and has responded to social, political and economic influences including the changing healthcare environment, diversity in nurse education programs and student cohorts and emerging nursing workforce roles. An appreciation of the history and development of nurse education in Australia is important in informing the nurse educator role and contexts of practice. Moreover, this thesis has empirically derived a hypothetical model that may be useful in undertaking initiatives to develop and maximize the nurse educator role in acute care hospitals.

1.9 Summary and Conclusion

Australia, in parallel with other developed countries, faces challenges to address population ageing, affordability, equity of access as well as safety and quality in healthcare. Health education and workforce reform are essential partners in the healthcare process, although continuing education and professional development in acute care hospitals and the role of the nurse educator have not been a specific focus for reform [8]. Workplace education is an important issue for consideration for the future, but the nurse educator role is unclear in the current acute care hospital [2].

In the following chapter, the role of the nurse educator in the health workforce and workforce education is described.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 2 –Literature Review

2.1 Introduction

Scholarly discussion and debate of the nurse educator role and their contribution to education and learning in acute care hospitals in Australia is minimal [1-3]. For the purpose of this literature review, a nurse educator is defined as a registered nurse and professional expert whose primary responsibility is to provide education to undergraduate and postgraduate nursing students, graduate nurses and other occupational groups within a hospital setting [1]. This broad definition embraces a range of titles for nurse educators (e.g. nurse educator, clinical nurse educator, staff development nurse) employed within hospitals across Australia assuming responsibility for educating the groups cited above [4]. This chapter critiques the literature pertaining to the role of the nurse educator in the health workforce and workforce education through an integrative review of the literature contextualizing the role. The purpose of this review is to summarize existing information on the role of nurse educators in acute care hospitals.

The review is presented in two parts: Part 1 provides an overview of the issues in the contemporary Australian health system while Part 2 reports findings of an integrative review investigating issues impacting on the nurse educator role in hospitals.

2.2 Background

Part 1 Issues in the contemporary health care system

2.2.1 Health reform

Healthcare and workforce reform initiatives in Australia are fundamental to achieving equitable access to high quality health services and patient safety [5]. A well-educated and competent health workforce is essential to achieving these goals [6]. However, the National Health Workforce Taskforce (2008) argues that clinical and continuing professional education programs have inadequately prepared the health workforce to deliver safe quality care [7]. This dilemma is not unique to Australia, but is endemic in health globally [8].

The interface between healthcare, the health workforce and nursing is necessary in achieving the healthcare goals of the Australian population [9]. An array of reform initiatives since 2000, such as the National Review of Nurse Education (2001), [10], and the National Nursing and Nursing Education Taskforce (2003), [9], have been the forerunners to a broader focus across health professions on what is ailing the health system and health workforce. The initiation of the National Health and Hospitals Reform Commission (2009) brought stakeholders together to develop strategic initiatives to improve healthcare quality and safety [5]. Resultant reform initiatives target the complex health needs of our ageing population, improving patient care safety and quality, healthcare equity and costs [5].

2.2.2 Health workforce reform

One of the five reform goals is focused on, “Creating an agile and self-improving health system,” that is driven by a “a modern, learning and supported workforce” (National Health and Hospitals Reform Commission, Executive Summary, p.9, 2009) [5]. However, as the Commission’s report acknowledges:

“The planning of our future health workforce requirements is a bit like Swiss cheese riddled with gaps and incomplete and poorly coordinated information” (National Health and Hospitals Reform Commission, 2009, p.128) [5].

In response to the factors identified above, one health workforce reform has been directed towards relieving health workforce shortages to better meet healthcare needs [11]. This strategy resulted in establishing new roles through health training packages (i.e. pathways from secondary school to a career in healthcare) [11]. Enhanced scope of practice, such as expanding the enrolled nurse role to include medication administration, has been another strategy. Other recently emerging workforce roles within nursing include undergraduate nursing assistants [11].

This growing mix of health employees with varying levels of education has created a health workforce of divergent knowledge, skills and experience [12]. The resultant dilution of nursing skill mix and lack of time to define structures and processes arguably influences the ability of these nurses to meet society’s health needs appropriately [11-13]. Significantly, diversification and skill mix dilution persists contrary to evidence asserting that a highly educated nursing workforce provides better patient outcomes [14].

2.2.3 Workforce education and reform

Workforce education comprises undergraduate and postgraduate programs as well as continuing professional education and development [8]. Clinical education refers to the clinical component of student or health practitioner education that allows the learner to apply theoretical knowledge to practice within healthcare or health-related settings [15]. Continuing education involves learning from registration through to retirement [8]. Clinical education facilitates health professionals to maintain currency about research outcomes to inform their practice and attain the skill acquisition required to care for their patients appropriately [8].

Continuing professional development includes some elements of continuing education but the focus is on the learner assuming responsibility for their learning [8]. This may include the individual identifying their learning needs and pursuing education or professional development courses or programs that are offered in modes best suited to their individual learning style, be it through face-to-face, podcasts or other means [8]. In particular, learning at the point of care is vital to successful continuing professional development [8]. In tandem with changes in healthcare, the nature of education in the acute care hospital has changed with the introduction of simulation - in part to address diminishing clinical placements for undergraduate students - and web-based education programs. Continuing professional development is also increasingly becoming mandatory for all health practitioners to meet annual registration requirements. In nursing in Australia, continuing professional development became a mandated requirement for continued registration in all States and Territories in 2010 [16].

2.2.4 Competency to practice

Some countries, such as the United States of America (USA), recommend all health professionals attain generic competencies [8]. Core competencies require health professionals to be capable of providing evidence-based, patient-centered care, working in interprofessional teams, implementing quality improvement practices and using informatics [8]. Health Workforce Australia (HWA) is investigating the concept of generic competencies for health workers and their application [17].

The nursing profession in Australia has recognized the use of competency standards to benchmark practice; underpin curriculum development and education as well as for workplace planning and management [18]. The

development of competency standards is important for nurse educators and the broader nursing profession to support nurse educator specialty capacity building by using competencies for the purposes described. Nursing practice standards aim to safeguard the public by promoting high standards of nursing practice. These were developed and endorsed by the Australian Nursing and Midwifery Council (ANMC) [19]. With the establishment of the Nursing and Midwifery Board, Australia (2010), the Council ceased to exist, though the standards remain unchanged and are endorsed by the Board [16]. The competency standards for registered nurses and midwives may be used for self-assessment, demonstrating continuing competence, and identification of practice and learning needs [19]. Standards may also be used in role development, performance review and career progression, as well as informing curricula and new graduate programs [19]. Specialty groups have also developed specific standards [20].

In Australia, national competency standards for nurse teachers, whose primary role is to teach but who may be employed in different practice settings were developed by a professional nursing organization, the Australian Nurse Teachers' Society (ANTS) in 1999, and were recently reviewed in 2010 [20]. The ANTS competency domains are: teaching and learning, communication, and professional practice [20]. In the USA, at least two sets of competency standards have been developed for nurse educators in all practice environments, and although the standards differed, they all included competencies on teaching and assessment, collaboration, scholarship, curriculum development, and leadership [21,22].

These competencies were not developed specifically for nurse educators employed in acute care hospitals and did not address the specific issues of context of the hospital environment and organizational context.

Engagement in clinical education and continuing professional development are responsibilities of the registered nurse [23]. Hospitals as organizations are also responsible for promoting an organizational culture embracing employee commitment to lifelong learning as well as conducting professional education [24]. Despite this mandate, existing educational structures and systems within Australia are ill equipped to meet the workforce capacity required to address healthcare needs [7]. Furthermore, while the focus of health education reform in Australia such as tertiary sector capacity, undergraduate programs, clinical placements and medical education is critical, a systems approach consistently addressing professional education across professionals' careers and workplaces has been

seemingly overlooked. The National Health Workforce Taskforce report (2009), [7] asserts that the focus for nurse education has been firmly on acute care services, as opposed to primary care, which is increasingly becoming a focus for service delivery.

This shifting of health care services to the community is important in the context of workforce education as the National Health Workforce Taskforce has suggested that undergraduate and postgraduate programs are not adequately preparing graduates to function effectively in emerging roles (e.g. nurse practitioner) and practice domains such as the community [7]. In part, this may be due to industry demands for throughput of nursing graduates [7]. However, Shields *et al.* (2011) argue, some students enrolling in nursing degrees have not attained suitable education standards for entry nor have appropriate literacy and numeracy and critical thinking skills necessary to become safe and competent nurses [25]. This view has been contested [26]. Changes in the acute care system, such as decreasing skill mix, challenge the new graduate role [26].

Education reform initiatives are increasingly important as the nursing labor supply and demand in Australia is progressively declining and will continue to do so into the foreseeable future [27]. Although the estimated 25,000 newly graduated nurses each year in Australia, within this period, will replace retiring nurses, the nursing workforce will be insufficient to meet the growing healthcare demands of an ageing population, the associated 40% increase in hospital bed days and attrition from nursing courses prior to graduation [24,27].

Among the 60% of nurses projected to retire by 2026 [27] will be skilled, experienced expert clinicians, nurse practitioners, researchers, educators and managers; many of whom will have completed one or more postgraduate qualifications to assume these positions [24].

A potentially shared issue with the USA is the unintentional outcome of multiple entry points to nursing, resulting in inadequate numbers of nurses progressing through the various degrees required to assume advanced roles such as a nurse practitioner, educator or academic [13]. Also, as young new graduates are paying off their first degree, perhaps wanting to take on a mortgage and have a family as well as working, their ability to engage in post-graduate studies may be diminished or postponed as a result of these other financial priorities. This outcome, Aitken (2011) argues, has the potential to adversely affect nursing

workforce and specialty development if inadequate numbers of nurses complete higher education courses. This may also result in a workforce with inadequate knowledge and skills to advance the nursing profession and, importantly, to meet patient-focused goals [13].

As nurses comprise more than 50% of the health workforce [7], describing the nurse educator role in acute care hospitals and identifying factors influencing their scope of practice and contribution to nurse education is important if issues impeding the required educational outcomes discussed above are to be addressed.

Part 2 Integrative Literature Review

2.3 Method

An extensive search of the literature was undertaken using the integrative literature review method to describe the nurse educator role in acute care hospitals. In this method, a question or questions guide the retrieval of information, its assessment and subsequent interpretation, synthesis and critique [28, 29]. The following questions guided the review: (i) what is the role of the nurse educator in the contemporary Australian healthcare system? (ii) what is the impact of the nurse educator role on patient outcomes? (iii) what are the key challenges facing the nurse educator role?

The method of an integrative review is an effective method for summarizing the literature, identifying gaps in the literature and recommending further research in a given area. The integrative review method was chosen as it provides a sequential process for identifying and interpreting themes and differing perspectives in the literature and is intrinsic of a range of study designs [28].

2.3.1 Search strategy

The search strategy was undertaken in two sequential stages. Firstly, bibliographic databases were searched using the Cumulative Index of Nursing and Allied Health (CINAHL), Cochrane, Johanna Briggs, Medline and Google Scholar, seeking Australian publications between 2000 and 2010. The term ‘*nurse-educator*’ was

supplemented with the terms '*clinical nurse educator*', '*education*', '*nursing*', '*teaching methods*', '*clinical*', '*outcomes healthcare*', '*acute care*' and '*Australia*'. A university librarian supervised the search strategy. Hand searching the references of retrieved articles and reports was performed to identify more sources. Notably, although a significant proportion of the nursing knowledge database comprises peer-reviewed literature, the 'grey literature' also contains important information. 'Grey literature' in the form of important reports, strategy and policy documents from Australia and other countries were retrieved and analyzed for relevance to the nurse educator role.

2.3.2 Inclusion criteria

The inclusion criteria for the database search specified that the literature retrieved was peer-reviewed, published in English between 2000 and 2010 and concerned nurse educators or clinical nurse educators in acute care hospitals in Australia. Any references failing to meet these criteria were excluded. Other specific exclusion criteria were papers focusing on the nurse educator role within universities.

Abstracts meeting the criteria were reviewed. Papers included in the review were descriptive and / or intervention studies describing the nurse educator role. A targeted review of the grey literature published reports and documents from peak organizations were reviewed.

2.4 Findings

Notably, limited literature (one peer reviewed article was retrieved) exists regarding the nurse educator role in Australia. Furthermore, the term 'nurse educator' was used generically within the literature, complicating extrapolation between the health sector and university role. In spite of this limited published data, a comprehensive view of issues impacting on the nurse educator role was retrieved.

The research questions served as a focus when considering reference articles and reports and for data extraction. Emergent themes from the literature review were role ambiguity, educational preparation for the role, career pathways, nursing workforce shortages and partnerships with academia. Findings from the literature

review are reported under the headings reflecting the questions that guided the review and the emergent themes affecting the nurse educator role.

2.4.1 The role of the nurse educator in the contemporary Australian healthcare system

In Australian acute care hospitals, two distinct educator roles exist: the nurse educator and the clinical nurse educator. Other similar positions include the 'new graduate program coordinator' or the 'clinical nurse educator after hours'. For the purpose of this thesis, both the nurse educator and clinical nurse educator roles in acute care hospitals are addressed. Although there is minimal discourse regarding the role of either educator in the literature, various descriptions of roles in Australia prevail. The definition provided in the Australian and New Zealand Standard Classification of Occupations (2006) is one example [30]. In this instance, nurse educators are classified together with nurse researchers [30]. This in itself is problematic as it is unclear where the nurse educator descriptors end and the researcher descriptors begin, or, as the case may be, overlap.

These definitions could also be aligned to the role of the nurse academic, which may be more inclusive of all of the associated tasks listed for the educator and researcher role they assume. The broad definition states that the nurse educator conducts both clinical and theoretical education, and professional development with nurses and midwives. Their role may include the development, management and implementation of nursing specific and/or staff development programs. Alternative titles ascribed to educators include nurse educator, clinical nurse educator and staff development nurse. Within this classification, the required skill level is equivalent or equal to a bachelor degree or higher qualification, in addition to 5 years of relevant experience [31]. The specified role tasks associated with this definition are identified in Table 2.1.

Table 2.1 Educator and researcher tasks

Nurse educator/researcher/clinical nurse educator/staff development nurse tasks [3].
Developing nursing curricula
Facilitating clinical education
Educational needs assessment and monitoring of education program outcomes
Policy development and implementation
Involvement in interdisciplinary research and research dissemination
Promoting evidence based practice
Supporting and teaching nurses undertaking research
Resource management

The Australian Nursing Federation (2009) proposed that the scope of practice for the clinical nurse educator was within a unit/facility or higher education setting managing nurse education [31]. The role specification requires 5-10 years of postgraduate experience and educational requirements specify a Bachelor of Nursing and postgraduate study in nursing and education [31]. An example of this role would be a nurse educator responsible for facility-wide education including mandatory education [31]. The confusion in nomenclature is apparent in this example where the term 'clinical nurse educator' is used and then interchanged with 'nurse educator'. The other difference between this and the previous description by the Australian and New Zealand Standard Classification of Occupations [30] is the requirement for a postgraduate qualification in education to perform the role.

Confusion in nomenclature and role demarcation challenges the nurse educator and clinical nurse educator to successfully establish role identity in clinical environments [3]. The overlapping roles of other clinical staff involved in clinical education, such as the clinical nurse specialist and clinical nurse consultant, as reported by Conway & Elwin (2007), add further confusion and ambiguity in

nomenclature [3]. These are listed in Table 2.2. The focus of Conway & Elwin's (2007) work is within New South Wales and therefore may not necessarily be representative of the role in other states and territories. However, it is difficult to specify role variations as a consequence of the minimal literature available.

Table 2.2 Role clarification and associated responsibilities for nursing education.*^[3]

Role title	Responsibilities
Clinical nurse educators	Bring clinical expertise, capacity to support learners in the clinical settings using a range of strategies that are dependent on context (e.g. direct interaction with trainee enrolled nurse/new graduate nurse or supporting others to support them, providing structure for and coordinating mandatory training)
Clinical nurse consultants	Provide clinical expertise, data analysis of incidents, audits, and research. They have the capacity to guide priority setting in education and knowledge of professional directions with regard to colleges, networks, other organizations.
Clinical nurse specialists	Bring focused clinical expertise relevant to their specialty area of practice, currency of practice in direct patient care, as well as support for their learners and peers
Nurse educators	Have instructional design and curriculum skills, ability to advise regarding outcomes of educational needs analysis process, evaluation experience, knowledge of education provider (e.g. university and TAFE)** curricula, systems and processes, and an awareness of how Area-wide initiatives affect education
<p>Note: These terms may not translate exactly to an international context but the descriptions of associated responsibilities for nurse education inherent within each role may assist the reader unfamiliar with the terminology used in NSW.</p> <p>*Used with permission.</p> <p>**TAFE: Technical and Further Education (TAFE) colleges provide secondary education, vocational education, and professional education courses from Certificate to Bachelor program level.</p>	

Globally, nurse educator titles and roles are also unclear as roles and functions intermingle across practice environments [3,32,33]. In the USA and the United Kingdom (UK), a nurse educator may have dual roles in academia and the hospital setting [33,34]. By contrast, the nurse educator and clinical nurse educator in Australia primarily work in hospitals [1,3].

From the introduction of nursing into Australia in 1868 until the mid-1980s, the nurse educator role was hospital based [35]. During this period, pre-registration education for nurses was undertaken in hospitals on the basis of an apprenticeship-training model [35]. The nurse educator was fully engaged in all aspects of these programs [35]. This included curriculum development, implementation and evaluation, as well as teaching in practice [3]. Now, undergraduate nurse education is provided in the tertiary sector [3].

Within Australian hospitals, two education roles commonly exist - the nurse educator and the clinical nurse educator [3]. Unless otherwise specified within this discussion, the term 'nurse educator' is used encompassing both roles. The nurse educator today is an advanced practice registered nurse [36]. An advanced practice registered nurse meets the domains of the national competency standards of the registered nurse [19] and builds on these through practice identified within advanced practice domains [36]. These domains focus on three aspects of practice - conceptualizing, adapting and leading [36]. Conceptualizing practice requires the nurse educator to use theory, research, evidence and their experience to explore, question and develop knowledge enhancing nursing education and nursing practice [36]. By adapting practice, the nurse educator considers research and knowledge prior to modifying nursing practice [36]. The nurse educator works as a leader in education and nursing practice by promoting best practice [36]. No specific nurse educator competency standards have been developed for nurse educators in clinical practice, although ANTS has developed generic 'nurse teacher' competencies that may be applied across roles and sectors [37].

Nurse educators assume complex, multifaceted roles that vary in accordance with location and the nature of the facility or service [1,3]. As expert nurses, they guide staff integrating their theoretical knowledge with practice [1,3]. They may assume responsibility for continuing professional development programs such as mentor programs or an educative focus within a specialty such as perioperative nursing [2-4].

This means nurse educators in acute care hospitals may work with students or registered nursing staff on an individual basis at the bedside, teaching, supervising or assessing competency. They may also conduct orientation and mandatory

education sessions as well as specific programs to address organizational education needs. On a cardiac unit, this could be conducting an in-service on the management of patients with a pacemaker. The educator could also assume broader education management functions such as undertaking needs assessment, planning, developing, implementing and evaluating a range of education programs to support the developing skill levels of new graduate nurses or registered nurses undertaking specialization [1,3].

2.4.2 The impact of nurse education on patient outcomes

Systemic failures in patient safety, the nursing profession's mandate for continuing professional development and the profession's code of ethics guiding practice, reinforce the need for nurse educators in acute care hospitals to work with nurses to influence patient outcomes [38]. To date, evidence supporting the impact of nurse education on clinical practice and patient outcomes is minimally described globally [38,39]. Internationally, attempts to clearly establish links between education and practice outcomes have been limited [39].

Duffield's (2007) study of the nursing workforce observed that the rate of adverse events decreased when a nurse educator was a member of the ward nursing team. The adverse events noted were associated with falls, medication errors and pneumonia [40]. This finding may be indicative of the clinical leadership and educational role nurse educators assume, thereby influencing nursing practice and safety by enhancing the knowledge and competence of nurses at the point of care. Duffield's study [40] clearly supports the need for nurse educators on wards to provide clinical education and leadership as they conceptualize, and adapt practice and maintain patient safety.

Positive improvements in patient practice will not occur as a consequence of a siloed approach to education [38]. Rather, the characteristics of a learning organization, as described by Kerka (1995), have been found to be useful tenets underpinning an organizational approach to learning in the acute care hospital [41]. Kerka describes learning organizations as environments that:

“ provide continuous learning opportunities...use learning to reach their goals...link individual performance with organizational performance...foster inquiry

and dialogue, making it safer for people to share openly and take risks... embrace creative tension as a source of energy and renewal ...(and) are continuously aware of and interact with their environment” (p.2) [41].

Hospitals that adopt these characteristics demonstrate their commitment to improving patient care and services through continuous learning. As this investment is significant, hospitals need to ensure that the education they provide meets the needs of employees as well as influencing the outcomes of patient care through the development of a skilled and competent workforce. Strategies to determine the impact of education on practice require consideration of the evidence base for professional education and associated evaluation methodologies [39,42].

Nurse educators need to understand that improving quality is within their sphere of influence and a priority. They need to be working at an advanced level of clinical practice, knowing and leading the implementation of evidence based practice that will improve patient care and outcomes [2,3,43]. This may be through working with a student or postgraduate nurse at the bedside, reviewing policies and procedures or implementing formal education programs. Evaluation of these activities may elicit whether or not they have influenced patient outcomes, for example, through diminished rates of infection or falls [40].

2.4.3 Key challenges facing the nurse educator role

Significant challenges are posed for education within the health reform agenda and changing workforce patterns, although these are only modestly described in the context of the nurse educator role. A key function within workforce reform is role redesign and differing scopes of practice [44]. Although the nature of these changes is not currently apparent, it may result in more workers entering the workforce without professional affiliations and limited educational preparation [26]. In the acute care hospital further divergence in skill mix will result in negative consequences for patient safety unless the nurse educator assumes influence as a clinical leader and role model, recognizing the scope of these new roles and the learning needs of these workers [1].

Nurse educators need to consider the advancing science of continuing professional education and engage in the development of inter-professional education policy and debate within the health reform agenda. They have an intrinsic role to play in

the transformation of nursing education in the clinical setting by initiating or collaborating in research focusing on learning for clinical practice [4].

Engagement within collaborative clinical and academic nursing and inter-professional partnerships may be the catalyst driving evolving dynamic and innovative continuing professional education. Central to nursing growth and development is sustaining and growing the nurse educator workforce to drive reform in education and practice. As the workforce continues to age and change, strategies affecting employee satisfaction and shortages in nurse educator positions in hospitals may also arise.

Identified themes within the literature pertaining to the nurse educator role were role identity and ambiguity, and education and career pathways [1-3]. Discussion of the literature concerning each of these challenges follows.

2.4.4 Role identity, ambiguity and conflict

As health workforce resources are reportedly underutilized [45], ensuring educators work to their full scope of practice is important for patient quality and safety as well as role sustainability. Although the concepts of ‘nursing scope of practice’, and ‘role enactment’ are widely used in the literature, they are not clearly defined [46] in terms of the nurse educator role. This lack of clarity has been further confounded following the restructuring of nursing in recent years and minimal acknowledgement of the effect of these changes and the subsequent potential for role conflict and ambiguity within nursing [3]. As other nursing specialist roles have emerged and assumed responsibility for engaging nurses in education in practice settings, the emphasis and responsibility for accountability for practice is less exclusively the domain of the nurse educator [3].

Conway and Elwin (2007) acknowledge that role identity and enactment may be eroded and blurred in health environments experiencing constant change and where there is overlap between roles supporting clinical education [3]. The described changes have significantly affected the nurse educator role and role erosion has occurred [3]. The threat of intra-professional discord, professional isolation and a lack of supportive relationships among nurses and nurse educators will likely prevail if the nurse educator role remains poorly defined [1,3]. The role may be undervalued and role enactment, job satisfaction and staff retention may

be negatively affected unless role uncertainty is resolved [2,3]. If nurse educators are to continue to facilitate empowerment of other nurses in developing skill proficiency, critical thinking and reasoning skills, enabling nurse educators to articulate their role and scope of practice is essential [2,4].

This is vital at a time when the sustainability of the role is questioned [1,3]. Importantly, the advancement of nurse education practice is contingent upon clarification of role boundaries and role description [4]. Furthermore, the literature is devoid of comment regarding the interface between the various nurse educator clinical roles. A strategic, structured approach to discipline-specific and inter-professional clinical education in the practice environment is required [4].

2.4.5 Educational preparation

Educators are no different from any other nurse in their requirement to practice within the competency standards for registered nurses in Australia. They also require specific further knowledge, skills and competence to undertake the role of educators. While educators may be clinical experts, clinical competence alone is insufficient to successfully assume an educator role [2-4,43]. Educational preparation about teaching and learning allows the novice educator to learn about teaching and learning theory, concepts and their application. This fundamental knowledge is enhanced through their experience informing competency and expertise in the art of teaching and learning. This knowledge is essential when facilitating learning, designing learning experiences and establishing and monitoring the learning environment [22,43].

Educational preparation for nurse educators in Australia is not mandated beyond that of a registered nurse by the profession or by any specific regulatory authority [1,3]. This would appear to reflect a lack of appreciation of the importance of educational preparation and, importantly, the science of teaching and learning [1,3].

Role criteria and education qualifications required vary between institutions [1]. For example, some employers require nurse educators to have a Certificate IV in workplace training and assessment as role criteria [3]. Yet, the expectations of the profession and consumers are that nurses must be well-educated to positively affect nursing practice and patient outcomes [26]. The ad-hoc and non-standardized educational requirements of the nurse educator role in acute care

hospitals are not helpful in fostering the identity and credibility of the role nor addressing consumer expectations and organizational needs [1,26].

An increase in the number of new graduate nurses entering the workforce and requiring clinical education, support and mentoring has resulted in nurse educators with a diverse range of skills and professional qualifications being employed [3]. Nurses in clinical practice need to be effectively supported to develop as lifelong learners. Nurse educators are responsible for creating engaging learning environments and experiences to support learning outcomes. They require knowledge and expertise in adult education principles to inform their practice. Clinical leadership, critical thinking, reflection, communication skills and knowledge of and commitment to learning and teaching processes are also necessary for nurse educators to perform successfully [4].

The knowledge and expertise that nurse educators gain through postgraduate study and experience is instrumental in their design and facilitation of learning experiences and evaluating learner outcomes [4]. Current variations in the nurse educator role, clinical competence and qualifications may complicate nurse educator preparation and subsequent role development. Study leave and fee support may enhance nurse educator participation rates in initial and continuing professional education and scholarship [47]. In light of recent public debate regarding the professional preparation of nurses, [26] it may be timely to reconsider the role of the nurse educator and the educational preparation required to perform in the role. Many nurse educators seek further qualifications in Faculties of Education or in specific clinical teaching courses (<http://www.australian-universities.com/schools/nursing/>).

2.4.6 Career pathways

An overwhelming body of evidence both locally and internationally, supports the imperative of a well-educated, competent nursing workforce [8,26,43]. New graduate needs and continuing professional education have been singled out as warranting specific attention [7,48].

The need for educational support for newly-qualified staff entering the workplace and the need to support the continuing clinical education of nurses is noted within key reports about advancing nursing and nurse education [48]. Although there has been a focus on funding to support nurses providing clinical education for

undergraduate students in the clinical setting, the literature is devoid of comment regarding educator positions in acute care hospitals [4,5]. Nurses aspiring to nurse educator or clinical nurse educator roles have varying experience and expertise. They may have assumed roles as a preceptor or mentor and have worked as a registered nurse or as a clinical nurse specialist.

Discussion regarding career pathways for the nurse educator and clinical nurse educator is also 'invisible' in the published literature and debate as these roles have not been a focus within the profession. Based on the review above it is likely that specialty development and sustainability is dependent on industry and specialty-endorsed delineation of the nurse educator and clinical nurse educator role and scope of practice. Articulation of a flexible career pathway may also contribute to specialty development, job satisfaction and retention, as has transpired for other specialty roles.

2.4.7 Partnerships with academia

The bridge to quality education requires paradigm shifts in thinking about professional education [8]. By shifting control of learning to individual health professionals, a system of continuing professional development with a trajectory from the classroom to the point of care will emerge [8]. A system embracing evidence-based theory as a framework for education methods and supported by information technologies that provide better opportunities to learn effectively is required [3]. Commitment to these strategies may enable the current and future nursing workforce to address their learning needs. In environments characterized by role blurring and ambiguity for roles assuming responsibility for education, however, conflict rather than collegiality and collaboration in nurse education may ensue.

An agenda for substantive partnerships between nurse academics and nurse educators is not new. However, such an agenda is imperative to enable education reform and leadership, and consequently encourage learner responsibility for knowledge, skill and competence development to provide safe patient-centred care within health teams [8,10,48]. Such partnerships could include nurse educators working in hospitals also teaching in undergraduate courses at the university, being engaged in curriculum development and establishing partnerships with their academic peers engaging in research. These partnerships may support the development of a comprehensive education system advancing evidence-based

practice and team approaches to inter-professional education and practice, culminating in safer patient care.

2.4.8 Nursing and nurse education research

Limited discussion and debate focusing on the nurse educator role has contributed to role ambiguity. The absence of systematic evaluation and research has negated the impact of nurse education practice on patient care being demonstrated in the Australian context. Measuring the process and outcomes of nurse education, particularly in supporting individuals in the practice setting, is important to identify opportunities to enhance teaching and learning experiences in the workplace as well as to identify gaps in knowledge and research [38]. Systematic evaluation of learning experiences of nurses in acute care hospitals may contribute to this gap.

To summarise, there is minimal evidence of research published about the nurse educator role in Australia. Although it is considered that every registered nurse should have a teaching responsibility, this negates the importance of the science of teaching and learning and the need for coordination of teaching and learning activities.

Diminished health fiscal resources [49] increasing role specialization assuming responsibility for nurse education [4] and the ageing population [49] emphasize the importance of examining the nurse educator role in Australian acute care hospitals. As discussed in Chapter 1, such issues provide a context for the information identified in this review. Scant data was found on the role of the nurse educator in acute care hospitals. The dynamic changes in the health care system likely explain some of this scarcity.

2.5 Conclusion

Chapter 2 has set the scene for the study, in particular outlining the dynamic state of the health system and evolving nursing roles and nomenclature. The literature review has highlighted the limited literature regarding the role of the nurse educator in acute care hospitals in Australia and the need for further research. From the available local and international literature, themes identified through the literature review were: role ambiguity [3,4], educational preparation

for the role [4], career pathways [4], nursing workforce shortages [3,4] and partnerships with academia [4]. The literature has also identified consumer expectations for the health workforce to be well educated, skilled and competent to provide the care and services required. However, the success of existing clinical education and continuing professional development paradigms has been limited. The review has identified that the role of nurse educators within acute care hospitals, as drivers of education and practice change is unclear and ambiguous [4]. The study's theoretical framework is outlined in the following chapter.

2.6 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 3 – Theoretical framework

3.1 Introduction

The framework to inform the study, design and methods and interpretation used in this thesis was guided by the perspectives of role theory and the philosophical perspectives of symbolic interactionism. Role theory is a useful framework for research aimed at exploring, understanding and relating role perceptions and individual human interactions and behavior within a social and organizational context [1]. Role theory describes how an actor performs in specific roles and circumstances [2].

The stance of symbolic interactionism provides a framework for understanding how individuals derive meaning during social interactions and how they define their self and role within social circumstances [3]. The chapter commences with a brief discussion of concepts underpinning the development and application of theories in scientific research. Historical perspective and a description of role theory and symbolic interactionism are then provided. These perspectives are useful for appreciating the utility of the theoretical framework for describing the nurse educator role in acute care hospitals. Understanding the role dimensions of the nurse educator role was considered of high utility for supporting the nurse educator role and development of competency standards.

3.2 Development and application of theories in research

Theories guide research by supporting or generating new knowledge [4]. A theory comprises inter-related concepts and statements that are either concrete or abstract [5]. Concrete concepts, for example 'lecturing', can be observed, whereas abstract concepts, such as 'learning', cannot be observed [1]. 'Role' is a concept that adopts different meanings when it is associated with other concepts such as 'ambiguity'[6]. The combination of concepts such as 'role' and 'ambiguity' to form 'role ambiguity' is called a construct [6]. Constructs allow us to examine a specific aspect or a concept. For example, when considering the concept of 'role' we may want to explore other concepts associated with the role such as 'ambiguity' or identity' [6,7].

Theoretical frameworks [8] are formed through the linkage of concepts such as '*clinical teaching*' and constructs such as '*role ambiguity*' [1,9]. They serve to link all aspects of the research study – the questions to be answered, the literature review, methodological considerations, data collection and interpretation.

3.3 Role theory

Role theory is defined as a group of concepts and hypotheses predicting '*actor*' performance in a specific role or anticipated behaviors in specific circumstances [1]. As a theoretical framework, role theory may accommodate connections between organizational and individual factors and behavior [10]. This may include exploring individual attitudes and perceptions of people in organizations [6].

Role may be defined as the character an actor assumes when performing activities or functions an individual may assume within an organization [6]. In the context of role theory, role may be defined as the behavioral characteristics a person may assume associated with their position and its functions. These characteristics may be influenced by their knowledge, attitudes, experiences and expectations of the role [6].

The utility of role theory has been challenged by Clifford (1996) as agreement regarding role definitions and the importance of role as a concept has not been reached [1]. That said, various role related studies have investigated role performance and self-appraisal as well as the impact of role performance on others [11]. Further studies have examined role conflict [12] and role strain [13] [13]. Although theoretical approaches to the role may vary, the theories have important common themes, namely: role acquisition, role behavior, normative behavior and social interaction [6].

3.3.1 *Historical perspectives*

The three key tenets of role theory are (i) social structuralism, (ii) symbolic interactionism and (iii) the dramaturgical approach [5,14].

(i) Social structuralism

Roles are functional components within a social system where the role and social structure may evolve and change along with the organization and society [6].

Structuralism provides connections with role theory and organizational nomenclature such as 'position' and 'office' as well as depicting role performance in a specific way [15].

Social structuralism theory asserts that there is a relationship between a role and a structural position where the individual assumes multiple roles within the position [1]. This theoretical perspective was further developed by Linton in the 1930s suggesting that the distinction needed to be made between social structures, such as an organization, and the individual [10].

Social structuralism focuses on society, social systems and structures that are perceived to influence individual behavior [6]. In this context, analysis is directed towards the structure as opposed to the individual in relation to the social environment [1]. The following section provides a description of the evolution of the theoretical constructs of symbolic interactionism.

(ii) Symbolic interactionism

George Herbert Mead (1863-1931) is considered to have laid the foundations for symbolic interactionism as an academic at the University of Chicago [3]. Mead espoused that humans are creative, active beings who influence the world in which they live [16]. In turn, he derived that these interactions and forms of engagement determine behavior [16].

He also noted that human beings are selective about what they learn and remember, and that they view and define objects subject to their perceived utility [16] generating meaning from the effect they produce [16]. Mead also observed that actions and interactions, as opposed to person and society, should be the foci for studying social phenomena [16].

The concepts of habit, instinct and self were associated with symbolic interactionism. William James (1892-1911) believed that habits developed in response to past experiences and as a result of repetition. In his view, habits influence how we go about modifying and inhibiting our instincts [17].

The term 'pragmatism', that is ways of thinking about or interpreting things, was coined by Pierce [18]. He argued that mental activity is associated with physiological brain activity [18]. The work of John Dewey (1859-1914) was also important, as he perceived that the origins of habit arise from social order rather

than from within the individual [18]. This underscores the importance of considering contextual factors and organization in understanding workforce behavior.

Another member of the Chicago school, William Thomas (1842-1910), is known for his concept of the 'definition of the situation' [17]. He suggested that definitions of situations often reflect a power imbalance which is a useful factor in interpreting social organizations. However, Thomas also suggested that social structure doesn't necessarily determine the definition of a situation allowing for a range of other interactive factors [17].

The concepts attributed to Charles Horton Cooley (1864-1929) are the primary group (significant others); sympathetic introspection (imagining situations as others perceive them) and the looking glass self (enabling us to view ourselves as others see us) [17]. These concepts are useful in interpreting how individuals are viewed and how they perceive each other within an organizational structure.

Herbert Blumer (1969) subsequently denoted three premises of symbolic interactionism:

- Humans act towards things as a consequence of the meanings these things hold for them
- Meanings arise through the process of communication
- Interpretation modifies the meanings [3]

(iii) The dramaturgical approach

The dramaturgical approach to symbolic interactionism was identified by Erving Goffman [6]. The dramaturgical approach is an extension of symbolic interactionism proposing that human beings act and behave differently in different settings and situations [6].

Symbolic interactionism asserts that a physical reality exists independently of an individual's social definitions. Social definitions occur in response to something real or physical [19]. Humans do not directly respond to this reality, but rather they define the situation as they encounter it. It can, therefore, be concluded that humans exist in both a physical and social reality.

Meaning is the driver of symbolic interactionism, interpreting how human behavior and interactions are considered through both symbols and their meanings [9, 17]. As humans, we do not simply respond to events we encounter; rather our previous experiences allow us to consider and give meaning to events. Our actions in response to an event occur as a consequence of the meaning the event holds for us.

As an application of this theory to the nurse educator role, the novice clinical nurse educator may lack confidence and not perceive him or herself to be very different from the nurses they are teaching. The nurses that the educator is teaching may have a very different perspective. They may consider the nurse educator to be an expert and very confident and competent. The title 'nurse educator' implies that this person is an educator and as a consequence of their title and the perceptions of the nurses they work with, nursing colleagues may defer to the nurse educator as a knowledgeable expert. Gradually, the interactions that occur between nurses and the nurse educator will shape the nurse educator's professional identity.

Similarly, the reactions of the nurse educator to a new graduate nurse seeking guidance to complete a complicated dressing are based on previous experiences and reference groups. The nurse educator's own experiences as a new graduate and the knowledge that being a new graduate signifies a turning point in their professional identity – marking the move from student to a professional – creates meaning for both the nurse educator and graduate. This meaning alters the approach the nurse educator may take to supporting the new graduate nurse to develop the requisite knowledge and expertise required to perform this procedure competently and confidently. The nurse educator also needs to be responsive to the learning and social support needs of the new graduate nurse to encourage future interactions.

Behavior and actions arise from the meaning attributed through interactions with ourselves (thinking) and others. Blumer (1969) described human beings as 'actors' who engage in self talk [3]. Human actions arise from interaction with other individuals as well as our own thinking. Understanding the active processes associated with thinking, self-talk and communicating with others are important to understanding action [16]. These are generally iterative and reflective processes and can be developed as part of professional development [20].

Blumer's (1969) second premise asserts that human beings learn meaning through social interactions [19]. Meanings result from how we respond to a person in relation to the object the person is trying to develop meaning for. The actions of others help define the object for the person. As mentioned earlier, Thomas was credited with the theory known as 'definition of the situation'[19]. He argues that before engaging in self-determined behavior, the individual always becomes absorbed in the 'definition of the situation'. In other words, human beings define the situation in which they find themselves and the role(s) they will play and expect of others, whilst they are in that situation. Although the situation may exist within an environment, it is the definition of the situation that becomes important [16]. Definition of a situation can guide the individual to gain an understanding of what is expected of them, or from Goffman's view, provides them with a broader perspective of what is occurring and how they should function in their particular role [19].

These concepts are demonstrated in the following example of a situation involving a clinical nurse educator and a new graduate. The clinical nurse educator's explanation and demonstration of the patient discharge process may differ from what the new graduate expected. The experience of the clinical nurse educator patiently discussing the process, supervising the new graduate discharging a patient from hospital and then giving them feedback regarding their performance, provides the new graduate with meaning about the discharge process and their competence and confidence when performing this task. Reflecting on the process and their performance (thinking and self-talk) may give the new graduate further meaning to their understanding of patient discharge now and in the future, as well as their perception of the clinical nurse educator's authority and role. The perspective of the new graduate also needs to be considered, the role they anticipate playing and how they interface within the organizational structure.

The term 'orientational others' was used by Kuhn (1972) to describe people who provide situational definitions such as the belief held by some that younger people are more valued than older people [19]. This meaning has arisen through the processes of interaction and observing interactions and the environment [19]. Reference groups, such as a group of friends or an organization, may also be used in defining situations. The culture of these reference groups may be used in defining situations for an individual [19]. Meanings may, therefore, result from the interaction with both orientational others as well as reference groups [19].

In summary, role theory demonstrates individual behavior and responses in specific situations [21] as well as recognizing how others may influence individuals through their behavior and their own perceptions regarding their role within an organization. Another important dimension of considering role interaction with the environment is that of the structuralist approach [14].

3.4 Structuralist approach

The structuralist approach asserts that an individual role associated with a position has set behavioral expectations [14], whereas the interactionist perspective accommodates individual traits, values and meanings to be brought and used by the new role occupant exploring and enacting the role [20]. Hardy and Conway (1998) argue that both approaches should be used to allow for careful examination of theoretical assumptions as opposed to using one approach in isolation [5].

3.5 Role theory as a framework for describing the nurse educator role

‘Role’ is a term used to describe a position. In the nursing profession, the role of the ‘nurse’ may be that of a practitioner, educator, academic or manager [6]. Each of these roles have described functions and attributes expected by peers, other professionals, employers, professional organizations and society [6]. Nurses, as individuals in society, may also fulfill societal roles including those of parent, friend and carer [6]. These perspectives regarding the concept of ‘role’ highlight the complexity of role-related attributes [6].

The concept of role in nursing contexts has been widely explored, including the role of the nurse practitioner [22], nurse manager [23] and the practice nurse [24]. In order to effectively perform their roles, these clinicians need clearly articulated role expectations and support to perform the role in their environment [22].

Role expectations, beliefs and attributes need to be defined for specific roles. Role expectation may be defined as attributes that other staff and the organization believe an individual assumes in their job [6]. Role conception is

individual role definition, whereas role performance is the individual's understanding of how other staff and the organization views their role. Therefore, the perceived value of the role by management and co-workers can shape the role.

The nurse educator role is reliant on the relationships occurring between expectations, conceptions and performance. This may occur between management, nursing co-workers and other health professionals. If the nurse educator role is poorly defined, then role conflict may emerge. Role ambiguity and role confusion may also arise as a consequence of differing expectations of staff and the organization, as identified in Conway and Elwin's study of nurse educators [25].

The rationale for choosing this theoretical framework to explain role and social interaction included:

- Nurse educators work in dynamic, social, defined environments
- Interactions take place at several levels – at the individual level as well as at the organizational and professional levels
- A nurse educator's values, attitudes and beliefs are linked to the role they play within the organization and the nursing profession

Figure 3.1 depicts relationships impacting on the nurse educator and accordingly, their role.

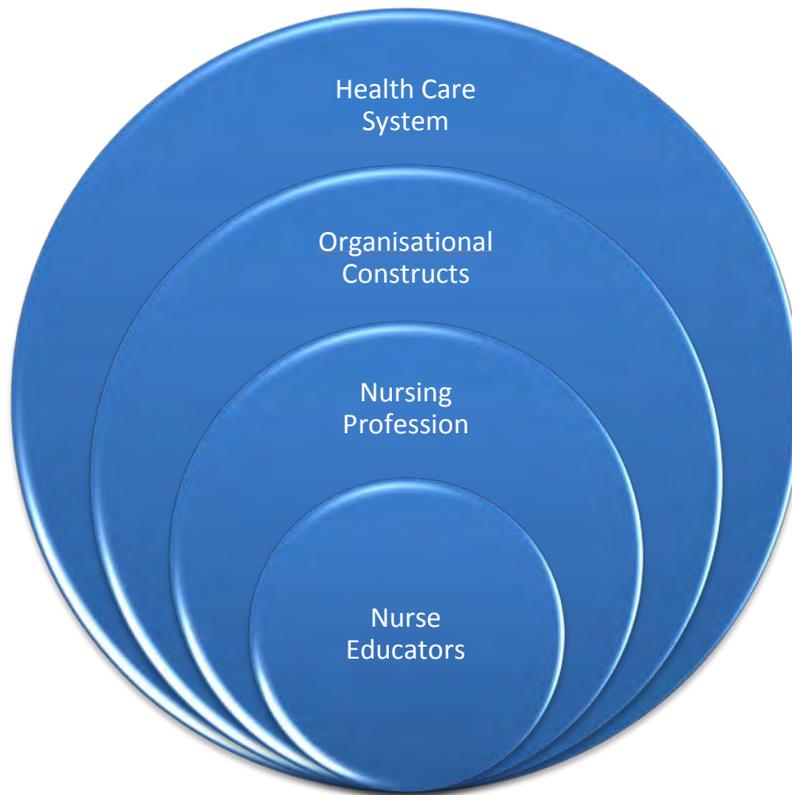


Figure 3.1 Relationships impacting on the nurse educator role

As human interactions underpin organizations and workforce hierarchies, role theory is an important approach to understanding communication and behavior of individuals within organizations. Definitions of situations together with an understanding of reference groups and environments may result in a more extensive view of issues such as role development [18]. Providing education to nurses in hospitals is a complex and multifaceted task.

The individual assuming the education role defines the educational experience in the context of their environment. The educator's behavior is a product of the role and the individual educator's personality, attitudes, knowledge and beliefs [2]. The way the educator behaves defines the experience in the context of his or her environment, not just for themselves but for the recipient.

In Chapter 2, the organizational context of the nurse educator role was described as well as their functions within the nursing workforce and clinical education. The application of role theory and symbolic interactionism to the study has allowed both micro and macro perspectives of the nurse educator role in acute care

hospitals to be examined and identified elements to be investigated in determining the nurse educator role.

As the focus of this study is nurse educators in a specified occupational context (acute care hospitals), the use of role theory as a theoretical framework examining role perception is useful and valid in investigating the nurse educator role in a dynamic, social context.

3.6 Conclusion

This chapter has described role theory and symbolic interactionism constructs as the framework for the study. These perspectives are useful in examining how nurses' professional identities develop and are interpreted within specific organizational constructs [18,25]. Considering issues such as role ambiguity, role clarity and role conflict is important in investigating the nurse educator role in acute care hospitals. These theoretical perspectives have guided the choice of study instruments, study design and interpretation of data.

3.7 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 4 – Methods

4.1 Introduction

Chapter 3 has presented role theory and symbolic interactionism as the theoretical constructs shaping the study design. This chapter describes and justifies the methodological approach for the NEACH Study. The philosophical underpinnings of mixed method research and the rationale for using an embedded design are also provided. A detailed description of the processes for instrument development, data generation and analysis strategies are explained, and ethical issues, quality considerations and the limitations of the study are also addressed. Methodological stages of the mixed method design are provided as well as ethical considerations.

4.2 The research process

Research methodology is the process the researcher engages in to illuminate, examine, interpret and answer a research question [1]. Koch (1996) considers that choosing one research paradigm over another requires informed decision making to support and justify the final choice and research rigour [1]. These philosophical viewpoints underpin the discussion in this chapter.

This study is concerned with people (nurse educators), their practices (nurse education) and the values, beliefs, attitudes, relationships, emotions and interpretations informing them. Importantly it refers to the way in which they interact within the broader health system (roles). This underscores the importance of the socially contextual framework of symbolic interactionism outlined in Chapter 3.

4.3 Study design

In order to provide a complex and multifaceted view of the nurse educator role in acute care hospitals, a mixed method research design was chosen. This approach involves the use of both qualitative and quantitative approaches within a single study [2, 3]. The key advantage of a mixed method approach is that it enables the

strengths and minimises the weaknesses of both qualitative and quantitative methodologies within a single study, permitting a more comprehensive interpretation of the issues [4].

The NEACH study was conducted in two phases, using a sequential mixed method approach [5]. Phase 1 comprised a key informant consultation process using a group interview and individual consultation (qualitative) [6] and Phase 2 a web-based survey (quantitative and qualitative) [7].

A mixed method design was chosen because of the need to describe existing characteristics, as well as exploring issues pertaining to the nurse educator role and importantly giving participants a voice in the study process. In this study, through engaging a purposefully selected sample of key informants, specialist input could be obtained into the survey and moreover development of competency standards for nurse educators in hospitals achieved [8].

4.4 Aims

The NEACH study sought to address the research questions: what is the role and scope of practice of the nurse educator in hospitals; what are the roles and competencies of the nurse educator in Australian acute care hospitals; and what are the factors that support and enable the role of the nurse educator. This was done by addressing the following specific aims:

4.4.1 Describe the existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care hospitals in Australia.

4.4.2 Describe the contribution of nurse educators to nursing and interdisciplinary education.

4.4.3 Develop competency standards to guide nurse educator practice in acute care hospitals.

4.5 Ethical approval

Ethical approval was obtained from Curtin University Human Research Ethics Committee prior to commencing data collection (Appendix 1). Key ethical issues in this study related to participant recruitment and confidentiality. Participation was

completely voluntary and participants were reminded that they could withdraw at any time without penalty. Informed consent was obtained from each participant at the time data were collected. The investigator gave her contact details to potential participants for the purpose of providing additional information, if required, allowing for informed consent. Furthermore, participants were provided with the relevant contact details of the Ethics Committee should they wish to discuss any concerns regarding the study. Informed consent was obtained for both the group interview and the online survey.

4.5.1 Confidentiality

Consent forms and notes, meeting minutes and reports were secured in a locked filing cabinet or were maintained through password protected computer files to prevent any tampering with the data collected. Replacing participants' names with numerical codes on all study documents ensured confidentiality. Data linking the participant's identifying information and participant code were kept separate and secured in a locked filing cabinet in the research centre, and were only accessible by the investigator. Other identifying information included in the data was removed prior to analysis.

4.6 Phase 1

4.6.1 Group Interview

This phase of the study informed addressing Aim 4.4.1, Aim 4.4.2 and Aim 4.4.3. Through engaging experts, important data was derived to inform the conduct of the study.

4.6.2 Participants and sample

Studies commonly appoint expert panels or steering committees to guide and inform research [9]. The NEACH study steering committee's role (involving the key informants) was to provide expert consultation on matters associated with the study and described in its Terms of Reference (Appendix 2). Steering committees may be integral to enhancing the researcher's ability to distil interpretations of varied evidence from diverse stakeholder perspectives [9].

As the literature has limited guidelines for the selection of committee participants [10], nursing experts from education services in hospitals, academia and professional associations were either nominated by their organization, invited to be members or self-nominated. Selection was based on individual expertise and interest in the study. The committee sample comprised 14 representatives: 5 were nurse educators from private or public hospitals; 4 were from the university sector; and 5 represented professional bodies (including the Royal College of Nursing Australia, the Australian Nurse Teachers Society, the Australian Nursing Federation and the NSW Nurses Association). The committee acknowledged the need for wider engagement with public sector nursing management and subsequently, the Chief Nurse of NSW was invited to attend subsequent meetings and comment on survey drafts.

Terms of Reference for the Steering Committee (Appendix 2) and an agenda were distributed to members prior to their first meeting so that they were aware of their role in the study. Given the diverse backgrounds of committee members, current government and professional reports relevant to the study were distributed to them prior to their first meeting to inform them of current issues that may have influenced the study design.

A group interview was conducted at the first meeting. Upon arrival, each member was given an information pack containing a consent form to participate in the study and a note sheet asking them to: 'Identify the key issues impacting on the nurse educator role in Australia'. Members were invited to take the time to record their views while waiting for the meeting to commence and to add to these at any time during the meeting. Prior to the commencement of the group interview, participants were requested to provide their consent to participate in the study. Participants were also asked not to discuss comments made by other participants following the meeting so as to maintain their privacy and confidentiality. Members were also offered the opportunity not to participate if they chose not to do so. As members introduced themselves, they were asked to identify a key issue or issues impacting on the nurse educator role in Australia. A facilitator (the Principal Investigator/Primary PhD Supervisor) recorded these on a whiteboard, while the PhD student recorded these into a field journal.

Prior to any further discussion, a presentation was given outlining the study intention, literature review findings and participants' role in the process. A

facilitated group interview followed with members responding to the question posed on their note sheet (as above) in response to discussion. Identification of issues was important to inform the study to facilitate development of the survey tool to be used as the second data collection strategy. During the course of this discussion and as emergent issues were stated, feedback was provided by the facilitator to the committee so that any relationships between issues and practice could be identified and explored. The interview continued until the topic drew to a close. Each participant was subsequently invited to add any further comments or views they wished to express prior to the meeting closing. At the end of the meeting the research assistants collected the note sheets.

Two experienced research assistants were asked to be note takers and record issues identified on the whiteboard by the facilitator during the group interview. The research assistants were briefed on the aims of the project and the need to maintain confidentiality prior to the interview. They also used an observation note template to record and categorise issues emerging from the discussion. The template used headings informed by the literature review in Chapter 2: 'factors', 'enhancing', 'constraining' and 'comments' to organize data entry. Under 'factors', additional headings were also used to further clarify drivers of the issues identified. These included 'health system', 'legislation/policy', 'financial', 'social', 'professional issues', 'education system', 'workforce', and 'public demand'.

In addition, to being involved in the group interview, the committee were engaged with the research throughout the conduct of the study through email interaction verifying group processes and outcomes as depicted in Fig. 4.1.

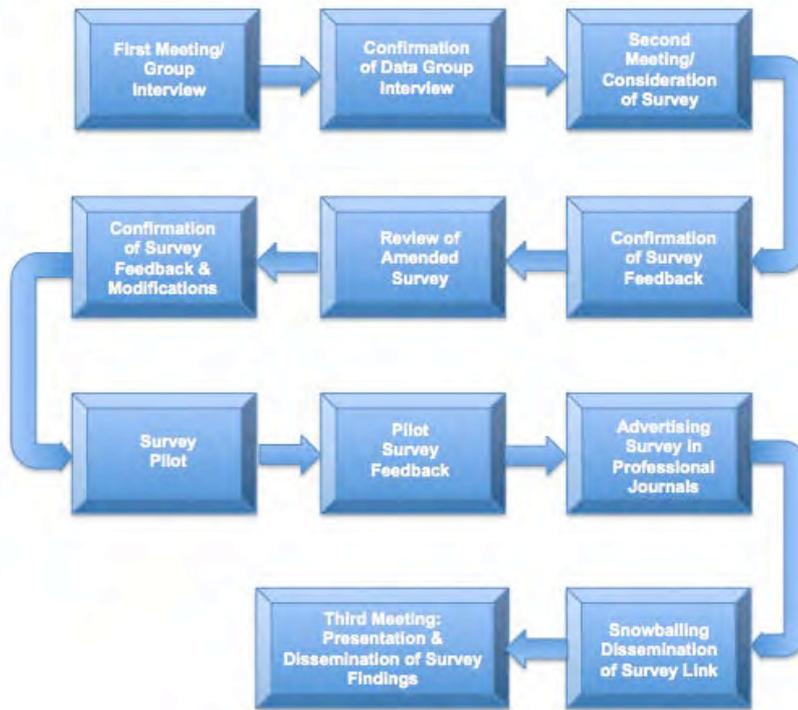


Figure 4.1 Researcher interface with Steering Committee

4.6.3 Data analysis

The researcher used the research assistants' observation notes and notes of individual participants to synthesise the discussion and determine and categorise issues emerging from the group interview. Researcher-devised headings were used to organize data. The researcher organized data under the headings 'factors', 'enhancing', 'constraining' and 'comments'. Under 'factors', additional headings were also used to further clarify drivers of the issues identified. These included 'health system', 'legislation/policy', 'financial', 'social', 'professional issues', 'education system', 'workforce', and 'public demand'. The discussion was validated with reference to the literature where possible. Use of a steering committee to guide this research was integral to the researcher's ability to distil interpretations of varied evidence from diverse stakeholder perspectives. In accord with qualitative research standards, a draft report (Appendix 3) was distributed to the Steering Committee to confirm discussions and seek feedback from members regarding the fidelity of the content. This iterative procedure strengthens research outcomes and enhanced procedural and interpretive rigour [11]. Through discussing content, reflecting on meaning and positioning of the researcher, the voice of the participants emerged.

4.7 Phase 2

4.7.1 Aims

Phase 2 of the study built upon formative data derived from the literature review and specifically sought to address Aim 4.4.1, Aim 4.4.2 and Aim 4.4.3.

4.7.2 Survey design

A survey instrument comprising both investigator developed instruments was informed by the study's conceptual model, literature review and data derived from Phase 1.

The 'Activities and Competencies of Nurse Educators' (ACONE) scale (Appendix 8) and the 'Importance of Support for the Nurse Educator Role' (ISNER) scale (Appendix 8) were researcher-developed.

Specifically, the ACONe sought to describe the daily work of nurse educators and the ISNER scale derived aspects pertaining to goals.

The other two instruments were internationally recognised data collection tools; namely the Nurses' Retention Index (NRI) [12] and the Professional Practice Environment scale (PPE) [13] (Appendix 8). Permission was obtained from the researchers to use the NRI and PPE instruments in the survey (Appendix 4 and 5). Psychometric properties of the NRI and the PPE are described below as well as the procedure for developing and evaluating the ACONe and ISNER.

4.7.3 Sample

The study used a national, descriptive, cross-sectional survey method using a convenience sample of nurses working as educators in acute care hospitals across Australia. Although surveys are an established method of data collection in research, a web-based strategy was chosen for this study as it offers a unique methodological tool for data collection in nurse education research and can cost-effectively engage large cohorts of geographically disparate nurse educators [10].

4.7.4 Web-based survey

As a data collection strategy, the web-based survey is advantageous over other methods as the format is considered to be easy to follow [14]. Contrary to this is

the potential for complex web page design resulting in poor response rates [15]. Sample bias is another consideration, subject to the target population's access to the internet and levels of computer literacy [16].

The study sample may be considered to be familiar with web-based platforms as these technologies are often used in nurse education [10]. However, because internet access in rural Australia is variable, postal surveys were also distributed to facilitate survey access in areas where the internet may not have been available.

4.7.5 Item generation

Survey items were generated from the synthesis of an integrative literature review as reported in Chapter 2, and subsequent consultation with the committee through a group interview as identified in the preceding discussion [17]. The theoretical framework discussed in Chapter 3 guided generation of items.

The committee group interview ($n=14$) identified barriers and facilitators to the nurse educator role from historical perspectives and contexts of practice, professional education, career pathways and policy. The committee also identified organisational considerations, similarly noted in the literature review. These include the dilution of clinical expertise in hospitals, the fragmentation of nursing roles and responsibilities, as well as funding and rural contexts [17]. These issues challenge the provision of nurse education in some hospitals and were explored in the survey to inform future role development. The initial survey comprised 105 items from these sources.

The survey had eight sections: (i) socio-demographic and educational preparation (17 items); (ii) reporting and performance (17 items); (iii) activities and competencies (36 items); (iv) career intentions (6 items); (v) professional practice environment (38 items); (vi) workplace issues (8 items); (vii) self-appraisal of performance (1 item); and (viii) role enactment (14 items). A single open-ended item was included at the end of the survey to capture individual respondent comments. These components are found in Figure 4.1

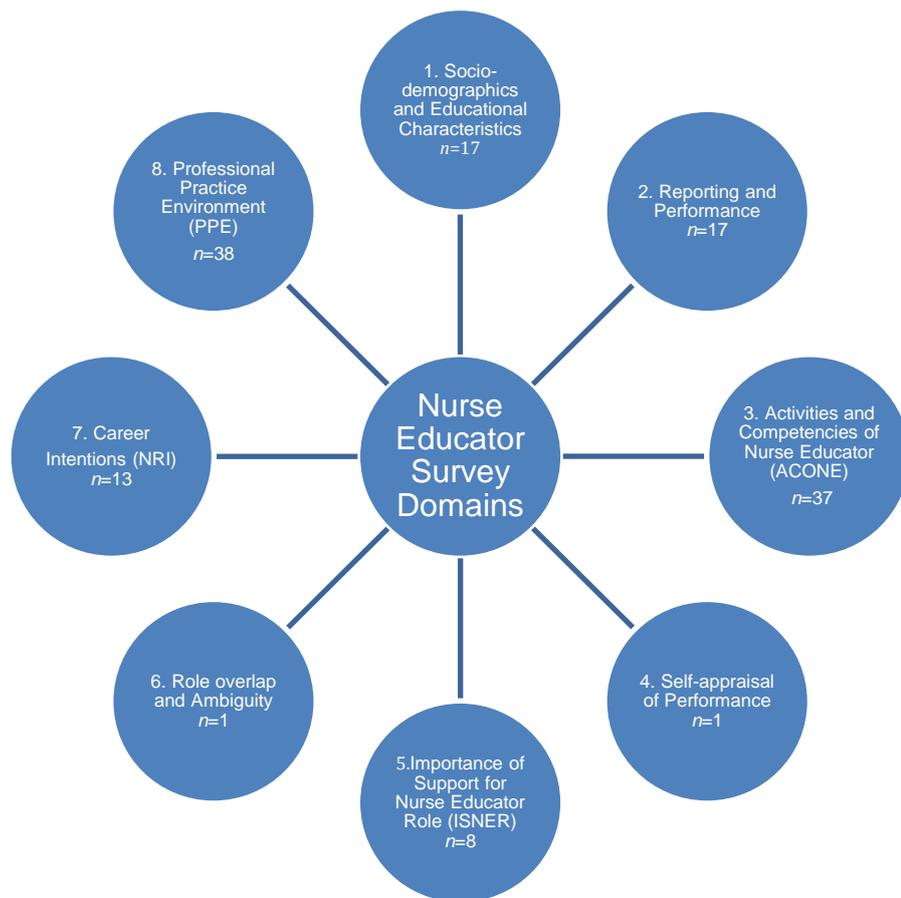


Figure 4.2. Nurse educator survey domains

Participant Information Sheet and Consent

Participant information (Appendix 7) was made available to respondents prior to accessing the survey. The first item (Question 1) within the survey was designed to identify whether or not respondents had read the participant information (Appendix 7) prior to providing consent. The second item (Question 2) was designed to obtain respondent consent prior to accessing the survey. The survey tool is located in (Appendix 8).

Socio-demographics and Educational Characteristics and Performance & Reporting. (Survey questions 3 to 28 inclusive)

The purpose of the items within these two domains was to determine socio-demographic (Questions 3-11), education (Questions 20-28) and reporting and performance (questions 12-19 and 35 and 36), characteristics of respondents, Items were generated by the researcher and used categorical responses.

Activities and Competencies of Nurse Educators (ACONE) scale (Survey questions 29 to 33 inclusive and 37 and 38)

The Activities and Competencies of Nurse Educators (ACONE) scale was generated from existing nurse educator competency statements [18-20] and eight position descriptions voluntarily forwarded to the researcher from a range of Australian hospitals. The purpose of the ACONe scale was to elicit the activities nurse educators engaged in and the scope of practice of nurse educators through competency statements. The intention being that these competencies could then be validated and used for self-assessment of performance and to guide practice and role development. The activities of nurse educators were identified through questions 37 and 38 using Likert scales.

Likert scales are commonly used in research to rank responses from high to low [21]. The ACONe and remaining domains used Likert scales. The Likert scale is an interval scale requiring respondents to nominate the category that best describes their response to the item being rated. The scale uses end points measuring, for example, the degree of agreement with statements ranging from 'strongly disagree' to 'strongly agree' allowing a descriptive account of the expanse and diversity of their work [7]. Using an 11-point response format, respondents identified time taken for specified activities - 0 denoted nil per cent time spent and 10 denoted 91-100% time spent each week on the nominated activity.

The criteria for these questions are presented in Table 4.1.

Table 4.1 Activities of nurse educators

ACTIVITIES OF NURSE EDUCATORS
Question 37 What percentage of time do you spend undertaking the following activities each week?
Providing direct clinical care
Clinical teaching
Competency assessment
Curriculum development
Education program planning & co-ordination
Classroom teaching
Relief of other nursing roles
Question 38 What percentage of time do you devote to educational activities provided to the following groups (% of hours per week)?
Nurses
Non health professional staff
Nursing students (baccalaureate program/university)
Nursing students (vocational training/TAFE)
Volunteers and community members
Other health professionals

The criteria statements for nurse educator competencies follow in Table 4.2.

Table 4.2 Competencies of nurse educators

COMPETENCY CRITERIA (Survey Questions 29-33)
Subscale 1. Engages in curriculum and program development and evaluation
Facilitate the development, implementation and evaluation of curriculum and educational programs incorporating professional standards, attitudes and values that reflect contemporary nursing practice
Collaborate with others in the development and delivery of nursing and interprofessional education programs
Integrates educational theory and evidence based approaches in teaching and education
Engage in the development and delivery of undergraduate or postgraduate tertiary programs
Participate in programs to facilitate clinical practice
Subscale 2. Facilitates effective learning
Recognise and identify the needs of individual learners and provide resources and support to facilitate learning
Use a variety of teaching strategies appropriate to learner needs and contexts in supporting the teaching-learning process
Foster opportunities for learners to develop their critical thinking and critical reasoning skills
Monitor and provide feedback to learners regarding educational achievement
Facilitate the development of professional behaviours and role socialisation
Promote positive learning environments through effective collegial working relationships
Facilitate learning activities to promote teamwork and interprofessional practice
Subscale 3. Educational and clinical leadership
Act as a role model, engaging in self-reflection, modelling critical and reflective thinking
Work as an expert clinician in the clinical setting
Engage in mentoring and motivating novice practitioners and other staff
Provide leadership in the ongoing review of education and clinical practice at a facility or regional level
Undertake primary responsibility for the planning and implementation of specialist clinical education in your hospital or health service

Provide leadership in the ongoing review of clinical education practice for a more complex service, such as a service provided at multiple sites
Assume leadership roles which promote broader advancement of clinical and education practice
Provide leadership in state, national and international nursing bodies or specialist clinical and interprofessional groups
Initiate collaborative ventures with academic colleagues
Subscale 3. Educational and clinical leadership continued
Contribute to formal service and strategic planning processes within your organisation
Provide ongoing analysis of current education and nursing practice and the impact of new directions on your clinical specialty or education service
plan implement and evaluate annual plans for your nurse education service
Manage complex projects relating to significant education and nursing practice change for your organisation
Monitor clinical outcomes in relation to educational activity
Subscale 4. Continuous quality improvement
Aware of current professional trends through your involvement in professional organisations
Involved in professional development activities to improve your performance
Demonstrates cultural competence by incorporating cultural beliefs and practices in teaching & learning
Uses feedback from learners, peers and your manager to improve role effectiveness
Uses clinical practice and outcome data to inform educational interventions
Subscale 5. Research and Scholarship
Uses evidence to inform educational programs to improve nursing practice
Incorporates findings from published studies in the development of evidence based teaching & simulation
Develops proposals or submissions for program development, policy and research
Manages clinical practice improvement projects
Initiates original research projects
Disseminates own research results through specialist publications and presentations

Self Appraisal of Performance Question 34: 1 item

The purpose of the self-appraisal of performance scale was to elicit respondent perceptions of their performance. The development of this scale was informed by position descriptions voluntarily supplied to the researcher by nurse educators. Self-appraisal of performance was assessed using a single-item measure with 0 depicting perception of poor performance and 10 depicting excellent performance.

Importance of Support for the Nurse Educator Role (ISNER) scale Question 39: 8 items

The development of this scale was informed by the literature review and data obtained from Phase 1. The aim of the scale was to determine whether or not the issues identified as being important factors impacting on the nurse educator role and future role development requiring support through policy and practice change, were representative of nurse educators' views. The scale criteria were developed from the literature review and opinions expressed in the group interview by key informants who were members of the Steering Committee. An 11-point Likert scale was used with 0 denoting the items to be of very low importance and 10 denoting they were very important factors impacting the nurse educator role.

Table 4.3 Importance of Support for the Nurse Educator role

Question 39. The nurse educator role is facing many challenges and opportunities. Please rate the importance of the following factors in developing and supporting the nurse educator role.
Increasing the focus on inter-professional teaching and learning
Developing strategies to promote an advanced practice role-promoting initiatives to foster teamwork team work and multidisciplinary care
Addressing factors relating to skill mix diversification in the nursing workforce
Endorsing the interface between health care setting and educational practices
Increasing the focus on research and scholarship
Linking nurse education activities to demonstrable patient outcomes
Advancing the nurse educator role within the profession

The Nurses Retention Index (NRI) (Survey questions 40 - 42 inclusive: 13 items)

Retaining the nursing workforce is a complex issue with several influencing factors [22-24]. These factors include job stress, remuneration and satisfaction with role enactment. These factors are considered to be important measures of workplace satisfaction. The Nurses' Retention Index (NRI) [12] was developed and validated by Cowin and colleagues specifically for the Australian context to determine nurses' intention to stay in the workforce. The NRI is a 6-item measure of career intentions, using an 8-point Likert scale. The NRI has a Chronbach alpha of 0.96 in initial validation [12]. The NRI was included in the test battery, as the researcher believed it was important to examine the retention attitudes of nurse educators. In this 6-item measure of career intentions, respondents reported on their job plans for the following 12 months using an 8-point Likert scale.

Table 4.4 Nurses Retention Index [12]

Item No.	Item
1	It is my intention to continue with my nursing career in the foreseeable future
2	I would like to stay in nursing as long as possible
3 R	As soon as it is convenient for me I plan to leave the nursing profession
4	I expect I will keep working as a nurse
5	My plan is to remain with my nursing career as long as I am able
6 R	I would like to find other employment by leaving nursing

R = Reverse scored items

Professional Practice Environment scale (PPE) Question 43: Items: 38

The Professional Practice Environment scale (PPE), developed by Erickson and colleagues, was comprised of 38 items and is a standardised nursing research instrument developed to measure nurses' work satisfaction within their practice environment [13]. The PPE scale was selected for inclusion in the survey because it was developed and validated by nurses working in acute care hospitals and was therefore generally considered to be reflective of the respondents' workplaces.

Because the instrument had not been tested with nurse educators previously, further psychometric evaluation was undertaken. The PPE has an alpha coefficient of 0.93 [13]. This scale contains eight subscales: handling disagreement and conflict; internal work motivation; control over practice; leadership and autonomy in clinical practice; staff relationships with physicians; teamwork; cultural sensitivity; and communication with patients. A Likert scale from 1 to 4 is used to rate agreement with the eight domains [13]. As psychometric evaluation is an ongoing and iterative process it was considered that evaluation within this particular setting would be undertaken as outlined in 4.11.1.

Table 4.5 Professional Practice Environment Subscales and Items [13]

Item No.	Item
<u>Subscale - Handling disagreement and conflict</u>	
21 R	When staff disagree, they ignore the issue, pretending it will go away.
22 R	Staff withdraw from conflict.
23	All points of view considered in finding best solution to problem.
24	All staff work hard to arrive at best possible solution.
25	Staff involved don't settle dispute until all are satisfied with decision.
26	All contribute from their experience, expertise to effect high quality solution.
27 R	Disagreements between staff are ignored or avoided.
28	Staff involved settle disputes by consensus.
<u>Subscale - Internal Work Motivation</u>	
29	My opinion of myself goes up when I work on this unit.
30	I feel a great sense of personal satisfaction for the work I do.
31	I feel a high degree of personal responsibility for the work I do.
32	I have challenging work that motivates me to do the best job I can.
33	Working on this unit gives me the opportunity to gain new knowledge and skills.

34	I am motivated to do well because I am empowered by my work environment.
35	Working in this environment increased my sense of professional growth.
<u>Subscale - Control Over Practice</u>	
5	Patient care assignments that foster continuity of care.
6	Adequate support services allow me to spend time with patients.
7	Enough time and opportunity to discuss patient care problems with other staff.
8	Enough staff to provide quality patient care.
10	Enough staff to get the work done.
11	Opportunity to work on a highly specialised patient care unit.
14	Not being placed in a position of having to do things against my professional judgment.
<u>Subscale - Leadership and Autonomy in Clinical Practice</u>	
1	Leadership supportive to department or unit staff.
2	My discipline controls its own practice.
3	Freedom to make importance patient care and work decisions.
9	A manager who is a good manager and leader.
12	Manager who backs up staff in decision making, even in conflict with MD.
<u>Subscale - Staff Relationships with Physicians</u>	
4	A lot of team work between physicians and staff.
13	Physicians and department or unit staff have good relationships.
<u>Subscale - Teamwork</u>	
17	This unit has constructive relationships with other groups in this hospital.
18 R	This unit doesn't get cooperation it needs from other hospital units.

19 R	Other hospital units seem to have a low opinion of this unit.
20 R	Inadequate working relationships with other hospital groups limit effectiveness of work on unit.
<u>Subscale - Cultural Sensitivity</u>	
36	Staff have access to necessary resources to provide culturally competent care.
37	Staff are sensitive to diverse patient populations whom they serve.
38	Staffs are respectful of their unit's diverse health care team.
<u>Subscale - Communication About Patients</u>	
15	I get information on patient's status when I need it.
16	When patient's status changes, I get relevant information quickly.
R = Reverse scored items	

Open Ended Item (Question 44)

The final item, an open-ended statement, asked respondents: “If there are any comments you would like to share regarding the nurse educator / clinical nurse educator role please feel free to make the comments below.” Given that much of the survey questionnaire focused on the type (what) and quantity of work (how much?) of nurse educators, this free text response allowed respondents to provide a descriptive account of the expanse and diversity of their work. Providing participants with a chance to voice their opinions was important as well as gleaning new information.

4.8 Survey pilot

The survey was initially piloted within the steering committee and two subsequent phases of iterations occurred within this group. Free text fields were provided to identify sections that were not clear, omissions or redundant items. A second pilot test was undertaken with another expert group of nurses working as nurse educators ($n=9$). This group completed the survey online and identified questions about potentially ambiguous and redundant content. A free text item asking respondents to evaluate the content of the survey was used to assess content

validity. This pilot group also identified issues relating to survey item clarity, overall layout and time required to complete the survey, to consider potential respondent burden.

In response to feedback from all stakeholders involved in the pilot survey, individual item modifications occurred and the number of items was expanded from 105 to 138 items. This allowed for the inclusion of additional items pertaining to nurse educator activities, competencies, reporting and performance, and workplace challenges enabling or hindering the role.

4.9 Survey distribution

As a national register of nurse educators does not exist in Australia, survey respondents were targeted through nurse leaders, peak nursing organisations and networks including the Australian Nurse Teachers Society, Royal College of Nursing Australia, Australian Nursing Federation and the NSW Nurses' Association. Importantly, the survey was not restricted to members of professional organisations. The study was advertised (Appendix 6) through professional nursing web sites, nursing journals and publications to ensure wide dissemination. Interested educators were invited to notify the researcher by email so that a database of potential respondents could be constructed. Nurse leaders (Chief Nursing Officers) in each state and territory were also requested to disseminate the survey website link to nurse educators in acute care hospitals. Further distribution occurred through snowball sampling [25]. Snowball sampling is the process whereby participants may be nominated by others or referred to a study by other study members [25].

An administrative assistant under the supervision of the researcher identified 356 acute care hospitals nationally through hospitals lists. Hard copies of the surveys were posted to these hospitals. The rationale for posting the surveys were four fold: (i) some nurse educators may not have access to a computer at work; (ii) internet access in some rural areas in Australia is known to be poor, potentially preventing some educators in these areas from responding [10]; (iii) to capture respondents who may not have otherwise received the survey; and (iv) to minimise the potential for sample bias associated with information-technology savvy respondents [16]. Distribution strategies are identified in Table 4.6

Table 4.6 Survey distribution strategies

Distribution strategies
Emailing web link to registered participants on the database
Snowball sampling through the expert Steering Committee and by inviting respondents to disseminate the invitation to their work colleagues and through professional networks
Posting hard copies of the information sheets and the surveys to acute care hospitals (identified through hospital lists).

4.10 Data collection

The web-based survey was administered through Survey Monkey, a commercial platform with data encryption. Data collection took place over a 4-month period between October 2009 and January 2010. The elimination of geographical barriers, characteristic of web-based surveys facilitated access to educators across Australia in urban and rural locations [10]. The web-based survey also accommodated respondent anonymity as no identifying data were collected. Posting hard copies of the survey to acute care hospitals Australia-wide ($n=356$) circumvented potential issues with limited access to the internet. Hard-copy surveys $n=43$ were either faxed ($n=4$) or posted ($n=39$) to the researcher and any origin-depicting information was removed prior to online data entry.

4.11 Data analysis plan

A description of the data analysis steps undertaken for both the quantitative and qualitative data are provided below.

4.11.1 Quantitative data analysis

On completion of the data collection period, the following steps were undertaken: data were imported from Survey Monkey to Microsoft Excel and downloaded into the Statistical Package for Social Sciences (SPSS) for Windows Version 18. The accuracy of data download was checked by crosschecking a random sample of

surveys (n=14). Data were rechecked and all reported data were successfully downloaded. Descriptive statistics (frequencies, mean, standard deviation (SD), and range) were undertaken to summarize each of the study items. As the ACONE and ISNER were investigator developed a series of analyses were undertaken to assess reliability and validity. Furthermore the factor structure of the PPE was determined. Internal consistency was measured using Chronbach's alpha to discrete the correlation of items within a single instrument. Factor analysis was undertaken to examine the relationship between latent, unobserved variables. Principal Component Analysis (PCA) was undertaken to assess whether the assumptions of the constructs were represented in the measures used [26]. In order to determine the relationship between explanatory and predictor variables, logistic regression analysis was undertaken [26]. Modeling with logistic regression was undertaken to test the theoretical sets of predictor variables thought to contribute to role clarity, function and a higher regard for the practice environment. The following hypothesis were then proposed: does the presence or absence of satisfaction with the professional practice environment relate to whether or not the nurse educator had: a master's qualification; regular meetings with their line manager; professional development and learning needs identified; and the length of time they had in their role as a nurse educator. Values of $p < 0.05$ were considered statistically significant. These techniques allowed the derivation of a hypothetical model to describe factors contributing to the satisfaction of nurse educators in the acute care setting.

4.11.2 Qualitative data analysis

Data analysis and synthesis was undertaken using a general inductive approach to identify themes within text data arising from the group interview notes and responses to the open ended questions in the survey. Data were read line by line and meaning derived. The inductive approach involved coding and recoding text from multiple pages of text to segments, then large numbers of categories until finally between 3 and 8 themes emerged [27]. During this process of thematic analysis, the researcher looked for patterns and irregularities within the data [28]. Moreover, the study questions provided a guide for the analysis and final coding.

4.12 Researcher rigour

The importance of researcher rigour cannot be underestimated if valid conclusions are to be drawn from the research [28]. Strategies used to enhance rigour were considered as part of the data collection and analysis processes. These included documenting the researcher's frame of reference, utilising a mixed method design, engaging in peer debriefing and researcher engagement in the study context. A description of these processes follows.

4.12.1 Researcher's frame of reference

The researcher, formerly a nurse educator in acute care and a manager of nurse education in an area health service, approached the study with an established frame emanating from these experiences. The researcher had previously been involved in educating undergraduate and postgraduate nurses at the bedside, education program and curriculum development and accreditation and implementation and evaluation within a ward, hospital and area health service. These roles also included facets such as role model, mentoring new educators, staff management, team building, financial management, as well as establishing and maintaining networks and relationships with key internal and external stakeholders. As such, she brought to this project an understanding of the position and its challenges.

The researcher role, however, required a shift from providing information to collecting and analysing it. This role transition required continual reflection to ensure that participant's perspectives were reflected. Interactions with educators, other researchers and professional groups facilitated additional insight into the researcher's frame of reference. These insights occurred throughout data collection and analysis and were diarised.

4.12.2 Synthesising data in a mixed method approach

The use of multiple methods in the study is important to overcome the potential for bias that may occur in single-method designs [7]. Combining qualitative and quantitative methods within this one study provided a fuller picture of the nurse educator role [6]. This process is known as triangulation [6]. Triangulation is not only a means of confirming data but also ensuring that the data was complete

maximising the information collected regarding the phenomena under investigation [6]. Method outcomes were complementary and revealed converging themes during data analysis and also addressed issues in promoting rigour. Findings are presented discretely in order to increase clarity of presentation and then data are combined to allow the interface of the complimentary lens afforded by a mixed method approach.

4.12.3 Peer debriefing

To facilitate rigour, data from the interview and qualitative data were disseminated to the research team (comprising the researcher and two other experienced researchers) prior to thematic analysis. Congruence between researcher perspectives was examined through three researcher meetings to discuss analysis and contrast findings.

4.12.4 Researcher immersion in study context

Researcher engagement with the study context and study participants contributed to credible data development [7]. Throughout the data collection phase of the study the researcher actively engaged with nurse educators in acute care hospitals through the presentation of information sessions at forums and professional evenings. This facilitated researcher insight into organisational culture and context as well as allowing the researcher to observe professional interactions between educators and others.

4.13 Conclusion

This chapter described the application of a mixed method using a sequential approach [7]. Ethical considerations and the application of web-based surveys in research were discussed along with the rationale for choosing this approach. Survey development processes, implementation and data analysis techniques were detailed, as were methods used to protect participant anonymity, privacy and confidentiality. Finally, strategies used to enhance trustworthiness of the findings were identified. The following chapter presents findings of the NEACH study.

4.14 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 5 – Results Part 1

5.1 Introduction

The premises of role theory and symbolic interactionism have framed the study design and also study interpretation. Specifically this enables an approach to examine how nurses' professional identity develops within specific organizational characteristics. Nurse educators, academics, professional bodies and health authorities all have integral roles to play in supporting clinical education and continuing professional development in the clinical setting. Each of these actors in this dynamic bring with them beliefs, attitudes, values, experiences, and philosophical perspectives about nurse education and the nurse educator role. The relationships between these stakeholders are critical for continually improving nurse education and optimizing the nurse educator role in clinical learning environments. At an individual level, a nurse educator's values, attitudes, beliefs and aspirations are linked to the role they play within the organisation and the nursing profession. These issues are investigated through the qualitative findings of the steering committee group interview and comments made by nurse educators within the survey. The two qualitative sources are discussed individually and then collectively.

5.2 Qualitative Results Group Interview

The steering committee comprised 14 representatives including nurse educators, academics and representatives from nursing professional bodies. A detailed description of committee selection and group interview data collection and analysis procedures were discussed in Chapter 4.

Inductive analysis [1] of the group interview data revealed commonality among the respondent perceptions of issues influencing the nurse educator role. Three central themes emerged: (i) challenges in enacting the role; (ii) education; and (iii) policy and funding.

5.2.1 Challenges in enacting the role

Historical perspectives

The committee discussed how issues pertaining to the nurse educator role have

been ‘simmering under the system’. Stressors on the health system such as increased workforce diversity and nursing shortages may have made the issue more acute. One member commented that this was one nursing role “...*significantly impacted by history*”.

Until the mid-1980s schools of nursing were primarily located within hospitals. Under this structure, it was perceived that nursing education and clinical staff worked together. However, the transfer of nurse education to the university sector saw a division between clinical practice and education.

Visibility

The committee concurred that the role is becoming increasingly invisible in the clinical arena and that this is associated with role erosion and a loss of identity. They cited poor promotion of the role to other health professionals as a contributing factor along with role redundancy and expendability, as when “...*budget issues occur the CNE [Clinical Nurse Educator] is the first to go*”.

Role definition

It was reported by the steering committee that seemingly no standard definition for the role applies among nurse educators and the nursing profession across the sectors, or by the Nursing and Midwifery Board of Australia [2]. This causes confusion within the nursing profession, health authorities and government. As one member stated, there is a:

‘...need to get the terminology right, especially in the political/policy spheres and then expanding this in the health community and broader community.’

There is an apparent lack of understanding regarding role expectations and performance at an individual and organizational level. The role is not always well supported, with some educators creating their own role and writing their own job description. Others may report to a clinical manager as opposed to a manager who has education experience.

Multiple titles exist for nursing education positions. Nurse educators, clinical nurse educators, nurse consultants, staff development nurse, are but a few examples [3]. Their primary function is to conduct education in hospitals while some (few) engage in research. It was clear that there are divisions between these roles,

particularly for nurse educators and clinical nurse educators. Clinical educators for example, may be based in an education department. They are often ‘pulled out’ of the education environment and ‘thrown’ into the clinical environment where their role is misunderstood. Another issue underscored by the data was the lack of synergy between clinical environments and academia.

The Steering committee concurred that although defining the role can be problematic, it is important to do so and to ensure standardization of the definition/s along with the systems and processes necessary to achieve this. It was agreed that a core set of principles would be required.

Role dilution in rural contexts

The committee concurred that any change to the role needs to be sufficiently flexible to meet the diverse contexts of practice and workforce requirements. Although nurse educators are employed in most city hospitals, in rural areas, disparities are evident. Some rural centres have no educator or limited availability of educators across a hospital or service. In some circumstances the nurse educator also has responsibilities for other portfolios. For example, in rural areas a nurse educator may also assume other roles such as infection control or quality manager.

Multidisciplinary role

This element of the discussion considered the:

‘...oligopoly of health. That is the entrenched idea within the Australian healthcare system that medical professionals are the team leaders.’

The committee observed that this constrains nursing in Australia and as a consequence, nurses have difficulty being autonomous. Some nurse educators found it difficult to promote a code of conduct and be a leader to other nurses when they were required to act as “...multidisciplinary police officers...”, policing the conduct of medical staff.

5.2.2 Education qualifications and career pathways

Within this discussion committee members spoke of the need for educators to have a greater understanding of educational theory, principles and practice and the use of appropriate language associated with education. As one member

commented, “*The use of the word ‘training’ devalues the work we do.*” They also highlighted the importance of recognizing that teaching is not the exclusive domain of nurse educators, but a requirement for all registered nurses and some specialty roles. This may be perceived as duplication of effort and lead to conflict where staff and management may perceive that there is no need for staff to have attained postgraduate qualifications in education as well as devaluing education. They also spoke of growing interest in interprofessional learning.

Qualifications

Although education requirements for the role are not mandated, inconsistencies regarding requirements for educational attainment were highlighted. It was explained that some employers required nurse educators to have a master’s degree in education, whereas others required a certificate level qualification. As nurses are educated at the baccalaureate level in Australia, the requirement for nurse educators to attain an educational qualification at a lower (certificate) level is contradictory and de values the higher qualification already obtained. It was suggested that a framework is necessary to facilitate standardization of the role and requirements.

Career pathways

The steering committee asserted that a career path has not been identified. They raised in discussion the importance of clarification of role-related education requirements to support the development of career pathways.

5.2.3 Policy and funding

Funding for positions around the clock

There was consensus within the committee that current funding restricts the role being implemented across all shifts, as stated here:

‘...[we] don’t have 24/7 coverage of clinical nurse educators as a result of budget constraints. Education is needed around the clock not just [during] business hours.’

The committee also identified the need for increased funding for clinical nurse educator roles to support undergraduates as well as nurses who are returning to the workforce.

Salary disparities devalue the role

Disparities in salary were raised in the context of role requirements. Nurses are sometimes appointed to the role without postgraduate qualifications and receive the same salary as an educator with postgraduate qualifications. This was also seen to devalue the role and the importance of staff being appropriately qualified. Differences in salary between an educator and other nursing roles were highlighted by this comment:

'How can you attract/motivate people to the role without financial stimulation?'

Another viewpoint expressed was the relationship between job status, income and power or authority:

'Salary is related to status, and status is related to power.'

The qualitative data findings detailed were also recorded in a report of the Steering committee group interview that can be found in Appendix 3. These data were used to inform the development of survey questions. Data specifically informed survey items allowing for further exploration of contexts of practice, role diversity, educational qualifications, as well as retention and the influence of the organization on role enactment.

5.3 Qualitative Results – Web-Based Survey

The collection of qualitative and quantitative data was undertaken concurrently. Qualitative data arose from the following free-text open-ended survey item asking: "If there are any comments you would like to share regarding the nurse educator/clinical nurse educator role please feel free to make the comments in the section below."

Of the total survey respondent group ($n=425$), 165 (38.3%) responded and were pleased to have the opportunity to express their views as demonstrated by examples of feedback within the survey comments shown in Figure 5.1



Figure 5.1 Study feedback from nurse educators

5.3.1 Thematic analysis

An inductive approach [1] to data analysis was used as described in Chapter 4. The three themes that emerged from the data related to the nurse educator role are shown in Figure 5.2 below. The following discussion identifies these themes and subthemes incorporating written comments transcribed verbatim from the survey.

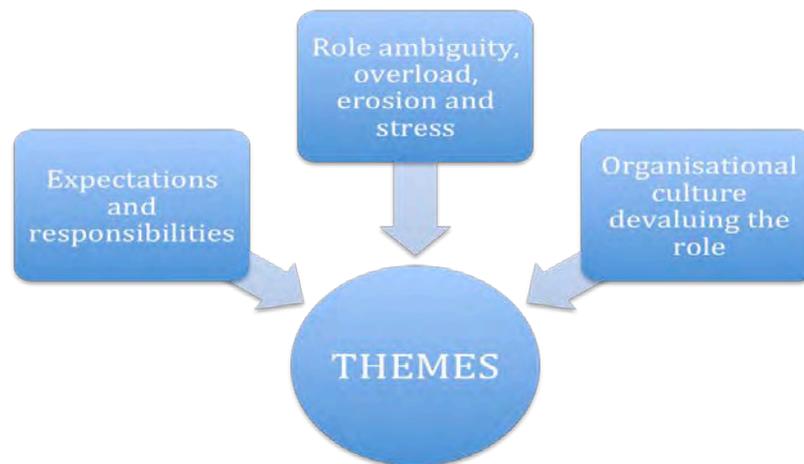


Figure 5.2 Themes emanating from survey qualitative data analysis

5.3.2 Theme 1: Expectations and responsibilities

Nurse educator roles, titles and functions are unclear across practice environments [3]. The nurse educator role is multifaceted and diverse, and dependent on context (geography, needs within a service or area health service, staffing, learning needs). The role and scope of practice for nurse educators in Australia is also unclear [3] and further exemplified through the free-text responses.

In the 'Expectations and responsibilities' theme, six subthemes have emerged: (i) variations in role descriptions from ward to ward and hospital to hospital; (ii) providing education requires specialized knowledge (iii) management support and structure; (iv) critical skills for nurse educators; (v) inadequate opportunities dissuade retention; and (vi) changing priorities. Theme 1 subthemes and issues raised in each are summarized in Table 5.1 below.

Table 5.1 Theme 1: Role expectations and responsibilities

Subthemes	Issues
Variations in role descriptions from ward to ward and hospital to hospital	<ul style="list-style-type: none"> • Contexts of practice • Wearing many hats • Role not clearly delineated • Clinical nurse educator role • Nurse educator role • Valuing the role • Job satisfaction
Providing education requires specialized knowledge	<ul style="list-style-type: none"> • Specialised education qualifications • Conceptions and misconceptions
Management support and structures	<ul style="list-style-type: none"> • Reporting structures
Critical skills for nurse educators	<ul style="list-style-type: none"> • Expert clinician • Expert educator • Co-ordinating clinical placements • Change agent • Researcher • Support person • Committee member • Student supervisor • Recruiter • Problem Solver
Inadequate opportunities dissuade retention and role sustainability	<ul style="list-style-type: none"> • Limited opportunities for continuing professional development • Need for mentoring and role support

	<ul style="list-style-type: none"> • Remuneration disparities • Shortages of educators are a universal trend.
Changing priorities	<ul style="list-style-type: none"> • Policy, regulation and professional recognition • The big picture – implications for policy

Variations in role descriptions from ward to ward and hospital to hospital

In this subtheme, educators commented on their contexts of practice and the associated expectations and responsibilities (their own and others) that may ensue. They also identified facets of the clinical nurse educator and nurse educator role from their own experiences. Others have spoken about how the role is positively valued in some clinical units and organizations.

Contexts of practice

Perceptions of role enactment in varying contexts of practice are illustrated through the following comments from nurse educators working in acute care hospitals in rural areas. These comments identify the complexity of the role covering several facilities or clinical areas, as opposed to an educator in a metropolitan hospital who may cover only an individual unit.

'The role of the nurse educator in regional and remote areas is very different in some ways to the metropolitan role. The regional Nurse Educator is responsible for many clinical areas, with diverse clinical requirements. I cover from a generalist medical ward to the specialist units overall approx. 192 staff. I also have program accountabilities such as undergraduate placements training for supervision, competency assessment and development etc etc for the entire health service - approx. 500 staff.'

Wearing many hats

Role diversity is even more pronounced in regional and rural contexts where the education function may be one of multiple functions or 'hats' that the nurse educator assumes responsibility for.

'My role is in a regional base facility. I also work in a role where a large percentage of my time is

taken up with management functions which is a result of being a bit of a jack of all trades due to a smaller facility.'

Differences in contexts of practice also affect role responsibilities. In this example an educator provides education to many units across a hospital or provides programs for all staff as opposed to providing education to one unit:

'The nurse educator in smaller facilities i.e. between rural and metropolitan size usually provides services related to their expertise to a facility as opposed to just one ward.'

Role not clearly delineated

Job descriptions were not reported as a strategy for distinguishing roles. Role definitions, role blurring and ambiguity, lack of communication about role descriptions, lack of role differentiation between nurse educator and clinical nurse educator roles, and unrealistic role expectations were cited as barriers to role enactment.

As this nurse educator has pointed out, role definitions are not finite but vary considerably:

'I feel there are great variations in the definition of Nurse Educator from hospital to hospital and even ward to ward.'

Role expectations also vary according to organizational structures and staffing. The following two respondent comments note that expectations of the nurse educator may increase in response to these factors.

'...The roles of the CNE and NE are not clearly delineated and this can lead to additional pressure and demands for the NE role.'

'Hospitals all seem to have different models related to clinical nurse educators. Whilst the education unit may be supportive and provide challenging work/structures, the clinical area or general nursing on the wards may vary enormously. The work of clinical educators is directed by a multitude of stakeholders ranging from management, individual nurse unit managers, medical staff and the education unit

managers and hence is complex, subject to change (with accreditation for example the role swings heavily toward supporting the facility attempt for reaccreditation).'

Clinical nurse educator role

The clinical nurse educator role is also multifaceted and involves the education of staff at many levels, including undergraduate students and registered nurses. This role may be attached to an individual ward or unit. Within this diverse skill mix the clinical nurse educator needs to be able to determine and support the individual learning needs of staff. Where job sharing of the clinical nurse educator role occurs, the individual professional expertise of the educators' offers extra strengths in targeting the specific educational needs of staff.

'We have two full-time positions shared between four of us each with our own specialty and areas of interest.'

Nurse educator role

The nurse educator role has a different focus to that of the clinical nurse educator. The nurse educator may work in a divisional structure and have responsibility for educating staff across several units within that structure. In addition to this, the educator may be responsible for managing and conducting education programs for the hospital or an area health service. This role provides education to staff from the time they commence employment at the facility, on a regular basis through mandatory education, as well as programs that focus on the needs of a specific group such as new graduates.

In the following comments, the nurse educator described and defined parameters of their role.

'I work within a divisional structure and act as a nurse educator for many work units. I also have portfolio responsibilities that encompass the whole organization (e.g. orientation, mandatory training, coordinate new graduate program). Role is spread across organization – support many units and along a continuum of employment.'

Another component of the role includes competency assessment. This may relate to the assessment of competencies of student nurses, new graduates, post-graduate students, as well as registered nurses who may for example have learnt a new procedure. In circumstances where a nurse is not performing satisfactorily, competency assessment may also be used as part of the performance review process or to diagnose learning needs.

Another respondent identified other elements of the role where the focus is supporting development of clinical knowledge and expertise along with performance assessment. The focus is not clinical teaching. Distinctions between the nurse educator and other roles with education responsibilities such as the Clinical Development Facilitator are raised.

'The Nurse Educator supports the clinicians to develop their theoretical knowledge based on best practice guidelines, whilst the CDF (clinical development facilitator) does the day to day clinical teaching. The involvement of the nurse educator in the clinical environment is more with poor performance management and competency assessments associated with poor performance.'

To achieve role clarification, this educator voiced a vision for nurse education services in their hospital to include a manager role:

'There is a blurring of role definition. I see an extra structure / level, that of education Manager / Coordinator and feel each separate department need a CNE specific to that department, with an overarching coordinator / manager.'

Valuing the role

Successful role relationships were associated with valuing the role, teamwork, and workplace culture and morale. In the following description the role is highly valued by staff:

'The Clinical Nurse educator role has been invaluable in our unit. It offers support to a wide variety of skill levels from the undergraduate student to the CNS.'

Job satisfaction

A passion and enthusiasm for the role is also noted:

'I love my job as a nurse educator although I am relatively new to this role...'

Valuing and supporting all team members enhances satisfaction.

'I love my job – my staff and my NUM are fantastic and supportive of each other.'

Workplace culture also has an impact on perceptions of feeling valued, together with morale and satisfaction in an education team.

'I work on a specific education unit which has a high morale within its team members...'

Rewards and satisfaction are evident to educators when the contributions they have made through their work are obvious.

'I really love working in my role as a Clinical Nurse Educator, the most rewarding part being watching the post grad students and other program participants grow in knowledge, skill, confidence and competence and witness the excellent care being given to patients. It is a privilege to be part of their learning journey and support, encourage and teach them along the way.'

Providing education requires specialised knowledge

Role specific education qualifications add meaning to a role and impart status and recognition of expertise, and the education required to develop that expertise. Specialized nursing roles require specialized qualifications. For example, the registered nurse working in intensive care is expected to undertake specialized education to provide the specific complex patient care required within that domain. A newly qualified registered nurse would not have that expertise. Similarly, the nurse educator requires specialized training in education to develop the expertise required to provide evidence-based teaching and learning experiences to diverse groups of staff. A registered nurse, for example, would not be expected to have the expertise to develop and implement an education

program for a postgraduate hospital-based cardiac course. This work would be considered a reasonable expectation of a clinical nurse educator working in cardiac services in a hospital or area health service.

Specialised education qualifications

This nurse educator endorses the requirement for educators to have education qualifications:

'Additionally, to provide a credible, reliable educational program requires a degree of specialized knowledge that is not available to all nurses and midwives.....'

Individual beliefs and perceptions

There were also individual beliefs and perceptions regarding what qualifications may be appropriate for the educator to have in order to perform their role. This response noted the importance of qualifications and questioned the level of qualifications that may be considered appropriate for the role.

'The concept that 'every nurse is a teacher' serves to obfuscate the real and pressing need to have NEs educationally prepared as educators. A generic Master's degree and perhaps a Cert 1V in TAA [Training and Assessment] are not enough to equip a nurse to meet the challenges of the NE role in clinical practice. I would suggest that it makes the role vulnerable to the pervasive devaluing of the role that I note in my Area Health Service.'

Management support and structures

Nurse educators identified various reporting structures and a range of views about their appropriateness from the perspective of management support.

'For effective education to be implemented in the ward area educators require the complete support of management and ideally should report to an education manager rather than a clinical manager, or at the very least have 2 reporting lines.'

They also highlighted their expectations in terms of the impact of policy, regulation and professional recognition of the role. Education qualifications required and the need for role sustainability through a career pathway, mentoring and support, and appropriate remuneration were also important to survey participants.

Critical skills for nurse educators

Despite role confusion, nurse educators reported that they have attempted to clarify their role boundaries themselves. The nurse educators who made the following comments have demonstrated a consistent understanding of their duties and responsibilities.

Respondents described the following facets of the role (or expectations that the nurse educator act as): expert (clinician and educator), coordinating clinical placements, change agent, researcher, support person, committee member, practitioner, student supervisor, recruiter, retainer, appraiser, preceptor, problem solver. These criteria can be further categorized into functions associated with being an expert educator, expert clinician and management tasks. Discussion of each of these criteria follows and a summary of the groupings and criteria are presented in Figure 5.3.

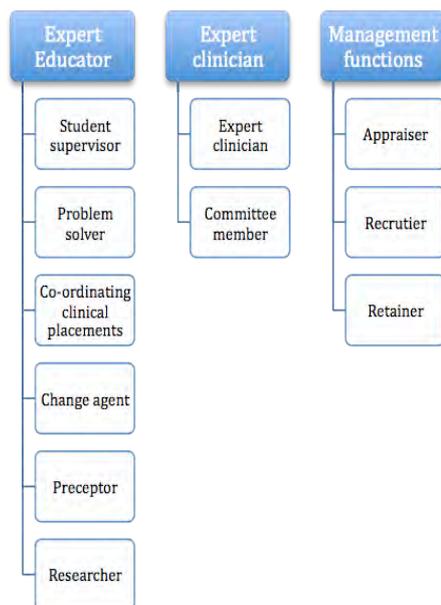


Figure 5.3 Examples of nurse educator role criteria

Expert clinician

These respondents expressed that the nurse educator needed to be an expert clinician – not to provide care, but as an expert to have the clinical knowledge, skills and expertise to critically analyze situations and recognize opportunities for practice improvement, and to inform and develop clinical practice in response to these insights.

'I feel that although the nurse educator role is not necessarily there to provide direct clinical care, a strong clinical background is needed...'

'...The critical skills for nurse educators to possess revolve around the educator's clinical acumen and the ability to analyze and constructively support the development of other's practice...'

Expert educator

The above respondent also specified that educators should not merely be clinical experts but also expert educators, knowing educational theory and principles and having the expertise and experience to apply these to their practice.

'... As such, an understanding of 'andragogy' is essential but this does not require exhaustive preparation in educational theory. Nurse Educators should accordingly be supported in the acquisition of specialist clinical skills and clinical teaching.'

Co-ordinating clinical placements

For this educator, role responsibilities were also perceived to be complex, extending across services and higher education institutions. Responsibilities related to student placements, the new graduate program and staff recruitment and retention, clinical programs, competency assessments and staff development.

'The majority of my time is devoted to coordination of clinical placements for 5 universities and 1 TAFE throughout the hospital and community plus coordination of newly graduated RNs program, recruitment and retention with focus group meetings etc. I also coordinate clinical programs, which include competency assessments and research information to the clinical areas. I also participate in ongoing staff development programs as well as develop, coordinate and participate in workshops with a clinical focus.'

The role was described as not bound by one institution, but by strategic partnerships with key stakeholders – universities and Technical and Further Education colleges (TAFE), hospitals and the community.

Nurse educators perceived themselves to be responsible for leading change – be it related to the translation of evidence to practice or policy. It was a burden, however, to implement change in the face of resistance from staff.

'I feel personally responsible if my teaching and learning strategies are not then applied in the clinical practice areas due to staff not wanting to change their practices despite all the best instructions etc...'

Researcher

Expert educators and clinicians lead and develop practice. Their role as a nurse researcher was perceived by this respondent to be emerging.

'In our hospital there is a push for a strong research component to the CNE role. I believe there needs to be the introduction of further clinical facilitator roles or a research CNE position in every dept. if this is to be the case, as a major component of the CNE role in my dept. is direct clinical education.'

Support person

The supporting role of the nurse educator is multifaceted. It may include teaching nurses to be preceptors to other nurses.

'My role is to develop nurses as teachers (preceptorship) and support the refresher/re-entry nurse in their relationship with their preceptor and guide their clinical experience during the relearning period.'

The supportive role may also involve the nurse educator being a support person.

'We are getting more overseas nurses that need a lot of support if they are going to fit into Australian models of care safely.'

Committee member

Being a team player in a multidisciplinary workplace requires the nurse educator to be proactive in seeking opportunities to engage with other members of an extended network, such as through committee participation. Through active engagement in decision-making in a committee at the facility level, this nurse educator identified the importance of raising the profile of the specific unit where the educator works as well as enhancing professional credibility.

'I have made myself available to various relative committees in the hospital such as Resuscitation and Clinical Nurse Council to gain some buy in on decisions that are made for the staff and patients at our facility, as my unit is somewhat isolated and we are often left out of the loop.'

Nurse educators assume roles as Committee members providing expert advice on education, clinical practice and policy issues. Committee membership was both a strategy for engagement and a response to a request for expertise.

'Also are called to be involved in committees etc only when members suddenly realize they might need our input because they are struggling with educational strategies to accompany dissemination of the associated change.'

Student supervisor

As a student supervisor the educator facilitates educational experiences in the clinical arena and monitors student learning. On reflection of student supervision activities, one respondent stated:

'I find Uni and TAFE students take up a lot of my time ... especially meeting them on the first day of placement as I have to go to all four hospitals on occasions to complete all the paper work that is required.'

Recruiter

Some educators are involved in employing staff including interviewing and selection processes.

'In my role as clinical nurse educator I am responsible for all stages of the recruitment process... over 100 applications per year for sixty new graduate nurse placements.'

Problem solver

Problem solving requires leadership, high-order skills and experience. The nurse educator is acknowledged as a problem solver and role model for staff.

'Nurse Educators provide flexible delivery of programs, and solutions to complex problems and act as role models to staff.'

Role sustainability

Role sustainability through a career pathway, mentoring and support as well as through appropriate remuneration was also important to educators.

Inadequate opportunities dissuade retention and role sustainability

It was suggested that the role was not seen to offer a career pathway within nursing and responses indicated that this was unfortunate and needed to be addressed.

'The Nurse Educator role is not perceived to offer a future career pathway. Not too many nurses see the role as a way of moving forward in a nursing career. THIS SHOULD AND NEEDS TO CHANGE.'

Limited opportunities for continuing professional development

The perception that opportunities for continuing education and professional development are limited is a difficult reality for survey participants:

'I personally am extremely disappointed at the lack of professional development opportunities for a clinical nurse educator. Positions seem to be available either in management or tertiary settings (the majority of which are sessional or casual in nature) with limited opportunity for education in the context of clinical care. This has resulted in me looking for options outside of nursing even though I am passionate about patients receiving a high standard of nursing care and gain a great deal of satisfaction from being part of the development of nursing practice. I am not willing to regress to a level 2 position when I have worked hard to increase both experience and skills and believe I am justified in expecting adequate remuneration for this.'

Other nurses don't perceive the role to be attractive as a consequence of remuneration, a culture of devaluation and high workload.

'I recently tried to gain 'expressions of interest' to backfill my role, and recently had to do the same for the CNE role. Lukewarm at best - seems you can't give it away. Understandable for the

CNE role when the remuneration is not commensurate with role expectations. And the NE role – few nurses choose this as a career path.'

Need for mentoring and role support

Mentoring and ongoing support of new staff is fundamental for successful transition to new roles. The need for mentoring and support is evidenced in these comments noting that mentoring and role modeling is expectations through varied transitions in the professional journey of the nurse.

'...It is just a struggle to find your feet as CNE, because you have no one to show you how to 'be' an educator. Unlike the RN role, as a nursing student you receive guidance and a role model from an experienced nurse on whom to base your practice on. I think there should be more avenues available for nurses thinking about becoming a CNE, in the form of courses that would give novice/would be CNEs an idea how to navigate their way into the role more confidently and effectively.'

Providing mentorship and support to new educators has been suggested as another strategy for helping registered nurses transition to an educator role.

'What I would really like to see for nurse educators in the future is a preceptorship type system for new educators to help with the transition from being an RN to a CNE.'

Other educators observed that the notion of transitioning to the role and subsuming an expert persona could be challenging, further highlighting the need for support.

'Being perceived as the 'expert' in the field I am responsible for is often overwhelming...'

'The role of CNE has been a particularly massive transition coming from a CNS role and suddenly being labeled the 'expert' in your field.'

Remuneration disparities

Educators voiced their concern that despite developing expertise as a registered nurse and completing post graduate clinical qualifications, these were not considered to be valued through additional remuneration.

'I feel that the CNE role is very under-supported at an Executive and Government level. We are encouraged to do this role but then take a large pay cut in order to do so.'

'Nurse education is becoming a hard role for a number of reasons for Nurse Educators we are required to have a post graduate qualification yet in NSW are the only professional group who do not receive a continuing education allowance all other staff RN's, EEN's, CNS, CNE and managers receive this –how does this value the work we do and the personal sacrifices (including financial) we have made to achieve this position?'

Unless these issues are addressed, organizational and professional cynicism may arise further devaluing the role.

'Clinical nurse educators work hard for little financial remuneration in NSW they get paid the same as a CNS – why would you bother it is a position which is often hard to fill and people burn out quickly so why not get paid the same as a CNS and do diddly squat.'

Educator shortages are a universal trend. Remuneration is seen as a contributing factor worldwide.

'Nurse Educators need to be financially rewarded. All over the world there is a shortage of persons working in this role as the remuneration is well below that paid to management and clinicians.'

Changing priorities

Participants not only identified the need for clear position descriptions, but also highlighted the need for a tangible commitment to continuing professional development through policy, beyond mere student support in the workplace.

The big picture – implications for policy

'The government needs to change its priorities and understand that cost savings will come with better educated staff who are able to care for patients appropriately thus decreasing incidents and mortality/morbidity and hospital length of stay. A band aid fix to decrease expenditure by cutting staff and neglecting to educate them is false economy and will not solve the problem in

the long run. The view is very short sighted (getting through the day) and not the long-term goal and what is required in that process. Most of my CNE colleagues feel undervalued and little more than an experienced pair of hands. The battle to change this continues.'

5.5.3 Theme 2: Role ambiguity, overload, erosion and stress

Theme 2 subthemes and where applicable a range of issues raised in each subtheme are summarized in Table 5.2.

Table 5.2 Theme 2: Role ambiguity, overload, erosion and stress

Subthemes	Issues
Role blurring and misperceptions	<ul style="list-style-type: none"> • Misconceptions • Role blurring
Role dissatisfaction, frustration and retention issues	<ul style="list-style-type: none"> • Role overload impedes the use of expertise and innovation • Fiscal restraint • Stress • Retention • Budget constraints
Eroding the nurse educator role	<ul style="list-style-type: none"> • Employment of clinical development facilitators
The need for direction	<ul style="list-style-type: none"> • Unclear role expectations

Role blurring and misperceptions

When the role occupant and other staff are unclear or the role has not been clearly communicated to staff, misperceptions or misconceptions of the role, and blurring and ambiguity may arise.

Misconceptions

Misconceptions regarding the differences between the nurse educator and the clinical nurse educator role are apparent.

'I work in a unit where the staff have no idea what the difference is between a CNE and a NE. For years they only had a NE who worked clinical when needed (regularly) and had no recognized post grad qualifications. When I arrived I pushed for the employment of a CNE to allow me to concentrate on the NE role. Now the staff don't think you do any work unless you work clinically which isn't in my job description. I have worked as an educator previously within the private sector and was given a lot more opportunity to function highly in the role. The public system seems to rely more on the non-clinical staff to back fill sick leave and relieve for meal breaks. This is extremely frustrating when I've studied very hard to get where I am. The staff don't understand the non-clinical skills that Nurse Educators have. The point I feel is that you don't have to be involved in direct patient care to help patients.'

Role blurring

Role blurring may also occur in situations where the incumbent is assuming responsibility for staff other than nurses.

'My role is often blurred, providing a wide range of services covering most hospital staff, not just nurses.'

Role blurring may also arise when the role isn't clearly communicated and understood by staff.

'The role is often blurred depending on the unit staffing and workload on any day.'

Changing contexts also influences roles. Blurring and ambiguity have arisen where the nurse educator and clinical nurse educator roles have changed over time in line with changing health care environments.

'I don't think there is such a diversity with nurse educators especially between CNE and NE's, I

don't think that this group can be linked in the same way it was a few years ago. CNE's tend to be able to care for one environment, but as an area educator with 11 hospitals it becomes very

difficult to do 'all' and support CNC's in research, development of unit specific policies/procedures, therefore the scope of practice tends to be blurred somewhat.'

Management is responsible for specifying role boundaries and for providing support to facilitate effective role enactment and appropriate utilization of human resources. Failure to meet these obligations may result in role overload and role erosion.

Role dissatisfaction, frustration and retention issues

Role overload breeds dissatisfaction, frustration and poor retention. Nurse educators assuming responsibility for staff education across an organization have identified role overload leading to neglect of their nurse education responsibilities.

'Hours for nurse education are insufficient for the amount of work expected. Nurse educator spends a lot of time on non-nursing staff e.g. allied health and support services as [the] only educator available on site; this aspect of the role is often ignored and [is] certainly not funded.'

Role overload was also identified in situations where responsibilities encompass staff on multiple campuses and therefore involve extensive travel.

'In my role, I have six areas of responsibility over two campuses and 100+ staff members..'

Responsibility for mandatory training and continued acting roles without appointment to a permanent position also contributed to role overload and frustration.

'At the moment, I am extremely dissatisfied with my role and have been acting in this position for 6 months. I don't feel I am fulfilling the role of a CNE adequately as I also run mandatory training for all staff (not only nurses). This training has four sessions a month but with preparation and

organizing included, it takes up approximately 10 days of my working month. I must say it is very frustrating.'

Although there is increased emphasis in the workplace to engage in multidisciplinary education, role overload and dissatisfaction emerged when this is expected in addition to a full workload but not acknowledged.

'I am made responsible for on-going education of medical students extending over some 16-hour days and receive very little acknowledgement from my line manager and am not permitted to recoup any of these hours either in a monetary sense or as time in lieu. The expectation is that this is 'the job' like it or not and seeking recompense has been challenged by middle hierarchy between myself and my manager.'

Impedes the use of expertise and innovation

Role overload is an impediment to the use of expert staff and to innovation.

'The issue of time or lack thereof, impacts not only on the ability to educate staff due to time constraints but also impacts upon the teaching methods used in both the clinical and non-clinical settings. The demands placed upon educators (students, program review, and development, lecturing, meetings etc) impacts on the time available to develop new, innovative methods of teaching in both the clinical and non-clinical setting.'

Fiscal restraint

Fiscal restraint across the health sector also influences role overload, particularly in instances when other staff cutbacks may affect patients and so nursing staff assume extra nursing duties to prevent patients being adversely affected. Nurse educators have frequently reported that they are assuming patient loads when there are insufficient nurses available to care for patients.

'If the Hospitality service cut their budget and will no longer supply early breakfasts to the ward areas, it is left to the nursing staff to collect and prepare the early meal or the patient misses out. This type of 'silo' cost cutting is occurring across every service and it is always the nurses who get left to pick up the short fall with no intervention by nursing managers. This is why the nurse educator often ends up helping on

the floor and why staff have little time, energy or interest in doing anything different or extra trialing a new evidence based intervention.'

Stress

The burden of additional workload is resulting in stress:

'Our nurse educator role is under great stress at this present time. We are expected to have patient loads and still provide education to staff. We are often removed from our educator role to make up staff numbers, which leaves staff with no support person. We are a unit with little senior staff and due to staff issues educators don't have time to adequately support junior staff. We rarely have time to give education in-services to staff due to the staff/stress/workload issues etc.'

Retention

Role overload may also affect retention.

'Although we may try very hard at work, there always seems to be more waiting to be done and less time in which to do it (leading to job dissatisfaction). Increasing demands does make you look elsewhere for employment outside the nursing field.'

Budget constraints

Budget constraints in rural areas also contribute to role overload.

'Rural areas where managers do not budget for clinical facilitators to assist are at risk of losing their educators. This does not provide for stability to supply small communities with long-term educators. Small communities take a long time to accept a new person and establish trust before effective learning needs analysis can be conducted and learning outcomes can be achieved for the learner. Nursing research also suffers as it cannot be done with limited resources, time and one educator to cover hundreds of miles.'

In summary, role overload may result in a number of unwanted effects on the nurse educator and the broader nursing workforce. These include poor staff

retention, decreased morale, less staff education, potential patient safety issues, decreased innovation and diminished nurse expertise, as shown in Figure 5.4.



Figure 5.4 Effects of role overload on role enactment and health care

Eroding the nurse educator role

Role erosion has been increased by the employment of clinical development facilitators.

'Clinical development facilitators have been employed in the clinical area with their emphasis being on supporting new staff in the clinical environment. Therefore, a portion of the nurse educator role has been eroded.'

This may indicate varying perspectives of the nurse educator and clinical nurse educator roles. Some perceive this support as allowing the concentration and use of expertise in other elements of the role, whereas others see this as an erosion of the position.

'[I am] concerned that the clinical nurse educators are consistently taking patient loads because of staff/skill shortages.'

The need for direction and unclear role expectations

The need for direction is valued, although the challenge to be self-directed allows for professional growth, confidence and autonomy.

'I feel that the limit of educator direction can be intimidating, but it allows a level of self-motivation and discovery.'

This educator noted the importance of directional support regarding the role. Working within a perceived dysfunctional education team and lack of appropriate Orientation to the role further compounded this.

'Lack of directional support and a cohesive Nurse Educator team can make the role very difficult. No clear direction of expectations given when commencing the Nurse Educator role.'

5.3.4 Theme 3: Organisational culture devaluing the role

Changes in organizational culture coupled with staffing issues preventing release to attend education impact role enactment, satisfaction and morale as depicted in

Table 5.3 Theme 3: Organizational culture devaluing the role subthemes

Subthemes	Issues
Organizational culture as a barrier – the battle for change	<ul style="list-style-type: none"> • Staffing levels impede attendance • Inadequate information technology infrastructure impedes alternative program delivery • Role devaluing • Geographic restraints amplify these inadequacies and barriers – rural contexts
Role devaluing	<ul style="list-style-type: none"> • Lack of recognition of role achievements and expertise • Assuming patient loads – the 'fallback' position • Trickle down of devaluing within the ranks • Other symbols of devaluation

Changes in organizational culture, commitment to education coupled with staffing issues preventing release to attend education, have an impact on role enactment, satisfaction and morale.

Organisational culture as a barrier – the battle for change

Organizational barriers to education are evident when the pervading culture of the organization excludes education as a central tenet of its mandate. A lack of understanding of the need for clinical education to address the requirements associated with higher patient acuity and a workforce of variable skill set and levels of educational attainment is apparent as highlighted by this respondent:

'Support not given to education – the culture is not focused towards continuing education, despite continually changing evidence ... Increasing patient acuity and decreasing staff skills/years of experience equate to a greater need for clinical education, but where is the initiative to support it?'

Staffing levels impede attendance

Patient care is the core business of hospitals. Adequate staffing levels are inherent in achieving this goal, as is having staff that are appropriately educated and competent to meet the complex needs of patients in acute care and to ensure patient safety. Continuing education is implicit in the development and implementation of evidence-based nursing practice. Study leave to attend continuing education courses is a condition of employment. However, efforts to balance skill mix and attract adequate staff so that nurses can engage in continuing education through their employment is impeding attendance.

'Management in public hospitals (thus the Dept. of Health) do not give nurse education the priority it deserves. To ensure safe, evidence based nursing care, the clinicians need access to quality ongoing education and the time to attend it. As a nurse educator I am continually frustrated with higher management (i.e. hospital not unit) not supporting education by decreasing the amount of nurses being able to be released for study leave to attend courses necessary to up skill them and keep them current. Even being able to get nurses out to our daily half-hour in-service is becoming impossible with units and wards being run on skeleton staff – with the increasing patient acuity and workload, and decreasing staffing numbers with poor skill mix, I fail to see how any nurse is able to be kept educated and up to date with the continually changing health environment.'

Staff rosters often resulted in smaller groups attending workshops.

'...I have trouble getting staff on study leave due to insufficient rostering or poorly staffed units. Always a problem which makes my workshop groups smaller than I would have wished.'

In units where shift lengths are 12 hours staff release during this time is difficult.

'[The] challenge for most nurses in critical care areas is 12 hour shifts. No guaranteed time for education.'

Inadequate information technology infrastructure impedes alternative program delivery

Alternative modes of education delivery are hindered by inadequate information technology infrastructure.

'...the reason why I don't provide a variety of learning options is due to a lack of IT infrastructure around e-learning – most of our clinicians do not have GroupWise or internet access for example. We also have big limitations around resources such as rooms and the ability to get staff released from clinical duties to undertake any type of training/education.'

Geographic restraints amplify these inadequacies and barriers – rural contexts

Devaluing of the role in rural areas may be worse than in city or metropolitan hospitals.

'In rural and remote areas, the nurse educator role is not well supported especially for novice nurse educators. Educators can function in isolation and have many barriers to overcome as management issues/decisions always tend to take precedence over or in place of education. However, when management have problems the educator is called in to troubleshoot. On this basis, the educator role is undervalued. There is not support in my state to provide rural educators with professional development support to learn how to better develop themselves and learn about their role, e.g. day-to-day requirements of role, problems encountered. It all has to be initiated by the educators themselves setting up networks and doing tertiary education to learn about education.'

Role devaluing

Organizational culture has an impact on staff culture, in turn devaluing the nurse educator role. A pervading sense of not feeling valued or recognized and feeling diminished by management and by other nurses was reported. These feelings arose where there was a lack of understanding of the role and its influence on patient outcomes and where there was a lack of management support.

'Educators need to be valued and respected for their contribution to client care; positive outcomes are often at the interface of indirect education even when managers take credit. Although I love this job and perform it to the best of my ability I feel it is undervalued by many nurses and I think that the clinical nurse educator is not seen as a relevant part of the team until there is a problem that we are expected to solve. From my discussions with many of the educators working within our facility, I believe that they experience these same issues.'

'...I love my education role but feel it is undervalued and frequently abused within the organization...'

There are also concerns that clinical facilitators are replacing the nurse educator role as a cost-saving measure.

'In my facility nurse educators are still not valued (although we are working hard to improve this) and are often called in to perform remedial work and performance management when it is too late. Even education management seems bent on replacing us with clinical nurse facilitators at a lower level – [I have a] feeling [that] management can't wait for us to retire so we can be replaced by lower tier staff at less cost to the organization. It seems that management think that good clinicians know how to be educators – which is not necessarily true. We wonder why we have bothered to obtain post grad qualifications in education if these are not valued.'

Lack of recognition of role achievements and expertise

A lack of recognition for the role through nursing awards has further contributed to devaluing of the role.

'I feel the Nurse Educator role is devalued ... profound neglect of the role and value of nurse educators, evidenced by no recognition in awards etc that highlight other resources/roles of nursing excellence... Nurse Educators who are quick to decry their diminishing professional prominence and contribution they could and should make to contemporary health care service, delivery and professional development.'

Nurse Educator expertise and credibility is perceived to be undervalued.

'I feel the value of the role in some cases is seriously underestimated by many of the 'powers that be' ... Clinicians undervalue the knowledge and clinical skills of educators and frequently they quip, 'they are just educators'. Educators are obviously not respected by the majority for whatever reason until such time as they feel that there is a role that can be added to their already overwhelming function.'

This educator feels the position is unrewarded:

'Nursing education is often a thankless position.'

Resource limitations also effects perceptions of feeling undervalued.

'At times I feel very frustrated by the area health services and their decisions which effect morale of staff.'

'This institution does not value education. Very limited resources available for nurse educators. Over 3500 nurses at our campus and less than 10 nurse educators and approximately 10 FTE Clinical nurse educators. Educators are expected to take a patient load if there is sick leave. No funds available for conference leave for educators – expectation to fund self and in own time.'

Assuming patient loads – the 'fall-back position'

The effects of devaluing within the organization continue when nurse educators are required to cast aside their primary role and assume patient loads providing direct clinical care. These additional workloads are the 'fall back position'.

'Educator time within our organization is not protected so when staffing numbers are low

educators are frequently pulled from their educational roles to provide direct clinical care and then still be expected to attend to other educational duties as well. Frequently excessive demands of the educator is utilized by other departments to meet educational scoping exercise requirements and reviews of organizational educational services when there is already somebody assigned to the job but [the] role is more of a coordination role rather than attending to specific requirements of the review and educators are required to pick up the slack.'

This also leads to educators believing the role to be not only undervalued but also exploited.

'I work closely with CNEs who are often pulled out of their role to take patient loads and pick up the slack. Their role (and mine (NE)) is undervalued and often exploited.'

Trickling down of devaluing within the ranks

A trickle down of devaluing through the ranks was described:

'District managers seem to not value educators and education units – this has been demonstrated by putting externally reviewed and approved training modules/core competency programs 'on hold' (for over 18 months) and by not supporting the education unit in other matters, such as resources. This is having a negative impact on staff morale, and quality care standards are dropping. Issues of 'incorrect skill-mix' evident as new staff are not adequately prepared for workforce specialist area, such as mental health – acute units. And experienced nurses are reducing their hours or retiring – and those that are staying are burning out under the extra load. They too are only relying on their sometimes dated knowledge and experience and are unable to access best practice/evidence based training opportunities. Mainly due to the above attitude & no relief/backfill-staffing issues. All staff have been told to avail themselves of on-line training, they either don't like this mode – no instant feedback, or don't have access, too tired or drained and no time at work ... regardless of which generation they come from. In all, I feel powerless as a P/T educator.'

Other symbols of devaluation

Other symbols of devaluation and fiscal withdrawal/limitations were described. Of particular concern was the potential loss of positions or reduction in hours occurring in response to financial constraints.

'...Our position is under reconstruction and we may lose hours due to financial issues.'

'I am just about to have my role decreased from a fulltime position to 0.6 fte by my AHS without having had any consultation or discussion with either my NUM or myself.'

A reduction in education staffing personifies the devaluing of clinical education and continuing professional education within the organization.

'...most of the clinical nurse educators are being forced to drop their hours from full time to 2 days per week. This is disappointing as we as nurses all recognize the need for staff retention and education is an excellent way to increase staff retention and morale.'

Another concern was that study leave is also not being supported because of financial constraints:

'...education is increasingly considered an area which can be consistently borrowed from – we are expected to create cultures of learning to enable and equip staff for clinical practice but are unable to support staff through study leave as all money that ... previously went towards this is being siphoned into other areas whilst health services are mismanaged at a state level. Education is the first thing to go in a budget crisis it is exceptionally disappointing that we cannot produce health services except from health care professionals because education is ultimately seen as an unworthy investment.'

The comments made by nurse educators are indicative of their beliefs that nurse education and in turn their role is devalued within their organizations. A summary of factors demonstrating this devaluation is shown in Figure 5.5.

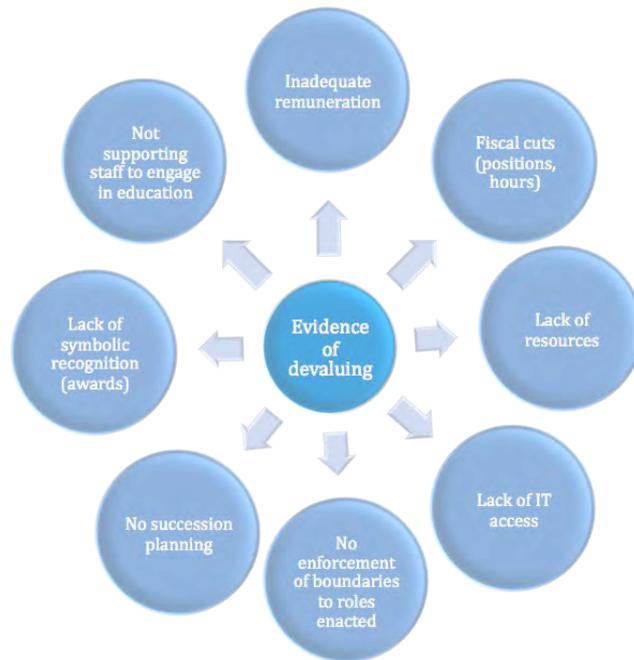


Figure 5.5 Perceptions of ways organisations devalue nurse education

5.4 Summary of findings

The group interview with the Steering committee identified the influence of historical factors in changes to the role over time. Moreover, the leadership composition of these groups was important in obtaining a comprehensive perspective. These data report that participants view the role as ambiguous, poorly defined and of low visibility in the nursing profession and broader health workforce. Participants considered that this decreased the influence nurse educators have on policy and practice.

Role development requires consideration of the qualifications necessary to perform the role, determinations regarding scope of practice, competencies and career pathways. The Steering committee also identified the potential impact of salary disparities on specialty recruitment.

The comments made by respondents in the survey reiterated and expanded on many of the comments made by the Steering committee. The major finding was concern regarding role ambiguity and devaluation of the role. The survey comments also identified a broad range of role responsibilities and expectations.

Views and opinions of respondents reinforced the appropriateness of the choice of role theory and symbolic interactionism as the theoretical framework underpinning this study. In particular, the associated elements of role theory such as ambiguity, conflict and role stress were amplified in respondent comments. The underlying assumptions within symbolic interactionism were also highlighted through comments identifying perspectives of how participants felt as individuals and, importantly, within the context of how they saw themselves in their profession and their organization.

5.5 Conclusion

This chapter has presented the qualitative findings from the group interview and one open-ended item on a survey highlighting the diverse contexts of practice of nurse educators in Australia. The need for standardized role definitions has been emphasized as role ambiguity pervades feelings of the role being devalued within organizations and the nursing profession. Education requirements, role expectations and responsibilities have been identified. These data were critical in generating statistical models and interpretation of the quantitative data presented in Chapter 6.

5.6 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

1. Thomas, D.R., *A general inductive approach for analysing qualitative evaluation data*. American Journal of Evaluation, 2006. 237(237-246).
2. Nursing and Midwifery Board of Australia, *Nursing and Midwifery Continuing Professional Development Registration Standard 2010*, Australian Health Practitioner Regulation Agency: Canberra.
3. Sayers, J.M., M. DiGiacomo, and P.M. Davidson, *The nurse educator role in the acute care setting in Australia: important but poorly described*. Australian Journal of Advanced Nursing Nursing, 2011. 28(4): p. 44-51.

Chapter 6 – Results Part 2

Nurse Educators, their Practice and Work Environment

6.1 Introduction

Part 1 of the results, the qualitative data analysis, was reported in Chapter 5. Chapter 6 reports Part 2 of the results from an online survey of nurse educators in Australia. Nurse educators' attitudes, values, practice and workplace environments were described through their socio-demographic and educational profiles, reporting and performance, competencies, career intentions, professional practice environment workplace issues, self-appraisal of performance, and role enactment. Integration of the results from Part 1 qualitative data (reported in Chapter 5) and Part 2 quantitative data are also presented accommodating a clearer understanding of the complexity of the findings.

6.2 Nurse educator survey

6.2.1 *Survey response rates*

The method for survey distribution was presented in Chapter 4. Survey data collection occurred between October 2009 and January 2010. The completion rate for the survey was 95% - 446 respondents commenced the survey and 425 completed all items. As this was a snowball sampling method, it was not possible to provide a response rate. Of the 365 hospitals that received the posted survey, 46 nurse educators from these hospitals completed and returned the surveys. These data were entered into the web survey platform and analyzed collectively. Two posted surveys were returned without being completed, as there was no designated nurse educator in the facility.

Respondents were from acute care hospitals in city, metropolitan, and rural centres in all states and territories in Australia. The demographic characteristics of the respondents were similar to nurses working in acute care hospitals Australia wide [1]. Nurse educators working in New South Wales

(NSW), however, may be over represented due to the networks of the researcher. Also there was only one respondent from the Australian Capital Territory (ACT). Fig. 6.1 displays respondent participation rates by state and territory.

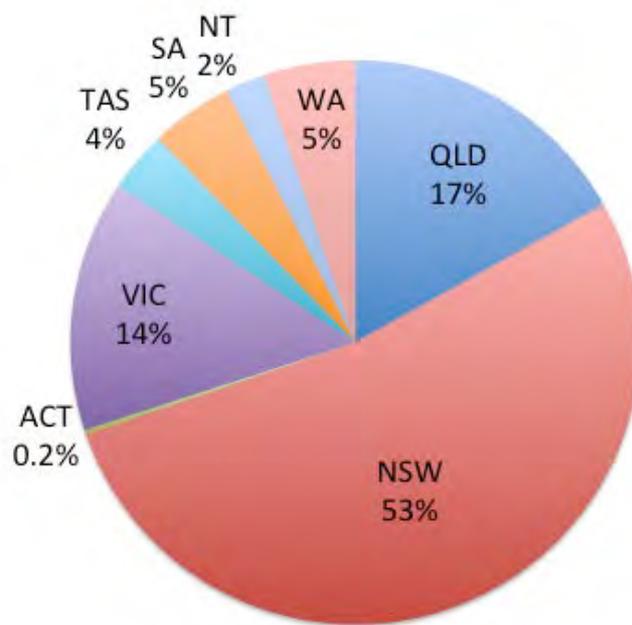


Figure 6.1 Percentage of respondents by state and territory

Glossary of states and territories:

Australian Capital Territory (ACT); New South Wales (NSW); Northern Territory (NT); Queensland (QLD); South Australia (SA); Tasmania (TAS); Victoria (VIC); Western Australia (WA).

6.2.2 Survey domains

As described in Chapter 4, the survey comprised eight survey domains. The findings from the domains are discussed in this chapter. The titles of the survey domains are provided again in Fig. 6.2 as a reminder.

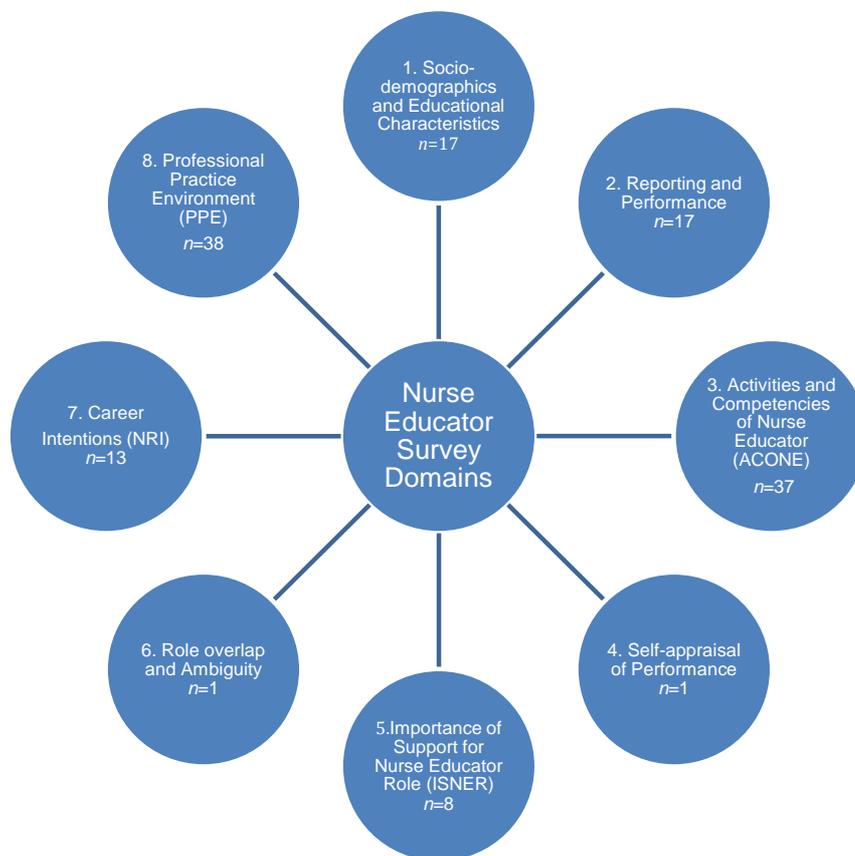


Figure 6.2 Nurse Educator survey domains

Domain 1. Socio-demographic and educational characteristics

All respondents were registered nurses employed role as a nurse educator in an acute care hospital. The majority of educators were female (88%; $n=374$). The highest percentage of educators (21%; $n=91$) was aged between 46 and 50 yrs. The most common designations were clinical nurse educator (40.2%; $n=171$), followed by nurse educator (37.6%; $n=160$). Table 6.1 summarizes the socio-demographic characteristics of the survey respondents.

Table 6.1 Socio-demographic characteristics of nurse educators (n=425)

Variable	n	%
Sex (male/female)	51/374	12/88
Age group (years):		
<30	36	8.5
31-35	46	10.8
36-40	81	19.1
41-45	70	16.5
46-50	91	21.4
51-55	64	15.1
56-60	27	6.4
>60	10	2.4
Employment designation:		
Clinical Nurse Educator	171	40.2
Clinical Development Nurse	6	1.4
Clinical Coordinator	6	1.4
Staff Development Educator	24	5.6
Nurse Educator	160	37.6
Clinical Facilitator	9	2.1
Nurse Education Coordinator/Manager	37	8.7
Clinical Nurse Consultant	9	2.1
Other	3	0.7
Employment status:		
Full time	272	64.0
Part time	145	34.1
Other	8	1.9

Of the respondents who reported a specialist clinical qualification, 21.8% (n=88) held this at a master's level. Of those who reported a postgraduate education qualification only 21.9% (n=93) had this qualification at a master's level. Table 6.2 summarizes postgraduate qualifications.

Table 6.2 Postgraduate qualifications of nurse educators (n=425)

Qualification	n	%
Completed specialist clinical qualification	369	86.8
Clinical qualification: master's degree or above	88	21.8
Completed specialist education qualification	315	74.1
Education qualification: master's degree or above	93	21.9

Domain 2. Reporting and performance of nurse educators

This question sought to obtain from nurse educators who they reported to and how their work performance was managed. Nurse educators most frequently reported to a clinical nursing manager (40.5%; $n=172$) or a nursing education manager (34.4%; $n=146$). The majority of nurse educators (94.8%; $n=399$) reported that they had a job description and 73.6% ($n= 310$) reported that they met regularly with their manager. In addition, 65.1% ($n=274$) had participated in performance review in the preceding 12 months. Within this group, 9.5% ($n=34$) hadn't had their professional development and learning needs identified.

The rate of respondents reporting that their role was not linked to clinical or outcome indicators was 69.6% ($n=272$). Specific clinical indicators were cited by 24% ($n=102$) of respondents. Clinical indicators reported relating to patient outcomes included falls, decubitus ulcers, medication safety, rehabilitation, changes in clinical practice (e.g. blood product management) and survival to discharge following medical emergency events. Other indicators reported were an increase in the number of women from Aboriginal, Torres Strait Islander and other culturally and linguistically diverse (CALD) backgrounds attending Well Women's clinics.

Non-clinical performance outcomes related to clinical competency achievement by staff, delivery of mandatory education, recruitment and retention of new graduates, and course-specific outcomes such as completion rates. A summary of reporting and performance review data are reported in Table 6.3

Table 6.3 Role reporting and performance of nurse educators (n=425)

Directly reporting to specified management position:	n	%
Nursing – Clinical	172	40.5
Nursing – Education	146	34.4
Professional Development	15	3.5
Non-nursing – Clinical	6	1.4
Non-nursing – Education	11	2.6
Other	75	17.7
Performance Management:		
Job description	399	94.8
Duty statement reviewed within past 12 months	177	41.6
Regular meetings with line manager	310	72.9
Appraisal and performance review within past 12 months	274	64.5
Role not linked to clinical indicators	272	69.6
Professional development and learning needs identified	263	61.9

The following discussion presents the results for the self-appraisal of performance and work environment domains, namely: competencies, self-appraisal of performance, workplace issues, and career intentions and professional practice environment. The mean, standard deviation and possible range for these domains are presented in Table 6.4

Table 6.4 Self-appraisal of performance and work environment domains

Survey Domains	Mean	SD	Range
Domain 3. Competencies - ACONE	56.3	245.6	0-360
Domain 4. Self-Appraisal of Performance	7.3	1.3	0-10
Domain 5. Workplace Issues- ISNER	65.3	9.5	0-10
Domain. 6. Role Blurring and Ambiguity	6.2	2.5	0-10
Domain 7. Career Intentions - NRI	40.4	7.9	6-48
Domain 8. Professional Practice Environment	106.6	14.5	38-152

Domain 3. Activities and Competencies of Nurse Educators

This domain comprises three components: nurse educator activities, target groups for education and the Activities and Competencies of Nurse Educator (ACONE) scale (Appendix 8).

Nurse Educator Activities

Firstly, to determine the range of educational activities undertaken by Australian nurse educators, respondents reported on a number of activities thought to be consistent with the nurse educator role. As discussed in Chapter 4, items were derived from existing competencies in the literature [2, 3] [4], role descriptions the researcher collected from advertisements and institutions, as well as advice from key stakeholders, particularly in group interviews. All respondents reported that they had participated in clinical teaching, competency assessment, curriculum development, education program planning and co-ordination, teaching non-nursing staff and classroom teaching as part of their role. Some respondents identified that they provided direct patient care and provided relief for other nursing roles. Fig. 6.3 summarizes the activities educators engaged in during an average week.

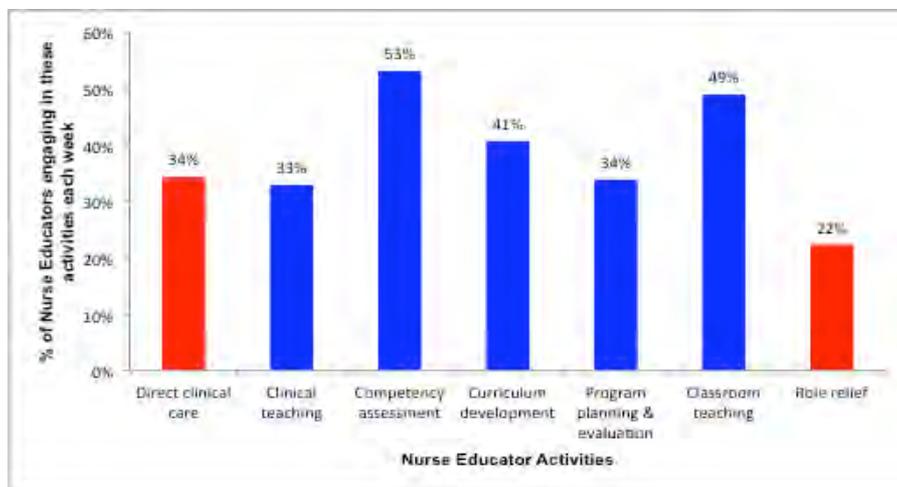


Figure 6.3 Nurse Educator activities and percentage of educators engaging in these activities each week

Activities and Competencies of Nurse Educators (ACONE) Scale

The Activities and Competencies scale was a 37-item measure reflecting the six practice domains: education program development; teaching and mentoring; educational and clinical leadership; professional practice improvement; research and scholarship and education management.

Activities and Competencies of Nurse Educators ACONe Scale Psychometrics

Data were investigated through factor analysis allowing for related items to be grouped as well as exploration of relationships between responses and other variables within the scale [5].

Internal consistency and inter-item correlations

Item total correlations were computed for the 37-item ACONe scale. One item, 'Works as an expert clinician in the clinical setting' was excluded from the final data set, as the corrected item-total value for this competency element was <0.3. This item was removed from the scale. The Cronbach's alpha co-efficient of the 36-item ACONe scale was 0.93. The corrected item total correlations for the 36-items were greater than 0.30. Reliability for all six subscales ranged from 0.72 to 0.87 as shown in Table 6.5.

Table 6.5 Component loadings: Extent of Activities and Competencies of Nurse Educators (Principal Components Analysis with Varimax rotation) (n=425)

Component	(% variance/Cronbach's alpha)	Comp. load
Component 1: Education Program Development (10.8/0.74)		
1. Collaborates with others in development and delivery of nursing and interprofessional education programs		0.79
2. Integrates educational theory and evidenced-based approaches in teaching and education		0.75
3. Facilitates the development, implementation and evaluation of curricula and education programs		0.71
4. Participates in programs to facilitate clinical practice		0.65
5. Engages in the development and delivery of undergraduate or postgraduate programs		0.46
Component 2: Teaching & Mentoring (18.2/0.87)		
6. Facilitates professional behaviors and role socialization		0.81

7. Facilitates learning activities to promote teamwork and interprofessional practice	0.76
8. Monitors and provides feedback to learners regarding educational achievement	0.75
9. Promotes positive learning environments through effective collegial working relationships	0.71
10. Uses feedback from learners, peers and managers to improve role effectiveness	0.70
11. Recognises and identifies individual learner needs, and provides resources and support to facilitate learning	0.65
12. Demonstrates cultural competence by incorporating cultural beliefs and practices in teaching and learning	0.63
13. Acts as a role model engaging in self-reflection, modeling, critical and reflective thinking	0.62
14. Uses a variety of teaching strategies (including information technologies) appropriate to learner needs	0.61
15. Fosters opportunities for learners to develop critical thinking and critical reasoning skills	0.60
16. Engages in mentoring and motivating novice practitioners and other staff	0.31
Component 3: Educational and Clinical Leadership (10.2/0.72)	
17. Provides leadership in ongoing review of education and clinical practice at local or regional level	0.70
18. Provides leadership in ongoing review of clinical education service	0.66
19. Undertakes primary responsibility for planning and implementation of specialist clinical education	0.65
20. Assumes leadership roles promoting broader advancement of clinical and education practice	0.46
Component 4: Professional Practice Improvement (10.1/0.78)	
21. Aware of current professional trends through involvement in professional organizations	0.73
22. Incorporates findings from published studies in development of evidenced-based teaching and evaluation	0.65
23. Uses evidence to inform educational programs improving nursing Practice	0.65
24. Involved in professional development activities to improve own performance	0.59
25. Uses clinical practice and outcome data to inform educational Interventions	0.35
26. Manages clinical practice improvement projects	0.31
Component 5: Research and Scholarship (8.3/0.78)	
27. Disseminates own research findings through specialist publications and presentations	0.87

28. Initiates original research projects	0.80
29. Initiates collaborative ventures with academic colleagues (e.g. projects determining current status and influencing future directions of nursing education and practice)	0.61
30. Provides leadership in state, national and or international nursing bodies and or specialist clinical and interprofessional education groups	0.56
31. Develops proposals or submissions for program development, policy and research	0.37
Component 6: Education Management (8.3/0.81)	
32. Plans, implements and evaluates annual plans for nurse education service	0.68
33. Monitors clinical outcomes in relation to educational activity	0.61
34. Contributes to formal service and strategic planning processes within their organization	0.60
35. Manages complex projects relating to significant education and nursing practice change for workplace	0.58
36. Provides ongoing analyses of current education and nursing practice and the impact of new directions on clinical specialty or education service	0.49

Comp. load., Component loading

Factor analysis

Factors analysis was used for the four embedded scales Activities and Competencies of Nurse Educator (ACONE), Importance of Support for Nurse Educator Role (ISNER), Nurse Retention Index (NRI) and Professional Practice Environment (PPE) scales. Factor analysis allowed for the relationships between variables to be examined and to group items [6]. This was a useful procedure for identifying dispersion [6, 7] of the nature and type of activities undertaken by nurse educators in their workplace. Factor analysis [6] also facilitated consideration of factors that may impact performance such as educational background and years of experience in the role.

Factor loadings may vary between 0.30 and higher [5]. The cut-off point for significant loading was greater than 0.3. The ACONe was then analyzed using the principal components analysis (PCA) data extraction method with Varimax rotation to examine characteristics of items. Using the PCA method with the Varimax rotation procedure, a 6-component solution was achieved, explaining

65.9% of the variance. Factor 1 comprised 5 items and was labeled ‘*education program development*’ as it contained all of the original components for program development and evaluation. Factor 2 consisted of 11 items and was titled ‘*teaching and mentoring*’. Items 13 and 16 in Factor 2 were originally labeled ‘*educational and clinical leadership*’, however review of the content of these items indicated congruence with ‘*teaching and mentoring*’.

Factor 3, with four items, was called ‘*educational and clinical leadership*’ and retained all the original items. Factor 4, ‘*professional practice improvement*’, consisted of five items. Items 22, 23 and 26 were originally labeled ‘*education and practice outcomes*’, but were a better fit with ‘*professional practice improvement*’. Factor 5, ‘*research and scholarship*’ contained five items. Originally items 29 and 30 were grouped under ‘*educational and clinical leadership*’ but were more logically aligned with ‘*research and scholarship*’. Factor 6, ‘*education management*’ contained five items retaining its original item structure. Table 6.6 reports component loadings for the 36-item Activities and Competencies of Nurse Educator scale. Table 6.6 identifies the internal consistency scores between scale items.

Table 6.6 Internal consistency of Activities and Competencies of Nurse Educator scale (ACONE) 36-items

No.	Competency	Corr. Item*	Cron. Alpha deleted**
1	Collaborates with others in development and delivery of nursing and interprofessional education programs	0.51	0.93
2	Integrates educational theory and evidenced based approaches in teaching and education	0.60	0.93
3	Facilitates the development, implementation and evaluation of curriculum and education programs	0.53	0.93
4	Participates in programs to facilitate clinical practice	0.61	0.93
5	Engages in the development and delivery of undergraduate or postgraduate programs	0.34	0.93
6	Facilitates the development of professional behaviors and role socialization	0.53	0.93
7	Facilitates learning activities to promote teamwork and interprofessional practice	0.53	0.93

8	Monitors and provides feedback to learners regarding educational achievement	0.55	0.93
9	Promotes positive learning environments through effective collegial working relationships	0.64	0.93
10	Uses feedback from learners, peers and managers to improve role effectiveness	0.51	0.93
11	Recognizes and identifies individual learner needs and provides resources and support to facilitate learning	0.57	0.93
12	Demonstrates cultural competence by incorporating cultural beliefs and practices in teaching and learning	0.52	0.93
13	Acts as a role model engaging in self-reflection, modeling, critical and reflective thinking	0.52	0.93
14	Uses a variety of teaching strategies appropriate to learner needs and contexts	0.54	0.93
15	Fosters opportunities for learners to develop critical thinking and critical reasoning skills	0.69	0.93
16	Engages in mentoring and motivating novice practitioners and other staff	0.40	0.93
17	Provides leadership in ongoing review of education and clinical practice at a local or regional level	0.67	0.93
18	Provides leadership in ongoing review of clinical education practice for a complex service	0.59	0.93
19	Undertakes primary responsibility for specialist clinical education in a hospital or health service	0.39	0.93
20	Assumes leadership roles promoting broader advancement of clinical and education practice	0.70	0.93
21	Aware of current professional trends through involvement in professional organizations	0.60	0.93
22	Incorporates findings from published studies in development of evidenced based teaching and evaluation	0.53	0.93
23	Uses evidence to inform educational programs improving nursing practice	0.56	0.93
24	Involved in professional development activities to improve own performance	0.60	0.93
25	Uses clinical practice and outcome data to inform educational interventions	0.64	0.93
26	Manages clinical practice improvement projects	0.52	0.93
27	Disseminates own research findings through specialist publications and presentations	0.40	0.93
28	Initiates original research projects	0.45	0.93
29	Initiates collaborative ventures with academic colleagues (e.g. projects determining current status and influencing future directions of nursing education and practice	0.54	0.93

30	Provides leadership in state, national and or international nursing bodies and or specialist groups	0.53	0.93
31	Develops proposals or submissions for program development, policy and research	0.54	0.93
32	Plans, implements and evaluates annual plans for nurse education service	0.63	0.93
33	Monitors clinical outcomes in relation to educational activity	0.57	0.93
34	Contributes to formal service and strategic planning processes within their organization	0.55	0.93
35	Manages complex projects relating to significant education and nursing practice change for workplace	0.66	0.93
36	Provides ongoing analyses of the impact of education on nursing practice	0.72	0.93

*Corrected item total correlation

**The range for the Cronbach's alpha if item is deleted was between 0.931 and 0.936

In the ACONE scale performance review, mentoring staff, role modeling, positive learning environments and assuming a leadership role reviewing education and clinical practice, were the five highest scoring items reflecting the scope of practice of the nurse educator role. These are summarized using mean scores and standard deviation in Table 6.7. The highest item on mean scores was 'uses feedback from learners, peers and your manager to improve role effectiveness' (7.88±1.03). The second-highest scoring item was 'engages in mentoring and motivating novice practitioners and other staff' (7.79±1.02). The high mean score for this item demonstrated that nurse educators consider mentoring and motivating staff an important role function.

Table 6.7 ACONE Competency items and descriptive statistics (n=382)

Competency	Mean	SD
Uses feedback from learners, peers and manager to improve role effectiveness	7.88	1.03
Engages in mentoring and motivating novice practitioners and other staff	7.79	1.02
Acts as a role model, engaging in self-reflection, modeling critical and reflective thinking	7.75	1.11
Promotes positive learning environments through effective collegial working relationships	7.63	.92

Provides leadership in the ongoing review of education and clinical practice at a facility or regional level	7.54	1.25
Uses evidence to inform educational programs to improve nursing practice	7.50	1.28
Incorporates findings from published studies in the development of evidence based teaching and simulation	7.46	1.53
Integrates educational theory and evidence-based approaches in teaching and education	7.42	1.21
Uses clinical practice and outcome data to inform educational interventions	7.42	1.17
Uses a variety of teaching strategies appropriate to learner needs and contexts to support the teaching-learning process	7.42	1.17
Monitors and provides feedback to learners regarding educational achievement	7.38	1.20
Participates in programs to facilitate clinical practice	7.33	1.12
Participates in professional development activities to improve performance	7.33	1.09
Collaborates with others in the development and delivery of nursing and interprofessional education programs	7.29	1.48
Fosters opportunities for learners to develop critical thinking and critical reasoning skills	7.29	1.36
Facilitates learning activities to promote teamwork and interprofessional practice	7.25	1.42
Awareness of current professional trends through involvement with professional organizations	7.17	1.12
Recognizes and identifies the needs of individual learners and provides resources and support to facilitate learning	7.13	1.56
Facilitates the development, implementation and evaluation of curricula and educational programs, incorporating professional standards, attitudes and values that reflect contemporary nursing practice	7.00	1.61
Facilitates the development of professional behaviors and role socialization	6.96	1.60
Plans, implements and evaluates annual plans for your nurse education service	6.96	1.87
Undertakes primary responsibility for the planning and implementation of specialist clinical education in your hospital or health service	6.92	1.55
Provides ongoing analysis of current education and nursing practice and the impact of new directions on your clinical specialty or education service	6.83	1.52
Manages complex projects relating to significant education and nursing practice change for your organization	6.79	1.95
Monitors clinical outcomes in relation to educational activity	6.63	1.95
Provides leadership in the ongoing review of clinical education practice for a more complex service, such as a service provided at multiple sites	6.54	1.86

Demonstrates cultural competence by incorporating cultural beliefs and practices in teaching and learning	6.54	1.58
Assumes leadership roles that promote broader advancement of clinical and education practice	6.42	1.84
Manages clinical practice improvement projects	6.42	1.84
Contributes to formal service and strategic planning processes within your organization	6.42	1.66
Develop proposals or submissions for program development, policy and research	6.29	1.51
Works as an expert clinician in the clinical setting	6.21	2.14
Engages in the development and delivery of undergraduate or postgraduate tertiary programs	5.29	2.29
Provides leadership in state, national and international nursing bodies or specialist clinical and interprofessional groups	4.88	2.67
Initiates original research projects	4.88	2.38
Initiates collaborative ventures with academic colleagues	4.58	2.14
Disseminates own research results through specialist publications and presentations	4.42	2.51

SD, standard deviation.

Domain 4. Self-appraisal of performance

Respondents demonstrated high levels of self-appraisal of their performance as 89% of respondents rated their performance to be above the midpoint mark of overall performance in their educator role (7.34±1.33).

Domain 5. Workplace issues – Importance of Support for the Nurse Educator Role (ISNER-8 scale)

The workplace issues section of the survey required nurse educators to rate items focusing on strategies that may enhance clinical learning and practice, teamwork and nurse educator role capacity building. Mean and SD scores are shown in Table 6.8. The ISNER scale was tested using Kaiser-Meyer-Olkin (KMO) and Bartlett's test of sphericity [6] to determine if the scale was suitable to conduct principal component analysis, as shown in Table 6.9.

Table 6.8 Importance of Support for the Nurse Educator Role (ISNER)

Item	Mean	SD
Advancing the nurse educator role in the nursing profession	8.93	1.15
Linking nurse education activities to demonstrable patient outcomes	8.73	1.65
Promoting initiatives to foster teamwork and multidisciplinary care	8.39	1.68
Addressing factors relating to skill-mix diversification in the nursing workforce	8.33	1.83
Endorsing the interface between healthcare settings and educational providers	8.26	1.80
Developing strategies to promote an advanced practice role	7.87	1.85
Increasing the focus on interprofessional teaching and practice	7.69	2.06
Increasing the focus on research and scholarship	7.15	2.08

SD, Standard Deviation.

Table 6.9 Kaiser-Meyer-Olkin & Bartlett’s test [6] of sphericity for Importance of Support for Nurse Educator Scale (ISNER)

Approximate Chi-square	df	Significance
0.840	792.203	28
		.000

KMO, Kaiser-Meyer-Olkin test [6]

Factor analysis of the Importance of Support for Nurse Educator Scale

The ISNER scale was analyzed using PCA. A single component solution explaining 42.98% of the variance resulted. This component was named ‘importance of support for the nurse educator role’. Table 6.10 reports component loadings for the ISNER-8 item scale.

Table 6.10 Component loading – Importance of Support for Nurse Educator Role (ISNER)

Component	Comp. loading
Promoting initiatives to foster teamwork and multidisciplinary care	0.71
Developing strategies to promote the advanced practice role	0.69

Endorsing the interface between healthcare settings and educational providers	0.68
Linking nurse education activities to demonstrable patient outcomes	0.68
Increasing the focus on research and scholarship	0.67
Addressing factors relating to skill mix diversification in the nursing workforce	0.63
Increasing the focus on interprofessional teaching and learning	0.61
Advancing the nurse educator role in the nursing profession	0.57

Item total correlations were computed for the 8-item ISNER scale. All items were evaluated for internal consistency as shown in Table 6.10. The Cronbach's alpha co-efficient of the 8-item ISNER scale was 0.81 confirming good internal consistency. The corrected-item total correlations for the 8-items were greater than 0.30. The ISNER scale had a mean score of 65.3±9.51. Greater than 98% of respondents rated above the midpoint score of 40.

Domain 6. Role overlap and ambiguity

All respondents indicated some degree of role blurring and overlap of their nurse educator activities with other nursing roles. The mean rating score was 6.2±2.50 as shown in Table 6.4. More than half of the respondents rated above the 5 midpoint mark regarding the degree of role blurring and overlap of their activities with other nursing roles.

Domain 7. Career intentions (Nurse Retention Index [8].)

Nurse Retention Index Psychometrics

In this 6-item measure of career intentions, respondents reported on their job plans for the following 12 months [8]. Factor analysis revealed a one-factor solution and inter-item correlation of 0.95. Item 3 (As soon as it is convenient for me, I plan to leave the nursing profession) and item 6 (I would like to find other employment by leaving nursing) were negatively worded and were reversed before the analysis. Scores ranged from 6 to 48. Higher scores reflected greater intention to stay in the nursing workforce as shown in Table 6.11.

Table 6.11 Factor analysis Nurse Educator Retention Index

Factor	Mean	SD
It is my intention to continue with my nursing career in the future	6.27	1.13
I would like to stay in nursing as long as possible	5.76	1.39
Reversed score item 3	6.80	1.51
I expect I will keep working as a nurse	5.81	1.38
My plan is to remain with my nursing career as long as I am able	5.61	1.54
Recoded NRI item 6	6.92	1.38
Given your present feelings about your work, how likely are you to stay in this clinical area in the next 12 months?	5.30	1.48

SD, standard deviation.

Nurse Retention Index Findings

Cronbach's alpha of the 6-item NRI was 0.91 with more than 90% of respondents having a score above the midpoint score of 27 on the NRI. This indicated a strong intention to stay in their current positions during the next 12 months as shown in Table 6.11. These findings reflected the age demographics identified in Domain 1. Although the majority of the nurse educators who responded (53% $n=225$) are aged between 41 and 55 years they see themselves continuing to work in the foreseeable future.

Domain 8. Professional Practice Environment (PPE)

Professional Practice Environment Psychometrics

Nurse educators reported their regard for their practice environment using Erickson's PPE instrument [9]. Respondents rated their agreement with each statement within the eight domains using a Likert scale from 1 to 4. The domains were previously reported in Chapter 4 but are noted here as a reminder. The domains were: clinical practice in the acute care setting, namely – handling disagreement and conflict, internal work motivation, control over practice, leadership and autonomy in clinical practice, staff relationship with physicians, teamwork, cultural sensitivity, communication about patients, workplace conflict, personal satisfaction, and continuity of care. Higher scores reflected higher regard for their practice environment. The PPE scale Cronbach's alpha coefficient was 0.92, comparable with the 0.93 reported by Erickson in studies in the United States [9]. The mean of the total 38-item PPE

scale score was 106.6±14.54 with more than 78% of respondents reporting a score above the 95 as shown in Table. 6.4.

The highly ranked factors of the nurse educator role in the workplace are shown in Table 6.12. The following items had the highest mean scores: ‘I feel a high degree of personal responsibility for the work I do’ (3.49±0.92); ‘I have challenging work that motivates me to do the best job I can’ (3.24±0.72); ‘Working on this unit gives me the opportunity to gain new knowledge and skills’ (3.24±0.70); ‘Opportunity to work in a specialized environment’ (3.07±0.74); ‘I feel a great sense of personal satisfaction for the work I do’ (3.07±0.74); ‘Leadership supportive to staff’ (3.04±0.86) and ‘Working in this environment increased my sense of professional growth’ (3.03±0.81).

Table 6.12 Descriptive statistics of the Professional Practice Environment (PPE) scores

PPE Item	Mean	SD
I feel a high degree of personal responsibility for the work I do	3.49	0.59
I have challenging work that motivates me to do the best job I can	3.24	0.72
Working on this unit gives me the opportunity to gain new knowledge and skills	3.24	0.70
Opportunity to work in a specialized environment	3.07	0.74
I feel a great sense of personal satisfaction for the work I do	3.07	0.74
Leadership supportive to staff	3.04	0.86
Working in this environment increased my sense of professional growth	3.03	0.81
I get information on patient's status when I need it	2.98	0.68
Staff are respectful of their unit's diverse health care team	2.96	0.62
Not being placed in a position of having to do things against my professional judgement	2.96	0.70
Manager who backs up staff in decision making even in conflict with medical practitioner	2.94	0.89
Staff are sensitive to diverse patient populations whom they serve	2.93	0.66
This unit has constructive relationships with other groups in this area	2.92	0.67
A manager who is a good manager and leader	2.92	0.95
Physicians and department or unit staff have good relationships	2.88	0.70
I am motivated to do well because I am empowered by my work environment	2.88	0.83
Freedom to make important patient care and work decisions	2.84	0.76

When a patient's status changes, I get relevant information quickly	2.82	0.72
All staff work hard to arrive at best possible solution	2.81	0.68
Staff have access to necessary resources to provide culturally competent care	2.81	0.71
All contribute from their experience, expertise to effect high quality solution	2.75	0.68
My opinion of myself goes up when I work in this facility	2.74	0.69
My discipline (i.e. nursing) controls its own practice	2.74	0.74
A lot of teamwork between physicians and staff	2.71	0.82
All points of view considered in finding best solution to problem	2.69	0.69
Patient care assignments that foster continuity of care	2.66	0.75
Staff withdraw from conflict	2.49	0.73
Enough time and opportunity to discuss patient care problems with other staff	2.49	0.74
Staff involved settle disputes by consensus	2.46	0.65
Staff involved don't settle dispute until all are satisfied with decision	2.45	0.65
Enough staff to get the work done	2.36	0.82
When staff disagree, they ignore the issue, pretending it will go away	2.32	0.76
Disagreements between staff are ignored or avoided	2.28	0.72
Enough staff to provide quality patient care	2.23	0.83
This unit doesn't get co-operation it needs from other health units and facilities	2.21	0.73
Adequate support services allow me to spend time with patients	2.19	0.76
Inadequate working relationships with other clinical areas limit effectiveness of work on this unit	2.19	0.74
Other units seem to have a low opinion of this unit	2.17	0.83

PPE, Professional Practice Environment; SD, Standard Deviation.

Assessment of psychometric properties is an ongoing process, particularly as instruments are used in alternate settings and populations. As part of assessing the psychometric properties for the PPE in the study population, as described in Chapter 4, an extraction procedure was used to examine the factor structure of the 38-item PPE scale using PCA with Varimax rotation [6]. The factor structure for this analysis was similar to those in the original PPE scale derived by Erickson [9]. Component 1, 'collaborative solution to problems' contained 5 items accounting for 8.5% of variance. Component 2 was the same 7-item '*internal work motivation*' dimension and accounted for 12.0% of variance. Component 3 was the same dimension, '*control over practice*' and contained

five items accounting for 7.4% of variance. Component 4, the same dimension '*leadership and autonomy in clinical practice*' contained six items and accounted for 7.7% of variance. Component 5, labeled '*interprofessional relationship, communications about patient care*' contained six items and accounted for 8.5% of variance. Component 6 was the same '*teamwork*' dimension and contained three items accounting for 6.8% of variance. Component 7 was the same three items as the '*cultural sensitivity*' dimension and accounted for 5.9% of variance. The final dimension, Component 8 labeled '*handling conflict*' contained three items and accounted for 5.6% of variance. Factor loadings for all 38 items ranged from 0.35 to 0.85, which were all above the 0.3-factor loading threshold. The components and percentage variances explained are shown in Table 6.13.

Internal consistency and inter-item correlations

All eight subscales ranged from 0.72 to 0.90 as shown in Table 6.13. The corrected-item total correlations for the 38-items were greater than 0.30 including all reversed items. All items were evaluated for internal consistency as shown in Table 6.13. Psychometric testing of the PPE-38 scale identifies robust psychometric properties and the usefulness for examining the professional practice environment of nurse educators in Australia.

Discriminant validity of total Professional Practice Environment scale

Discriminant validity allowed for differentiation between high and low PPE-38 scores with participant characteristics. Using stepwise entry, two variables emerged as significant and independent predictors of PPE-38 scores. As shown in Table 6.14, participants who had regular meetings with their line manager ($B=0.21$, $P<0.001$) and those whose professional development and learning needs were identified ($B=0.12$, $P=0.038$), reported significantly higher levels of total PPE-38 scores.

Table 6.13 Component loadings: Nurse Educators' Professional Practice Environment (PCA with Varimax rotation) (*n*=382)

Component	Comp. Load
Component 1: Collaborative solution to problem (8.5/0.83)	
25. Staff involved don't settle a dispute until all are satisfied with decision	0.75
24. All staff work hard to arrive at best possible solution	0.70
28. Staff involved settle disputes by consensus	0.67
23. All points of view are considered to find the best solution to problem	0.67
26. All contribute from their experience and expertise to affect high quality solution	0.66
Component 2: Internal work motivation (12.0/0.90)	
32. I have challenging work that motivates me to do the best job I can	0.84
30. I feel a great sense of personal satisfaction for the work I do	0.78
35. Working in this environment increased my sense of professional growth	0.77
33. Working in this unit gives me the opportunity to gain new knowledge and skills	0.76
34. I am motivated to do well because I am empowered by my work environment	0.75
31. I feel a high degree of personal responsibility for the work I do	0.65
29. My opinion of myself goes up when I work in this practice	0.65
Component 3: Control over practice (7.4/0.82)	
8. Enough staff to provide quality patient care	0.83
10. Enough staff to get the work done	0.81
6. Adequate support services allow me to spend time with patients	0.69
7. Enough time and opportunity to discuss patient care problems with other staff	0.61
5. Patient care assignments that foster continuity of care	0.35
Component 4: Leadership and autonomy in clinical practice (7.7/0.78)	
9. A manager who is a good manager and leader	0.73
1. Leadership supportive to staff	0.67
12. Manager who backs up staff in decision making, even in conflict with medical practitioner	0.64
3. Freedom to make important patient care and work decisions	0.48
11. Opportunity to work in a specialized work environment	0.42
2. My discipline (i.e. nursing) controls its own practice	0.41

Component 5: Inter-professional relationship, communication about patient care (8.5/0.80)	
16. When a patient's status changes, I get relevant information quickly	0.80
15. I get information on a patient's status when I need it	0.80
13. Physicians and department or unit staff have good relationships	0.58
4. A lot of team work between physicians and staff	0.49
17. This unit has constructive relationships with other groups in this area	0.48
14. Not being placed in a position of having to do things against my professional judgment	0.40
Component 6: Teamwork (6.8/0.72)	
20R. Inadequate working relationships with other clinical areas limit effectiveness of work on this unit	0.79
19R. Other health care providers seem to have a low opinion of this unit	0.78
18R. This unit doesn't get the co-operation it needs from other health units and facilities	0.67
Component 7: Cultural sensitivity (5.9/0.82)	
37. Staff are sensitive to the diverse patient populations they serve	0.85
38. Staff are respectful of the need for a diverse, multiprofessional health care team.	0.76
36. Staff have access to necessary resources to provide culturally competent care	0.68
Component 8: Handling conflict (5.6/0.77)	
22R. Staff withdraw from conflict	0.75
21R. When staff disagree, they ignore the issue, pretending it will go away	0.72
27R. Disagreements between staff are ignored or avoided	0.61

Comp. load., Component loading.

Establishing the relationship between variables was an important step in providing a clearer interpretation of the data. Linear regression is a measure determining the relationship between variables [6]. Linear regression analysis was used to explain variances in the total PPE scale scores, with the threshold for statistical significance set at $p < 0.05$. A measure of linear regression is known as R^2 and is between 0 and 1. Adjusted R^2 indicates the percentage of variance explained by the model [6]. The higher the value of R^2 , the stronger the relationship is between the variables [6]. As demonstrated in Table 6.14 a correlation between regular meetings with the line manager $p < 0.001$ and

identification of professional development and learning needs was identified with $p = 0.03$ and $R^2 = 0.05$. These findings indicated that those who met regularly with their line manager were more likely to have their professional development and learning needs identified.

Table 6.14 Discriminant validity: Multiple regression of management practices to Professional Practice Environment scores

Variables (total scale: PPE-38)	Beta	p value	R and R^2
Regular meetings with line manager	0.21	<0.001	R = 0.23
Professional development and learning needs identified	0.11	0.038	$R^2 = 0.05$

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As a consequence of the above parsimonious model, it was also thought that relationships between other variables might exist. Logistic regression was then used to explain the outcome variables with other independent variables in the survey.

Important relationships emerged from this analysis. Independent variables emerging as significant were having a master's degree qualification, a longer length of time in the role as a nurse educator, engaging in regular meetings with their line manager and the opportunity to identify their professional development and learning needs. The scope of practice of nurse educators was identified as a mediating variable and the dependent variable was the PPE scale.

The following hypothesis was then proposed: does the presence or absence of satisfaction with the professional practice environment relate to whether or not the nurse educator has:

- A master's qualification
- Regular meetings with their line manager
- Professional development and learning needs identified
- The length of time in their role as a nurse educator

A sequential logistic regression analysis was then undertaken using the Statistical Package for the Social Sciences (SPSS) to assess prediction of work satisfaction in the professional practice environment, first on the basis of personal and work setting predictors (master’s qualification, length of time as nurse educator, professional development and learning needs identified, and regular meetings with line manager) and second, as influenced by the scope of practice of nurse educator scale and the importance of support for the nurse educator role scale. Table 6.15 shows the correlation between these survey variables.

Table 6.15 Regression coefficients nurse educator role

Variable	B	Std. Error	Beta	t	Sig.	VIF
Constant	80.169	4.950		16.195	0.000	—
Master’s qualification	-6.966	1.695	-0.197	-4.110	0.000	1.066
Time in current role (years)	-0.424	0.131	-0.153	-3.230	0.001	1.040
Regular meetings with manager	5.637	1.568	0.171	3.596	0.000	1.052
Professional development and learning needs identified	3.957	1.402	0.136	2.823	0.005	1.083
Activities and competencies of nurse educator	0.059	0.013	0.230	4.441	0.000	1.244
Importance of support for nurse educator role	0.142	0.077	0.093	1.842	0.006	1.180

Std. error, Standard error; t, t test distribution; Sig., significance; VIF, Variance Inflation Factor.

VIF Variance Inflation Factor

In order to implement interventions to increase the functionality of the nurse educator role and individual nurse educator’s workplace satisfaction, a model was developed based on testing the hypothesis above. A regression model was developed where the contributions of education (nurse educator

qualifications), reporting and performance, the ACONE elements and ISNER scale items to the professional practice environment and workplace satisfaction are demonstrated. This is shown in Fig. 6.4.

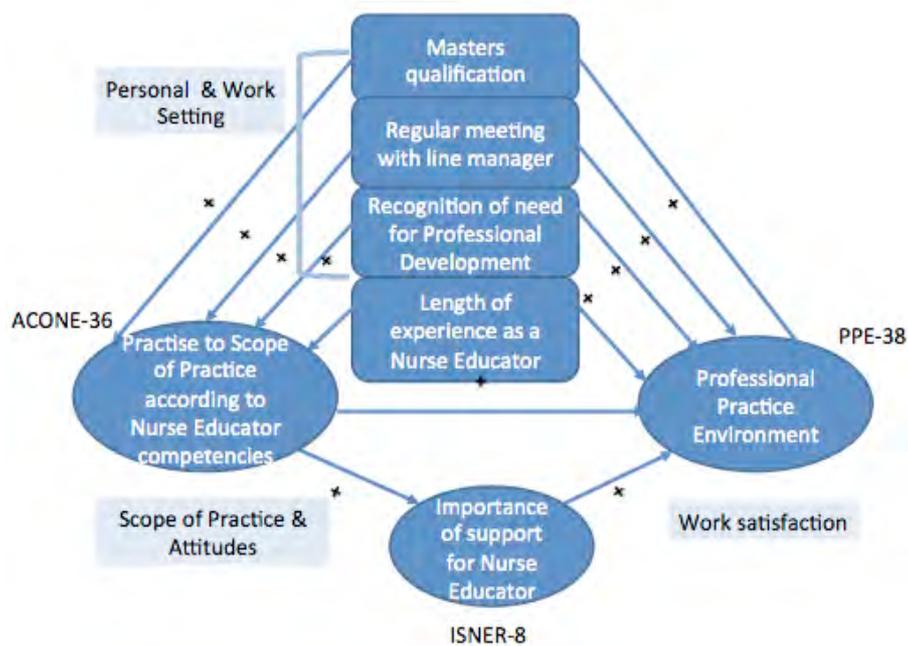


Figure 6.4 Regression model 1 nurse educator work satisfaction

The mediating variable in this model was the scope of practice. The direct relationships to the PPE are recognition of the need for professional development and regular meetings with the line manager. The indirect variables are a master’s qualification and length of work experience as a nurse educator. These factors significantly influence nurse educator practice within the professional practice environment and as a consequence, work satisfaction.

A further ‘trimmed’ model demonstrated that the nurse educators who have a master’s qualification, have their professional development and learning needs identified and/or have regular meetings with their line manager, are more likely to fulfill the key domains of the ACONE scale criteria. These items reflect the scope of practice of the educator. Personal and work characteristics of the

nurse educator influence their scope of practice and in turn their work satisfaction in the professional practice environment. These findings are presented in Fig. 6.5.

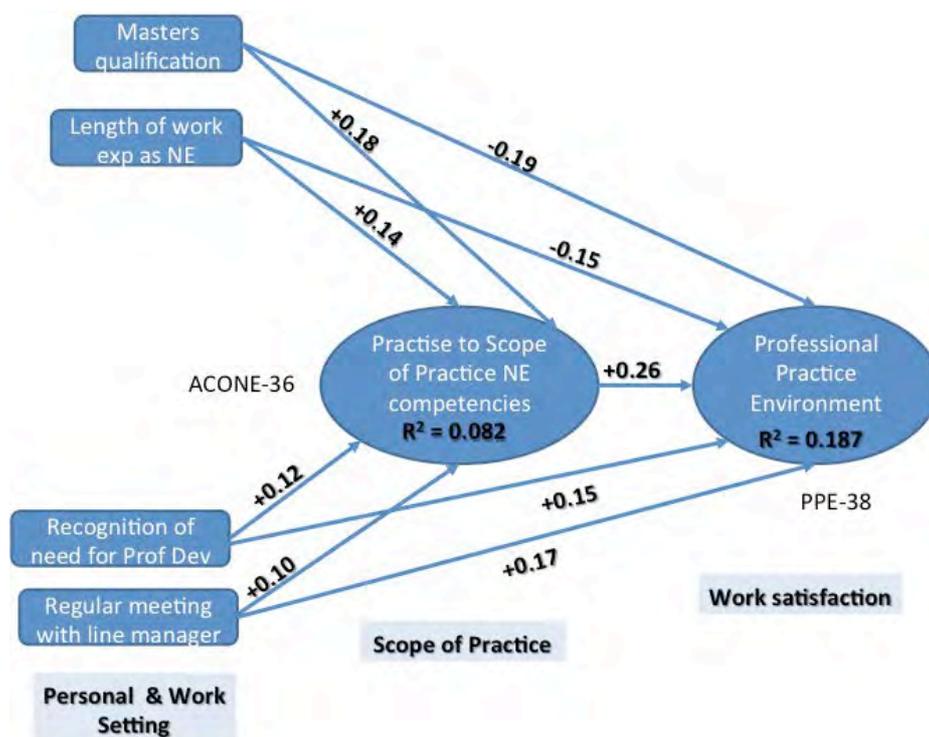


Figure 6.5 Trimmed model – nurse educator work satisfaction

6.3 Summary of Findings

Chapters 5 and 6 have presented data from two groups of stakeholders in nurse education in acute care hospitals. Qualitative and quantitative findings informed data analysis. Themes resulting from both data sets identified the enablers and barriers to nurse educator practice. The themes arising from the group interview identified in Chapter 5 – visibility, role blurring and ambiguity, role definition, career pathways, rural contexts and the multidisciplinary nature of the role – resonated with the qualitative findings from the survey described in Chapter 6.

Preliminary evaluation of the ACONE and ISNER scales has demonstrated reliability and validity and are worthy of future evaluation to determine predictive validity. As these instruments have not been previously validated, it is not possible to provide normative data. The potential for floor and ceiling effects of these measures need to be considered in future investigations. Emergent themes from the qualitative data were confirmed in the quantitative data, particularly in respect of issues in the workplace.

Ensuring roles and expectations were clearly documented and monitored was a key factor emerging from both the quantitative and qualitative data. Data synthesis has resulted in the generation of a hypothetical model that may be useful in developing the nurse educator role. Ensuring clarity of the role, clear documentation of competencies and strategies to support role enactment are likely to leverage benefits.

In summary both the qualitative and quantitative data themes provided confirmatory findings. These data have generated a model to be tested in future studies.

Role ambiguity, level of education qualifications and competency standards emerged as important in moderating performance and role enactment. The recurrence of these factors across the data sets reinforces the importance of these issues in considering the nurse educator role and the workplace satisfaction of nurse educators. Fig. 6.6 has summarized how the information generated from each data set has contributed to addressing the study questions and these perspectives will be elucidated in the following chapter.

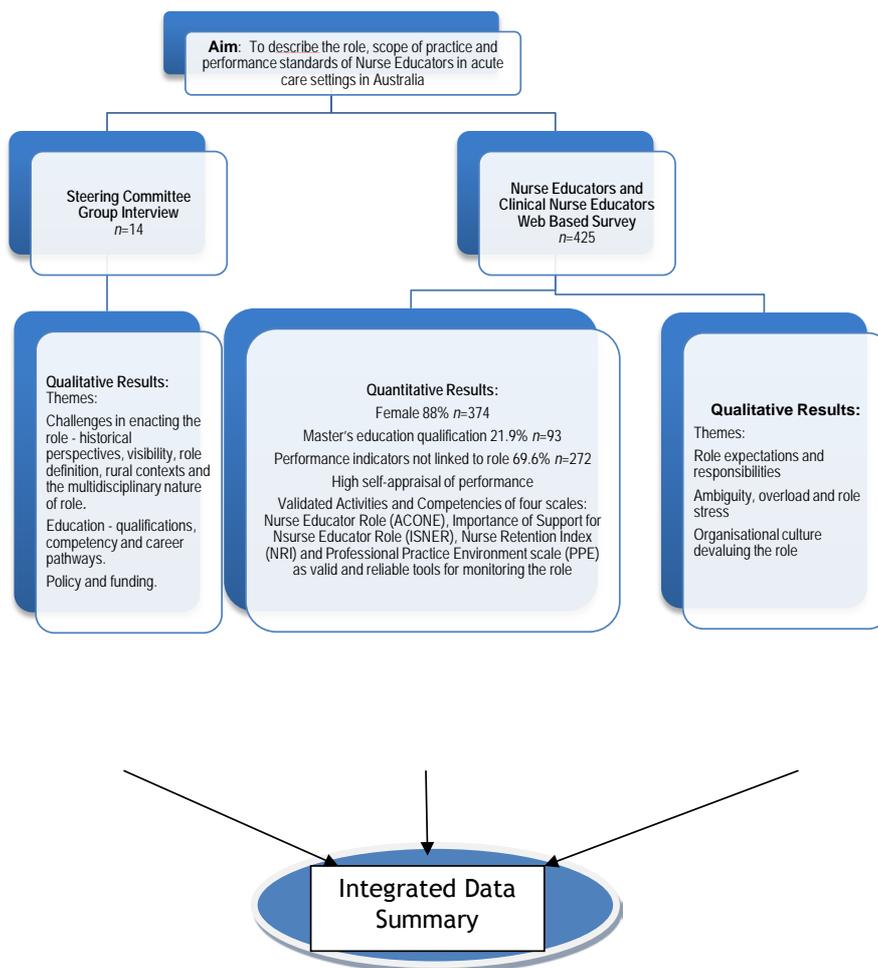


Figure 6.6 Summary of the Nurse Educator in Acute Care Hospitals Study

6.4 Conclusion

This chapter has presented the quantitative findings from the survey, describing the socio-demographic and educational profile of nurse educators, their reporting lines, activities and competencies, and self-appraisal of performance. It has also applied qualitative data from the group interview and survey to confirm and elucidate findings. The findings have demonstrated psychometric principles showing the ACONE, ISNER, NRI and PPE scales to be reliable and valid instruments to monitor the nurse educator role.

The key findings of the survey were: (i) role blurring and ambiguity affecting role visibility, optimization and work satisfaction; (ii) nurse educators with a Master's qualification, were more likely to identify professional development and learning needs, and those who have regular meetings with their line manager, were more likely to identify their role using the ACONE scale items; (iii) clinical performance outcomes are necessary to demonstrate the contribution of nurse educators to patient care and education; (iv) limited engagement in research and scholarship influences evidence-based practice, role visibility and career development.

The survey provides an important baseline for future role development and capacity building initiatives for nurse educators in acute care hospitals. The integration of data highlights differences and similarities between the data sets to be explored further through the discussion of findings in Chapter 7.

6.5 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 7 – Discussion

7.1 Introduction

Implicit in the development of nursing workforce education models in the acute care sector is an understanding of the role of the nurse education workforce. To date there has been limited investigation of the nurse educator role in acute care hospitals. The purpose of this study was to investigate the nurse educator role in acute care hospitals in Australia and make recommendations for the development of the role by addressing the following study aims:

1. Describe the existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care hospitals in Australia.
2. Describe the contribution of nurse educators to nursing and inter-disciplinary education.
3. Develop competency standards to guide nurse educator practice in acute care hospitals.

By combining quantitative and qualitative analyses, a comprehensive picture of the nurse educator in acute care hospitals emerged increasing the convergent validity of the study findings. This approach to triangulation enabled comparisons to be made about differences in role enactment and responsibilities, facilitating deeper insights and understanding of the nurse educator role.

Chapter 7 has integrated and interpreted the data sources reported in Chapters 5 and 6 identifying how the findings from this study address the study's aims and add to the body of knowledge on the role of nurse educators in acute care hospitals in Australia. Findings from the group interview revealed three common themes influencing the nurse educator role namely: (i) challenges in enacting the role; (ii) education and (iii) policy and funding. Thematic analysis of qualitative data within the survey identified three role related themes namely (i) expectations and responsibilities; (ii) role ambiguity, overload and stress; and (iii) organizational culture devaluing the role. Quantitative findings presented in Chapter 6 related to the eight survey components: (i) socio-demographic and educational characteristics; (ii) reporting and performance; (iv) Activities and Competencies of the Nurse Educators (ACONE); (v) self-appraisal of performance;

(vi) Importance of Support for Nurse Educator Role (ISNER); (vi) role overlap and ambiguity; (vii) Career Intentions (Nurse Retention Index (NRI) and (viii) Professional Practice Environment (PPE).

Key issues emerging from the NEACH study are the importance of developing and implementing standardized role definitions, identifying performance indicators influencing patient outcomes and monitoring the practice environment. In this chapter, these issues are also discussed in the context of the extant literature and the strengths and limitations of the study are also addressed.

7.1.1 Characteristics of survey participants

The NEACH survey respondents were predominantly female (88%), slightly less than the percentage of females within the nursing population in Australia (90.6%) [1]. However, this sample had a higher population of males (12%) than the wider Australian nursing population of male registered nurses (9.6%). Nonetheless, gender imbalance in the nurse educator workforce exists and may be further explored in future nursing research. The respondents for this survey were older than the mean of 44.1 years for the Australian nursing population, reflecting the seniority of several participants [1]. The titles clinical nurse educator (40.2%, $n=171$) and nurse educator (37.6%, $n=160$) were the two most common role titles given, although seven other titles were reported. This is consistent with other studies reporting ambiguity and inconsistencies in nursing roles [2,3].

A number of nurse educators were employed part time (31.4%, $n=145$). This was described in the qualitative data and appeared to be an increasing trend characteristic of employer-initiated reductions in working hours related to budgetary requirements, as opposed to employee choice.

The higher number of respondents in NSW (53%, $n=225$) may be associated with a higher percentage of nurses overall in NSW, and a higher percentage of acute care hospitals, as opposed to other states and territories. This response rate may also reflect the researcher's networks, including academia, the Australian Nurse Teachers Society, and NSW health services.

The one respondent from the ACT may have reflected limited dissemination of the survey advertising through hospitals in that territory. In one instance, a hospital manager contacted the researcher advising that information regarding the survey

would not be disseminated unless ethics approval was sought through hospital processes. However, University ethics approval had been obtained as noted in information disseminated that advertised the survey. As the research was deemed 'low risk' and was being conducted with nurse educators as private individuals as opposed to as employees in specific hospitals, ethics approval from individual hospitals was not sought. Respondent rates were anticipated to be small given there are only two acute care hospitals in the ACT.

7.1.2 Qualifications and continuing professional development

Nurse educators assume an advanced registered nurse role performing in accordance with the competency standards for registered nurses defined by the Australian Nursing & Midwifery Accreditation Council [4]. All nurses require core knowledge and skill development to achieve competence and performance expectations of their role. Nurse educators are advanced registered nurses and a specialty group within the nursing profession. Arguably, specialty nurses require advanced knowledge, skills and expertise to perform within their specialty practice [5].

Although the nurse educator, as an advanced registered nurse, needs to be clinically competent, it is argued that this expertise and a qualification at the baccalaureate level or less is insufficient to adequately prepare nurse educators to assume this advanced specialty role [6]. Although the majority of nurse educators who completed the survey reported having tertiary qualifications in education, few (21.9%, $n=93$) were prepared at the master's level.

Master's programs with an educational and research focus would ideally prepare individuals for the advanced role of the nurse educator [7]. Programs at the Master's level are designed to provide students with the theoretical knowledge and critical thinking skills necessary to assume advanced roles in their career [7]. Preparation at the master's level enables graduates to research, critically appraise, synthesize and apply advanced education and research concepts to lead nurse education and nursing practice that will optimize patient outcomes [7]. Nurse educators who engage in postgraduate master's programs harness this advanced knowledge and expertise to inform their competency in facilitating authentic learning and professional development in the clinical setting [8].

In the Australian context, registered nurses are required to have a minimum of a bachelor's degree and some nursing programs leading to registration are conducted at the master's level [9]. There is an increasing consensus identified in the literature review discussed in Chapter 2 that the specialty education for nurse educators should be at a master's level.

The existing ad hoc approach to education requirements required to perform the nurse educator role is unhelpful in fostering role identity and credibility as an advanced registered nurse [6]. Models in medical education [10] together with the focus within the ANMC competencies for the registered nurse to assume a teaching role [4], have potentially influenced perceptions that nurses can and do provide education to one another [11] and that the nurse educator role is less important. In redefining their role, nurse educators should consider the qualifications and continuing professional development requirements required to support role enactment [8,12]. As the Steering Committee noted, this is also important to support the development of career pathways [13].

7.1.3 Postgraduate program curricula requirements

To further support nurse educators to perform their role and address health service challenges, postgraduate curricula reflecting the role of nurse educators in addressing health care quality and safety through their work is important. Curricula reflecting leadership, management and partnership concepts as tenets for creating and sustaining clinical learning environments are required [11]. Grounding in foundational aspects of education, teaching and learning in clinical practice will provide requisite knowledge and skills [6,8].

7.1.4 Challenges in enacting the nurse educator role

The qualitative data from the group interview (Chapter 5) identified the impact of changes in the models of nurse education and professional development identification. Stakeholders discussed that the move of undergraduate nurse education from schools of nursing to universities, although welcomed, has decreased the visibility and power of the nurse educator role within hospitals [14].

Moving undergraduate education to the university sector has signaled an increasing distinction between clinical and educational contexts, not only for students but also for educators and academics. These findings correlate with those described in international contexts [15], as well as the literature review reported in Chapter 2.

During the last decade, further changes for nurse educators have ensued including the introduction of other nursing roles with responsibility for nurse education, such as nurse consultants, nurse practitioners and, in some states, growth in education programs (such as nurse initiatives in schools, the Trainee Enrolled Nurse Program, and graduate certificate courses). This period of growth has been followed in the past 5 years by the loss of provision or co-provision of these programs from local health services, due in part to financial pressure within health services [14-16].

Changing health priorities, services and the education required to provide optimal care have provided additional challenges for nurse educators including an enhanced focus on chronic and complex care, working across services and hospitals and providing education to an increasingly diverse workforce [17]. As a result of these changes, nurse educators have become more engaged in clinical education, specialty and facility-wide clinical education and professional development programs. This has included new graduate programs with the option for a 'second year' rotation, mandatory education, a range of clinical-education specialty courses and continuing professional development programs such as clinical leadership, preceptor and mentor courses [6].

Change is a constant feature of the clinical practice environment [18]. As a consequence the nurse educator role in acute care hospitals will likely continue to change and evolve over time. The opportunity to reconsider and change the nurse educator role in the next few years is real and feasible in light of the opportunities for role review as described by the National Health and Hospitals Reform Commission Final Report and Health Workforce Australia initiatives to build workforce capacity and skill development and in view of key reports highlighting the need to transform nurse education to develop a competent and skilled workforce [18-20].

7.1.5 Role blurring, ambiguity, conflict and stress

The data presented in Chapter 5 and 6 underscore the utility of the construct of 'role' in describing how the nurse educator position interfaces with the broader hospital organization. Role blurring and role ambiguity emanating from role theory afford a construct for considering how nurse educators may be influenced by, and respond and interact with, their colleagues and the practice environment [21]. The restructuring of nursing roles and minimal acknowledgement of how these changes may have influenced role enactment further compound role ambiguity and blurring [14,17,22]. Study findings have identified role blurring and ambiguity between the nurse educator role and other nursing roles [6,14].

Job satisfaction and motivation is strongly influenced by role identity [22]. Failure to address role blurring, ambiguity and role overlap may adversely affect nurse educator job satisfaction and motivation [21]. In turn, motivation and satisfaction may be further influenced by loss of group identity in response to changing health care environments and workforce reform [22]. Although individual nurse educators may be conscious of threats to their professional identity, they frequently fail to acknowledge the significance of communicating their practice and professional and organizational contributions [14]. This perspective personifies findings from the literature review reported in Chapter 2 noting limited evidence of the nurse educator role in Australia [6]. These findings also personify the relationship between role and role identity as described in Chapter 3 [23].

7.2 Reporting and performance

7.2.1 Defining the role

The ability to define the work of nurses is important and applicable to all nursing roles [24]. Role definitions provide clarity not only to the specific professional group but also importantly to peers, other professional groups within the workplace and the community. Defining what we do and informing others of our role provides clarity in expectations and performance of the behaviors and characteristics we assume within a position as described by role theory in Chapter

2. Redefining nursing roles also presents challenges and opportunities underpinned by imperatives to integrate professional and educational requirements and practice competencies within role development frameworks [25].

In the Australian context, as noted in the literature review in Chapter 2, there is no consensus in terminology used for nurse educator roles. This is consistent with the vague terminology applied to nursing and midwifery roles noted in government reports and regulatory guidelines [26]. An important factor in employee performance and satisfaction is having a clearly defined role, job description and regular feedback on performance [27]. Without a clearly defined role, nurse educators may have differing notions of role parameters, as may their managers and other nurses and health professionals with whom they interact. Collaboration between nurse educators and other key stakeholders is important to determine an appropriate role definition.

The findings from the NEACH study emphasize the importance of identifying roles, responsibilities and expectations of nurse educators and of developing and validating nurse educator competencies. This highlights the need for educators, employers and professional associations to work collaboratively to determine the role and scope of practice of educators. The definition posed by the researcher in Chapter 1 that ‘a nurse educator is defined as a registered nurse and professional expert whose primary responsibility is to provide education to undergraduate and postgraduate nursing students, graduate nurses and other occupational groups within a hospital setting’ is a broad definition embracing a range of titles for nurse educators (e.g. nurse educator, clinical nurse educator, staff development nurse) employed within hospitals across Australia assuming responsibility for educating the groups cited above. This definition may provide the starting point for further discussion within the profession to gain consensus regarding a role definition.

7.2.2 Feedback to improve role effectiveness

Performance review provides the opportunity for nurse educators to receive feedback on their performance and to identify and negotiate performance goals and career aspirations [27]. Nurse educators require regular feedback to validate that they are performing to their full scope of practice and to acknowledge their achievements. This view was apparent when respondents ranked the item ‘uses feedback from learners, peers and your manager to improve role effectiveness’ (7.88±1.03) with the highest score in the ACONE scale. This finding demonstrates

that the nurse educator values feedback and performance review. Without this performance review and support, nurse educators are likely to disengage from their roles and workplaces or perform inadequately.

7.2.3 Clinical and performance indicators

Specifying performance indicators is increasingly necessary as ‘non-clinical roles’ – that is, roles not directly responsible for providing patient care – such as the nurse educator role, are under scrutiny to provide evidence of their contribution to patient and health outcomes by health managers at all levels, particularly in the current climate of fiscal restraint. This is not an unreasonable response on the part of health managers in the face of limited empirical evidence demonstrating the effectiveness of continuing professional education and significant monetary expenditure associated with these programs [28].

As nurse educators reported in the qualitative findings in Chapter 5, they are at times ‘...taken out of their role to take patient loads and pick up the slack’. When this occurs, management may well assume that nurse education and research is less important than the ability of educators to assume a clinical load. Management may also perceive that the work of an educator does not equate to a full workload. This leaves the ‘door wide open’ for managers to speculate that the nurse educator position is unnecessary or that fewer hours are required to perform the role. It is a strategy employed to meet budget targets.

Nurse Unit Managers need to ensure they have adequate staffing, but they also need to ensure that their staff receives ongoing education and support to achieve safe patient outcomes. This cannot be achieved if nurse educators are used as ‘casual’ staff that can be called upon to provide direct clinical care as and when required, while their primary responsibility of educating staff is negated.

As described in the literature review in Chapter 2, nurse educators influence patient outcomes through teaching and supervising staff, improving recognition of the deteriorating patient, and preventing and managing falls and medication errors [29]. It is important to align performance indicators to the work of nurse educators to ensure that every effort is made to optimize patient outcomes.

Only 69.6% ($n=272$) of study respondents reported that their role was linked to specific clinical indicators or performance outcome measures. Although some

nurse educators reported that they had clinical indicators for their role associated with falls, changes in clinical practice and medication safety, for example, it is important that nurse educators discuss and achieve consensus regarding appropriate clinical indicators, how they will be measured and, if appropriate, benchmarking these across units and facilities.

Nurse educators also indicated that they ‘monitor outcomes in relation to educational activity’ (ACONE: 6.63±1.95). It is important that nurse educators work with their peers and managers to determine appropriate performance indicators that capture their contribution and impact on nurse education, as well as identifying opportunities for performance improvement. Performance outcome measures also provide evidence to peers, managers, health organizations and the nursing profession of the contribution of nurse educators to patient outcomes and education.

7.2.4 Identifying learning needs

Nurse educators appreciate the importance of professional education and supportive work environments in influencing the delivery of safe, quality patient care [30]. Identification of learning needs, career aspirations and the development of a professional development plan in support of continuing professional education are also important factors that support performance [31, 32]. The study findings reported in Chapter 6 show that staff whose professional development needs are identified as part of the performance review process, perceive their contribution to the workplace to be valued and are likely to have a higher level of job satisfaction [27]. Organizations delivering safe, quality nursing care value their employees and value these processes [32].

7.3 Activities and Competencies of the Nurse Educator

7.3.1 Competencies informing role description and guiding practice

Competencies reflecting the scope of practice of nurse educators were measured using the researcher-developed ACONe scale (Survey Domain 3) as reported in Chapter 6. The six competency domains: education program development,

teaching and mentoring, educational and clinical leadership, professional practice improvement, research and scholarship, and education management, are a reflection of the scope of practice of nurse educators across Australia on the basis of these survey findings.

Psychometric properties of the scale were measured and results indicated that the scale was reliable and had adequate content and construct validity. The scale provides a promising measure for managers and educators in both acute care hospitals and other settings to be used as a framework for developing position descriptions and performance indicators. This should be a focus of future studies.

7.3.2 Role expectations and responsibilities

Responses to the ACONE scale, presented in Chapter 6, indicate that such competencies reflect nurse educators' scope of practice. These have been further informed by the values, attitudes and beliefs of nurse educators identified in the free-text survey comments reported in Chapter 5 (Figure 7.1).



Figure 7.1 Role expectations and responsibilities of the nurse educator - Findings from Qualitative Survey data

Written responses in the free-text survey question indicate that nurse educators have attempted to clarify their role criteria and scope of practice for themselves and demonstrated a consistent understanding of their responsibilities, despite the confusion that exists regarding their role.

Of particular note within the qualitative data from the survey, was the belief that nurse educators need to be expert clinicians to assume a nurse educator role. These findings may reflect that nurse educators value the knowledge and expertise they have developed as a clinician and the transferability of these attributes in role enactment irrespective of their workplace. Likewise, nurse educators reported that they valued the knowledge and expertise developed as an educator through formal completion of study in education. Although nurse educators use their clinical and education acumen to lead and develop practice, their skills as researchers and scholars are slowly emerging.

The ACONE instrument criteria have further clarified the role and responsibilities of nurse educators in education program development, teaching and mentoring, educational and clinical leadership, professional practice improvement, research and scholarship, and education management. The criteria within each of these competencies reflect the range of activities engaging educators in each competency domain. They also reflect the tenets of symbolic interactionism where human interactions, situations, reference groups and environments within which nurse educators work allow for a broader understanding of the meaning of communication and behaviors of nurse educators within acute care hospitals.

Education Program Development

In Competency Domain 1, 'Education Program Development', respondents demonstrated that they are actively engaged in developing and delivering education programs to nurses and other staff. The integration of educational theory and evidence-based approaches in teaching activities is important to nurse educators and they are actively engaged in programs facilitating clinical practice. However, they have minimal involvement in the development and delivery of undergraduate and postgraduate education and do not view these activities to be central to their role. This is similar to findings by Guy *et al.* (2010) in their study identifying curriculum development as not being a core element of the nurse educator role [12]. These findings may also have developed as a consequence of the terminology used, where 'curriculum' may be more often associated with

universities. Respondents may not have perceived the criteria 'Facilitates the development, implementation and evaluation of curriculum and education programs' as relating to the education programs they already engage in, such as hospital-based cannulation courses, for example, as opposed to courses leading to a formal tertiary qualification.

Teaching and Mentoring

In Competency Domain 2 'Teaching and Mentoring,' respondents, prioritized teaching as a core element of nurse educator practice, reflecting findings from the literature [14,15]. The responses in this domain, have demonstrated that nurse educators consider their engagement in self-reflection and modeling critical and reflective thinking as the most important facets of their role in teaching and mentoring. These attributes reflect the skills of an advanced nurse and demonstrate their potential to influence patient outcomes through problem solving of clinical and professional issues with nurses.

Equally important is the feedback from multi-leveled staff with whom the nurse educator works. This reflects nurse educators' awareness that receiving feedback is as important as giving feedback and in the case of the nurse educator, is fundamental for improving teaching practice to achieve defined education outcomes. Feedback may be obtained using resources such as the 360 degree feedback survey to assess performance, teaching and learning effectiveness, as well as return on investment from education for the organization [33]. This is important to facilitate role optimization and effectiveness as well as in identifying learning needs and opportunities for improvement [33].

Although nurse educators in this study acknowledged the importance of promoting the development of professional behaviors and role socialization, promoting positive learning environments and using various teaching and learning strategies, their perceptions of the importance of cultural competence and the application of associated principles in their work was not a high priority. Given the ageing population and cultural and socio-economic diversity of the Australian population as reported in Chapter 1, nurse educators may need to consider their knowledge and application of cultural competence in their teaching and interactions with students and other health professionals [34].

Mentoring

Nurse educators surveyed in this study agreed that mentoring is an important role function and assume mentor roles supervising and providing expert guidance to registered nurses engaged in clinical teaching with peers, novices and students. Reflection and exploration of their practice through engagement with students and novices may contribute to their own learning [35].

Educational and Clinical leadership

Responses to Competency Domain 3 'Educational and Clinical Leadership' indicate that nurse educators perceive their role to provide leadership in ongoing review of education and clinical practice at the local level. The impetus for developing leadership capacity in health care globally has arisen from change and technological innovation. This has resulted in the identification of clinical leaders capable of leading change, teamwork and evidence-based education and patient-centred care [36].

The majority of respondents are seemingly less involved in educational and clinical leadership at a broader level than nurse education managers. This reflects that the activities within this domain are not necessarily considered by nurse educators to be core elements of their role. These activities may better reflect the responsibilities of a nurse educator who manages a new graduate program, for example, or an educator working across a health service or working as a nurse education manager.

Developing leadership capacity

Nurse educators perceive themselves as clinical leaders and role models as indicated by their high ratings for the item 'Provide leadership in the ongoing review of education and clinical practice'. The development of leadership capabilities to reconfigure practices and processes encouraging new practice and new learning are important [37]. This requires nurse educators to be change agents as well as transformational role models by modeling and fostering expert behaviors [18]; demonstrating proficiency in care provision [37]; fostering team integration and acknowledging contributions that encourage staff to teach and learn [11].

The impact of effective role modeling on learning cannot be underestimated in influencing attitudes, behaviors and practices of both students and experienced nurses, as verified in Henderson's work on learning environments [11].

Leadership is an important attribute for nurse educators developing and monitoring learning environments to build workforce capacity [11]. Clinical and educational leadership will be increasingly important as the healthcare sector faces difficulties associated with recruitment and retention, consumer demands, increasingly costly technological treatment methods and the requirement for efficient, effective care. The skill set of nurse educators will include the requirement for educational and clinical expertise, critical thinking and problem solving capabilities, as well as the capacity to be knowledgeable of the political and policy imperatives of influencing nursing education and healthcare. They will also need to welcome change, be adaptable to withstand these environments, and create supportive and empowering workplace cultures [37].

Professional Practice Improvement

Professional practice improvement occurs as a consequence of the nurse educator reflecting on their performance, identifying whether or not they have met performance expectations and identifying how they may improve their performance. This can be accomplished through considering evidence of achievement in relation to performance indicators, as well as verbal and written feedback on performance through education program evaluation tools and performance review [36].

Nurse educators have reported – in Survey Component 4. 'Professional Practice Improvement' – on their awareness of current issues and trends in nursing practice and education through their involvement in professional organizations. However, the data presented demonstrates they are less involved in professional practice improvement at the local level. This finding highlights the importance of nurse educators identifying opportunities for practice improvement and assuming a leadership role in leading these activities. For example, nurse educators may lead a collaborative project to identify, monitor and evaluate nurse sensitive outcome indicators demonstrating the contribution education makes to developing clinical competence and patient outcomes.

Research and Scholarship

The means scores for the domain 'Research and Scholarship' suggest that study participants do not priorities research and scholarship as highly as other tasks within their portfolio. Considering the importance placed in nursing curricula within undergraduate and postgraduate programs across Australia on the value of research, and the global recognition of evidence-based practice to improve patient outcomes [18], there seems to be a gap in applying these principles to nurse educators' own practice. If educators are not engaging in research or scholarship, then it is unlikely other nursing staff would be encouraged to investigate their practice. This also highlights ambiguity between practice development, translational research and investigator-driven research. Similar to Guy's study [12], some nurse educator comments from the qualitative data within the survey stated that they thought research was important - '*I am an enthusiastic advocate of research*' but they lacked support from management to engage in this activity - '*...management neither values our contribution to workforce education nor perceives research to be an integral part of our role*' or identified that it was not a performance criteria within their job description. These findings may partly explain the results in the NEACH study. The other contributing factor may be that nurse educators who have not studied at a master's level or who have undertaken a master's by coursework degree may not have the skills and competencies required to identify research needs and conduct or collaborate in research studies. Engagement in nursing research drives evidence based practice and optimal patient care [38].

Embracing research and scholarship is an essential tenet of nurse educator practice [18]; nurse education research will not only inform nurse educator professional practice but may also inform nursing policy and practice in acute care where identified research priorities are established and implemented and subsequent findings disseminated through publication, conference proceedings and other professional presentations but importantly applied in practice. Failure to engage in nursing research and scholarship diminishes nurse educator credibility and potentially their viability within the nurse education workforce. Nurse educators who aspire to work in academia also need to be developing their research and scholarship profile to enable them to progress in this career pathway [18].

Engaging with university providers

Study findings identified that engagement in academic activities and seeking partnerships with academic colleagues were not perceived as highly as other activities. This finding is further verified by the limited literature published in Australia by nurse educators. Ultimately, research success is dependent on collaborative relationships within a research team [39]. Research collaboration facilitates novice researchers, such as nurse educators, in the development of research skills and allows knowledge development through partnerships and shared meaning across practice contexts [39]. Partnerships such as this between academia and the practice environment also serve to unify nurse education endeavors across sectors as well as fostering effective clinical education [39,40]. As healthcare globally focuses on the challenges associated with the needs of ageing populations and those living with chronic illness, nurse educators can contribute to addressing these challenges. Research adding to the evidence base for education and nursing practice and education programs focusing on changing healthcare and workforce needs are required [39].

Developing and informing policy

An understanding of the social, economic and political drivers impacting the health system is necessary for nurses to be influential in initiating and managing change and reform to policy and practice [41]. Policy to support role review and funding for nurse educator positions will engender change and, ultimately, the quality and safety of care provided. The time has come for nurse educators to be visionary, to establish and voice the agenda for role advancement and educational transformation in clinical practice. Failure to take up this challenge increases the risk of further role ‘invisibility’, particularly when evidence that roles not directly responsible for patient care are under scrutiny [14]. The nurse educator role is not redundant, but instead is central to effective education in clinical practice.

Education Management

In Competency Domain 6 ‘Education Management’, educators acknowledged that they identify with the domain criteria as part of their role, although the level of importance of these items may be subject to the role the nurse educator assumes – such as a clinical nurse educator with unit specific responsibilities compared to an area educator who may assume a more strategic role developing education programs and services for a larger group of educators. This finding may also

reflect that nurse educators may not have the expertise to initiate or engage in these activities as a consequence of limited experience and professional development in project and change management.

7.4 The Professional Practice Environment

Health workforce research demonstrates the link between ‘high performing’ human resource practices that value employee participation and organizational outcomes, including patient care [27,42]. As well as determining the reliability and validity of the professional practice environment, group differences between the professional practice environment subscales and total scale provide important insights about nurse educator role performance and satisfaction. Specifically, staff who had regular meetings with their line manager and those whose professional development and learning needs were identified, reported higher overall satisfaction with their professional practice environment.

These findings support the assertion that staff that have identified career opportunities and an emphasis on professional development perceive that their contribution is valued in the organization they work for [27]. Performance review provides the opportunity for staff to receive feedback regarding their performance and to clarify and negotiate performance goals and career development strategies [27]. It is also influential in motivating employees – an important factor particularly amid times of change and health reform that may be challenging [27]. Nurse educators need to have the opportunity to engage in performance appraisal including feedback regarding their performance, the achievement of performance indicators and development of a professional development plan.

Nurse educator responses within the PPE scale concurred with Buchan’s view, (2004) acknowledging that they perceive a high degree of accountability and responsibility for their work [27]. Working within a specialty also influences work motivation.

Specialty practice in the acute care setting may include emergency, intensive care and cardiac services. Within these units patients are high acuity and require specialized care. They may also have co-morbidities that increase their risk of adverse events. In these high technology high-pressure environments, employee motivation – the desire and willingness to work and to meet personal,

professional and organizational goals – is very important in maintaining patient safety and minimizing adverse events [18, 36]. If nurse educators are motivated in the performance of their role, they may be influential in motivating nurses with whom they work, further enhancing patient outcomes and an empowering practice environment. Nurse educators perceive the promotion of positive learning environments through collaborative partnerships as a high priority. Their engagement through this teamwork also highlights the clinical leadership role they assume, demonstrating the importance of collaborative teamwork in arriving at decisions where stakeholders have had the opportunity to voice their expert opinion and move forward as a team to enact care, policy or education.

Lower scoring items within the PPE scale reported in Chapter 6 ‘Control over practice’ may reflect the diversity of educator practice and acknowledgement that their role does not include a patient load. Component 4 ‘Leadership and autonomy in clinical practice’ had lower scores that related to (i) nursing as a discipline having control over practice and (ii) ‘my opinion of myself goes up when I work in this practice’. These reflect the diversity of practice across units and hospitals. Scores on ‘Interprofessional relationships, communication about patient care’ highlight the need to improve interdisciplinary teamwork and communication and the need for professional expertise to be acknowledged and valued. This finding concurs with issues regarding teamwork and communication highlighted in the literature as important predictors of adverse events [43].

Monitoring of work performance and goals within a professional development framework appear to be important to nurse educators as they provide evidence of their achievements and contribution to patient care and nurse education. Conway and McMillan (2006) emphasize that factors impacting health service delivery and nursing work are dependent upon knowledgeable nurses exposed to multifaceted education, enabling their appropriate responses to challenging health care and nursing practice in diverse contexts [44].

Nurse educators need to be knowledgeable workers capable of addressing health service challenges [6]. However, their contribution to patient care through nurse education needs to be measureable and visible to sustain role viability [6]. This can be achieved through role delineation, clearly identified performance indicators, research and scholarship and active engagement in policy.

Consideration of the characteristics of the professional practice environment in which nurse educators are employed and identifying strategies for improvement may optimize their performance and enhance strategies for recruitment and retention of nurse educators.

7.5 Professional visibility and viability

Study findings suggest that the discrete nurse educator role in hospitals is becoming less visible. Assertions regarding loss of visibility and identity are attributed in some degree to other nursing roles assuming responsibility for education such as clinical nurse consultants [14]. Other reasons may relate to lack of role promotion among other professionals together with role redundancy, as reported by survey respondents.

Diminished visibility could also reflect the reliance of nurse educators on existing systems to enact their role with limited opposition and stress. This occurs with role blurring [45]. Educators may also have been unprepared or unwilling to engage in shifting paradigms in education in clinical contexts. This has been brought about not only by role changes but also by health reform, the amalgamation of services and, in some areas, the loss of nurse educator and nurse manager education positions, as reported by respondents.

Another emerging factor contributing to identity loss may be increasing advocacy for registered nurses to teach in clinical practice, a requirement within the scope of practice of the registered nurse [11]. Nurse educators need to recognize that this does not mean that the nurse educator role will be eradicated [46].

7.6 The way forward: revitalising the role – nurse educators leading nurse education and practice change

Study data reveal that nurse educators may not necessarily perceive themselves as assuming a leadership role nor recognize that they are expected to be change agents within the profession, leading and bridging the gap between theory and practice. Nurse educators combining their clinical practice expertise and passion for teaching are role models for students and graduate nurses and are integral to the development and implementation of evidence in clinical practice [18].

The challenge for nursing leadership is to raise the nurse educator profile through industry and specialty role validation and capacity building. This is important as professional support and supportive work environments are acknowledged to be influential in the delivery of patient outcomes and nurse educators are integral to achieving this [47].

Nurse educators have been described as central to providing education programs and assessing competency to practice in nursing roles at all levels [18]. The challenge for nurse educators is to redefine their role, building capacity to address the education requirements of the nursing and health workforce [18]. Consistency in role titles and development of core competencies are needed. To address the specific needs of diversely skilled students and graduates, educators require expert knowledge to guide and support individual staff as they transition from novice to expert. This is contingent upon healthcare infrastructure to recruit, support and sustain competent generalist and specialty nurse educators. A career pathway including joint appointments between health services and universities at varied stages may also enhance role development and career advancement.

Continued development of the nursing profession and its ability to address society's healthcare needs is implicit upon the nurse educator role [18]. If teaching and learning are valued as core business requirements in clinical practice environments, the contribution of nurse educators through role modeling, guiding the development and implementation of evidence, and supporting learning and skill acquisition is invaluable.

The recent move to national nurse registration and the associated requirement for mandated continuing professional education in Australia may also impact on the provision of nurse education in clinical practice environments [13]. Consequently, the role of the educator in providing these programs needs to be addressed. Ultimately, sustaining and developing the nurse educator workforce is crucial to the achievement of a competent well-educated workforce – a key issue in health reform and patient-centred clinical practice.

Enhanced job satisfaction, as a consequence of valuing and supporting staff, may also influence nurse educator retention [27]. The correlation between work factors and job satisfaction, coupled with the ability of nurse leaders to impact these factors is an important step in addressing nursing workforce issues [31]. The

model for nurse educator satisfaction, as shown in Figure 7.2, is derived from the survey analysis and demonstrates the influence of individual and workplace characteristics, scope of practice and the professional practice environment on work satisfaction. The model derived from this study needs to be tested in future studies and may provide a framework for future studies. These elements include the length of time employed as a nurse educator, having a master's qualification, recognition of the need for professional development and the need to meet regularly with a manager.

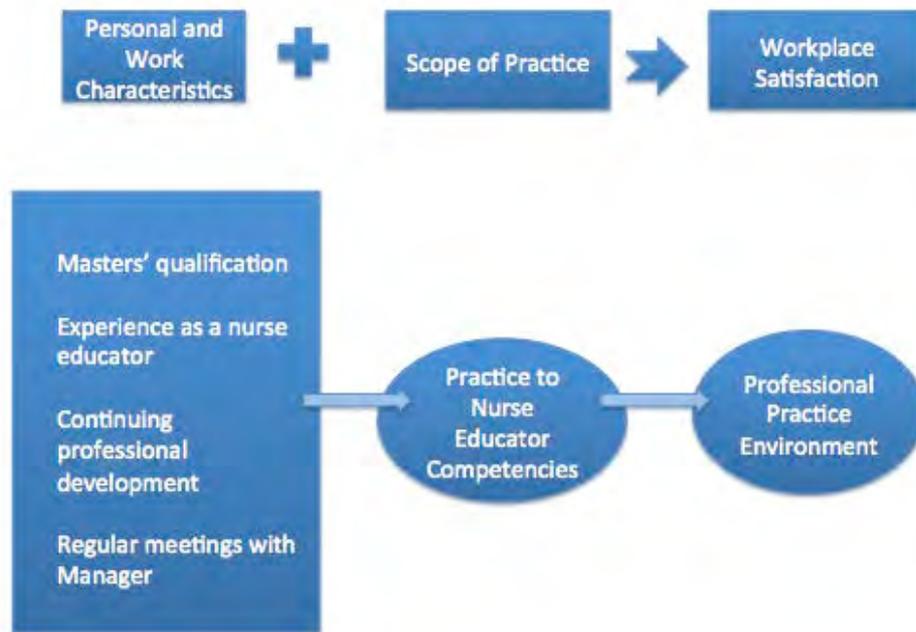


Figure 7.2 NEACH Model of Nurse Educator work satisfaction

7.7 Strengths and limitations

The NEACH study has provided a useful snapshot of the nurse educator role in hospitals in Australia. The study has been strengthened by using a range of data approaches. Where possible, valid and reliable measures have been employed to make the study more robust and four measures, the ACONE, ISNER, NRI and PPE instruments have been found to be valid and reliable. In essence, the study is sequentially and conceptually sound.

Nonetheless, study limitations require consideration. Using a self-report survey design renders issue of responder and sampling bias. The survey items were developed *a priori* from the literature review [6] and group interview findings,

items within each survey domain demonstrated a high internal consistency. The lack of a sampling frame for the survey precluded random sampling. This is a clear limitation. Although exhaustive means of contacting nurse educators were used and different methods of completing the survey, representation across States and the public and private sectors was limited. A sample with larger participation rates from states and territories other than NSW would have provided a richer data source from which to draw conclusions.

In spite of these limitations, data from the NEACH study have provided not only a snapshot of the nurse educator role in Australia, the instruments provide a useful starting point for both process and outcome evaluation.

7.8 Conclusion

The key findings of the study are that the nurse educator role is characterized by role ambiguity arising from blurring of role responsibilities for education within practice settings. Role ambiguity is likely heightened in organizations where the role is less well defined and the role of education is not as prioritized as other tasks. Strategies for enhancing role definition and capacity building through career pathways and professional education and competencies for guiding and evaluating practice were identified from the study data. The strong marker of tertiary education in moderating the outcomes of the nurse educator role is an important observation. The hypothetical model derived from this study has identified the influence of individual and workplace characteristics, scope of practice and the professional practice environment on work satisfaction. Chapter 8 provides a summary and conclusions of the study and its findings.

7.9 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Chapter 8 – Summary and Conclusions

8.1 Introduction

This thesis has reported a mixed method study to describe the nurse educator role and practice in acute care hospitals in Australia. The study identified issues impacting on role enactment of the nurse educator as well as barriers and facilitators to the optimal functioning of this role. These data present a real opportunity to develop and refine this important position in facilitating effective health care. Role theory and symbolic interactionism have not only informed the study design and interpretation, but have also enabled the formulation of recommendations. These perspectives underscore that nurse educators perform their role in highly contextualized environments with varying roles and expectations internal and external to the organization.

This chapter provides a summary of study findings. Specifically, this summary is linked to each of the study aims. Implications for policy, practice and research are identified, as well as recommendations for the further development of the role, education and practice of nurse educators in acute care hospitals.

8.2 Background

The purpose of this study was to describe the nurse educator role in acute care hospitals in Australia. Nurse educators were chosen as a discreet professional group within nursing. Unlike other nursing roles in the tertiary health setting, their role is not clearly aligned to patient outcomes. Support for the role within the nursing workforce and the contribution of nurse educators to patient care are ‘invisible’ in the nursing literature [1] and in the Australian health workforce reform agenda [2].

The aims of the study were to:

- Document an account of existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care hospitals in Australia.
- Describe their contribution to nursing and inter-disciplinary education.

- Develop competency standards to guide nurse educator practice in acute care hospitals.

8.3 Key findings

The study has described the complexity of the nurse educator role, and the demanding nature of acute care hospitals within which they work [1]. Role theory and symbolic interactionism provided useful theoretical perspectives for describing the nurse educator role in acute care hospitals. Understanding the dimensions of the nurse educator role was considered of high utility for supporting the nurse educator role as well as the development of competency standards.

Nurse educators work in a range of geographical settings including, metropolitan, regional and rural centres. These factors can impact on the nurse educator role and activities. The scope of the nurse educator role may include responsibility for education in one unit within a hospital, or responsibility for education across a hospital or health service. Where nurse educators assume responsibility for education across a health service, the geographic size of the area health service may span hundreds of kilometers – further highlighting the complexity of the environments within which they provide education. An understanding of role theory has allowed for connections to be made between the intersection of these factors, the individual, their work and their work environment and how these relate to nurse education and patient care, as a result of this national study.

8.4 Summary of study findings

The key findings are presented below where the study findings are evaluated in the context of the outcomes of the study aims.

Aim 1: Document an account of existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care settings in Australia.

As roles within the Australian health care system are being reviewed [2], this study was timely in identifying imperatives for reviewing the nurse educator role. Prior to this study, the Australian nursing literature was limited in knowledge of the nurse educator role in acute care hospitals, their scope of practice and

performance standards [1]. As identified in the literature review in Chapter 2, the role of nurse educators in acute care hospitals in Australia is distinct from nurse academics, who mainly work in universities [1, 3]. The complex clinical environments do not always value and appreciate the nurse educator role.

The study sample was consistent with the demographics of the ageing registered nurse population in Australia [4]. Role expectations, beliefs and attributes need to be defined for specific roles (as described in Chapter 3) [5]. Role expectation may be defined as attributes that other staff and the organization believe an individual assumes in their job [5]. However, the use of multiple titles for the role of educator, such as nurse educator, clinical nurse educator, and clinical nurse consultant, for example, (as described in Chapters 5 and 6) arguably result in confusion regarding role expectations and responsibilities in the workplace, nursing and the broader health workforce.

Role ambiguity was found to be a feature of the nurse educator roles in acute care hospitals, further reinforcing confusion in nomenclature, expectations and as a consequence, work plan. Role ambiguity has also increased as multiple nursing roles, including the registered nurse, assume responsibility for education in the workplace, rather than the responsibility for education falling to nurse educators alone [1, 3]. Role ambiguity potentially leads to role stress, overload and dissatisfaction as documented in the study findings and may be linked to educators feeling the role is devalued in the workplace.

Meaning is the main idea behind symbolic interactionism, whereby human behavior and interactions are considered through both symbols and their meanings [6]. As humans, we do not simply respond to events we encounter; rather our previous experiences allow us to consider and give meaning to events. Our actions in response to an event occur as a consequence of the meaning the event holds for us. This meaning can be applied to the study findings demonstrating some educators believed they were valued in the workplace although more educators reported that their role was insufficiently acknowledged. The concept of feeling devalued was perceived to be at the level of government, workplace executive and among managers, nurse managers and nurse colleagues.

Within the study data, at the government level, devaluing was perceived by participants to be reflected in lower salaries making the role less attractive and not valuing the education some have attained in order to work as an educator.

Respondents to the survey commented that devaluing is linked to workplaces where education is seemingly not valued at the executive level, where nurse educator positions are seen to be expendable, where budget restraints are imposed and where positions such as nurse managers responsible for education and nurse educator positions are not filled when they become vacant. As the study described, the trickling down effect of devaluing also occurred among nursing peers where the contribution of nurse educators was seemingly invisible, notably through recognition from nursing awards and scholarships.

Nurse education in the acute care hospital requires skilled educators capable of understanding and contributing to patient care outcomes by conducting contemporary evidence-based education and developing and contributing to policy and practice that supports a safe workplace and positive patient outcomes [7]. However, the low numbers of nurse educators holding a post graduate qualification in education (22%) or a clinical qualification at a master's level (22%) reflects both a decreased emphasis on the importance of education from the perspective of both the individual and organization.

In tandem with other nursing research [8-10] in this study, the quality of the work environment is an important factor in employee satisfaction and in turn effective nurse education and patient outcomes. The Professional Practice Environment (PPE) scale [11] used in this study was demonstrated to be a valid and reliable tool for assessing the work environment among nurse educators in both private and public hospitals.

As described in the model of nurse educator satisfaction in Chapter 6, Fig. 6.5, nurse educators who have a job description, meet regularly with their manager and who have spent a number of years performing in their role are more likely to be satisfied with their professional practice environment than nurse educators without this structure. Work motivation, control over nurse education practice, engaging in collaborative solutions to problem solving and cultural sensitivity were also identified as important elements of the work environment contributing to satisfaction. These findings may inform the development of integrated professional practice environments where professional practice and workplace satisfaction of nurse educators are optimized influencing safe, quality patient care.

Additionally, the results described in Chapter 5 showed that nurse education requires appropriate staffing levels (skill mix of educators and dedicated staffing hours for education), as well as organizational commitment in support of lifelong learning. This includes recognition that clinical education and continuing professional education are intrinsic components of core business supporting patient safety in healthcare environments. The findings of this study highlight the need for career pathways and building nurse educator capacity to support specialty sustainability [10].

Aim 2: Examine the contribution of nurse educators to nursing and interdisciplinary education.

In the NEACH study, nurse educators identified their contribution to nursing and interdisciplinary education through their involvement in undergraduate and postgraduate education and continuing professional development programs where they assumed varying roles and responsibilities. Nurse educators work with nurses, undergraduate and postgraduate nursing students from TAFE colleges and universities, medical students, other health and non-health professionals and volunteers.

In this study, nurse educators described varied responsibilities including the management and co-ordination of hospital-wide programs such as new graduate programs or mandatory education, such as cardio-pulmonary resuscitation, or for area health service programs, such as preceptor courses. Nurse educators also identified responsibility for managing and conducting education programs with a specialty focus such as midwifery, and the responsibility for managing and/or facilitating student clinical placements for TAFE colleges or universities. Some assumed roles as managers of nurse education within a hospital or health service.

They engaged in a range of activities including clinical teaching, competency assessment, curriculum development, education program planning and co-ordination, and classroom teaching. For some nurse educators, additional tasks include teaching non-nursing staff, related to organization orientation, and mandatory education programs such as occupational health and safety and manual handling. Nurse educators also reported they may provide direct patient care. This may occur regularly when inadequate staffing levels occur and the nurse educator is required to assume a patient load.

Further research is required, however, to quantify engagement in interdisciplinary education and practice and to determine strategies for ongoing collaboration – identified by nurse educators as an important priority within their work.

Aim 3: Develop competency standards for nurse educators working in acute care hospitals.

Although competency standards have been developed by ANTS [12], these potentially lack specificity in the acute care hospital. Being able to enact a role is dependent on clearly articulating capabilities and responsibilities. Following identification of core skills, the investigator-developed Activities and Competencies of Nurse Educator (ACONE) scale has identified practice domains. Preliminary evaluation has identified these factors to be useful in describing the nurse educator role and scope of practice. The competency domains – education and program development, teaching and mentoring, educational and clinical leadership, professional practice improvement, research and scholarship, and education management – reflect the broad scope of practice of nurse educators in acute care hospitals and a useful framework for role development.

Each item within the domain describes elements of practice. As summarized in Chapter 6, psychometric properties of the ACONe scale were reported. Domains reported as being performed the most were facilitating effective learning and engaging in quality improvement initiatives. The domain engaged in least was research and scholarship. In view of the contribution of nursing research to informing evidence-based practice [13], a gap in the application of these principles to nurse education practice has emerged. Nurse educators who do not perceive research and scholarship as an integral role function may not necessarily encourage other nurses to investigate their practice [1]. Further, this finding may indicate that some educators are not applying evidence to their own practice.

This lack of engagement in research and scholarship potentially minimizes the contribution nurse educators can make to improving education, clinical practice and patient outcomes. The scale is an important tool providing a framework for role development and establishment of performance criteria. It may also be harnessed in future research contrasting similarities and differences in nurse educator roles in variable contexts of practice. Importantly, the NEACH study has identified the ACONe scale as a tool for use in self-assessment of performance of nurse educators.

Nurse educators concurred with the investigator-developed Importance of Support for the Nurse Educator Role (ISNER) scale reported in Chapter 6 that identified priorities for advancing the role in the nursing profession and broader health workforce. These priorities included the delineation of scope of practice, determining and endorsing performance indicators, the development of relationships with academia through collaborative projects promoting research and scholarship and the development of strategies to promote the role. A discussion of priorities follows in recommendations for policy, practice and research. A summary of study findings is listed in Table 8.1.

Table 8.1 Summary of study findings

Aims	Chapt.	Key findings
Document an account of existing knowledge of the role, scope of practice and performance standards of nurse educators in acute care settings in Australia	2,7	<p>The nurse educator role is characterised by:</p> <ul style="list-style-type: none"> • Role ambiguity and confusion regarding expectations and responsibilities • Role stress, overload and dissatisfaction and devaluing in the workplace • A gap between desired standards of education and education attained at the master's level • The need for greater emphasis on role performance and review
Describe their contribution to nursing and inter-disciplinary education	5 - 7	<ul style="list-style-type: none"> • Nurse educators provide education to undergraduate and postgraduate students from colleges and universities as well as hospital staff. This includes nurses, doctors, allied health professionals, non-health professional staff and volunteers. • Nurse educator responsibilities for education may include management and co-ordination of unit, hospital wide or area health service programs including, orientation, mandatory education, new graduate programs, continuing professional development courses and specialty courses such as midwifery.

Develop competency standards to guide nurse educator practice in acute care hospitals	4,6,7	<ul style="list-style-type: none"> Using prospective methods a researcher-generated list of items was developed. Consequently the ACONE scale was developed, identifying six practice domains: education and program development, teaching and mentoring, educational and clinical leadership, professional practice improvement, research and scholarship, and education management. Psychometric properties of reliability and validity for the ACONE scale were demonstrated. Nurse educators accepted the ACONE scale as a legitimate tool for use in self-assessment of performance.
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In response to these issues, the following recommendations are made in the context of policy, practice and research.

Implications for policy

Establishing a strategic agenda and directions for the nurse educator role requires collaboration between key stakeholders to consider the NEACH study outcomes and specified implications for policy, practice and research. This may be achieved by convening a national forum of key stakeholders to drive this reform. The stakeholders required to drive this reform include the Chief Nurse Australia and chief nurses from State and Territory health departments and nursing professional groups.

These professional groups include the Australian Nursing Federation (www.anf.org.au); the Australian Nurse Teachers Society (www.ants.org.au); the Coalition of National Nursing Organisations (www.conno.org.au), the Council of Deans of Nursing and Midwifery of Australia and New Zealand (www.cdnm.edu.au) and the College of Nursing Australia (www.cna.org.au).

Other key stakeholders who may collaborate with nursing organizations in considering the outcomes of this study are the Australian Private Hospitals Association (www.apha.org.au), Health Workforce Australia, (www.hwa.gov.au)

and state clinical education entities such as the Health Education and Training Institute in NSW (www.heti.nsw.gov.au), as well as health services and hospitals, and universities and TAFE at the local level.

Developing a career framework is an important aspect for development of a clear professional role for the nurse educator within the multidisciplinary team as well as ensuring specialty capacity building to meet future health workforce needs. Specialty capacity building in the nurse educator workforce needs to be informed by evidence about role, practice and activities. Engagement in research and policy debate is essential for nurse educators to influence decision-making regarding their role in education in practice settings [1]. Policy mandating competencies and performance standards is important for increasing role accountability, credibility and visibility. Furthermore, policy endorsing regular performance review and monitoring of performance indicators to demonstrate nurse educator contribution to education and nursing practice and their influence on patient outcomes will support the continued development of nursing research and scholarship [14].

Policies that ensure the availability of a nurse educator on every ward will contribute to safer environments for patients and will positively influence care outcomes [9]. This may also help to address factors related to skill mix, such as differing levels of education, competency and scope of practice that arise within a diverse workforce [7, 14, 15]. Furthermore, this would maximize opportunities for nurse educators to support learning in the clinical setting and encourage staff to capitalize on opportunities for career development [16]. It may also enhance teamwork and multidisciplinary care initiatives.

Implications for practice

An explicit component of the Australian health reform agenda is developing and sustaining a skilled, competent health workforce supported by clinical and professional education [17]. Globally, it is acknowledged that teaching and learning in clinical environments is pivotal to achieving this goal [18]. Through their roles as expert educators and change agents, nurse educators can provide clinical and professional education and leadership to promote positive learning environments in clinical contexts [18]. In the health reform agenda, opportunities for role review have been suggested though they are nonspecific [2]. The NEACH study findings demonstrate the need for nurse educator role review, delineation and standardization both nationally and at the local level. Nurse educator

competencies are integral to professional role development, advancing specialty capacity building and enhancing recruitment, retention and career progression. The development and validation of the ACONE scale provides a measure of nurse educator activities and competence that can be used by the profession, managers and educators to inform role definitions and position descriptions that increase the focus on inter-professional education and practice, research and scholarship. The identification of performance indicators linked to practice change and patient outcomes is also important to further demonstrate the need for the role.

Implications for research

This study has provided contemporaneous descriptions of nurse educators in the acute care hospital. Further monitoring of the nurse educator role may ascertain the continued effects of role change and service provision. Future research may also canvas the opinions of directors of nursing and nurse unit managers regarding their expectations of the nurse educator role and performance.

The absence of key performance indicators for the role linking the contribution of the nurse educator and nurse education with changing clinical practice and the influence on patient outcomes is a research priority. Research identifying the links between nurse educator practice and patient outcomes is important to demonstrate that the role influences patient safety in addition to advancing nursing practice. This is particularly important where skill mix and varied educational levels are known to influence adverse outcomes [2], and in settings where organizational culture may not embrace lifelong learning and continuous professional development. It is also important to demonstrate return on investment for expenditure on education. This may further highlight disparities in role expectations between urban and rural settings.

Further research in a variety of settings is needed to substantiate the ACONE results and to evaluate the psychometric properties of the scale across a range of settings. Adoption of these competencies may facilitate standardization of the nurse educator role, education and practice.

Research to elicit the continuing professional development needs of nurse educators and the development of an agenda for nurse educator led research is also important to develop specialty capacity.

8.5 Conclusion

The NEACH study has used a mixed method approach to describe the role of nurse educators in acute care hospitals. Hospitals as organizations and management as hierarchies are complex systems influencing communication, behaviors, workplace cultures and human interactions in the workplace. The application of role theory and symbolic interactionism as a framework for role exploration has underscored the importance of understanding individual and group needs and behaviors and environments to allow both micro and macro perspectives of the nurse educator role in acute care hospitals to be examined and strategies for change and innovation to emerge.

This thesis has focused the spotlight on the role and on the contribution of nurse educators to nurse education in acute care hospitals in Australia, together with barriers and facilitators to role enactment. The study has highlighted role ambiguity and practice limitations and presented competencies for role development and self-assessment of performance for use by nurse educators in acute care hospitals. The identification of barriers and facilitators to nurse education practice in this study may enable nurse educators individually and collectively, as well as the nursing profession and health workforce to have a broader perspective of the nurse educator role in hospitals and contextually within nursing education and healthcare.

It is likely that nurse academics and professional nursing alliances may be influential in providing opportunities for nurse educators to define and redesign their role and advance specialty development. Ultimately, professional nursing bodies and nurse educators need to seek role clarity and status in contemporary Australian hospitals. This will be important in ensuring the increased visibility of the nurse educator role in acute care hospitals and articulating the contribution of this role to health professional education and patient outcomes.

8.6 References

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

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Appendices

**Appendix 1 Human Research Ethics
Committee Approval**

memorandum

To	Jan Sayers
From	Associate Professor Dianne Wynaden
Subject	Protocol Approval SON&M 23-2009
Date	11 th September 2009
Copy	Professor Davidson

Office of Research and Development

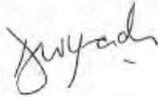
**Human Research Ethics
Committee**

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your "Form C Application for Research with Minimal Risk (Ethical Requirements)" for the project titled "**THE ROLE OF THE NURSE EDUCATOR IN ACUTE CARE HOSPITALS IN AUSTRALIA**". On behalf of the Human Research Ethics Committee I am authorised to inform you that the project is approved.

Approval of this project is for a period of twelve months **11th September 2009 to 11th September 2010**.

If at any time during the twelve months changes/amendments occur, or if a serious or unexpected adverse event occurs, please advise me immediately. The approval number for your project is **SON&M 23- 2009**. *Please quote this number in any future correspondence.*



Associate Professor Dianne Wynaden
Low Risk Coordinator
School of Nursing and Midwifery

Please Note: The following standard statement must be included in the information sheet to participants: *This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784.*

Appendix 2 Steering Committee
Terms of Reference

The role of the Nurse Educator in Acute Care Hospitals



Steering Committee Terms of Reference

1. Background / Context

In recent years the nursing profession in Australia has reviewed the efficacy of nurse education and nursing roles to address the needs of contemporary health systems. Simultaneously, constant change in the health care environment has occurred. These factors and quantum health care reform significantly impact nursing roles. However, there has been minimal acknowledgement of the impact of these changes and the associated potential for role ambiguity and conflict within nursing roles. Diverse and fragmented systems have contributed to confusion surrounding the role and scope of practice of Australian nurses and subsequently their impact on nursing and service delivery.

Although the registered nurse has always played a role in education, the impact of these changes on the nurse educator role has been significant. Nurse education is increasingly less the mandate of the nurse educator as clinical nurse specialists, nurse consultants and nurse practitioners independently engage nurses in education in the clinical practice environment. Historically, the nurse educator has played a pivotal role in preparing nurses for their professional role although the role is largely invisible in the contemporary discourse. The reasons for this can be the blurring of the role between other classifications of nurses including clinical nurse consultants and clinical nurse specialists.

Whilst the nurse educator role is not clearly defined the threat of intra professional discord including professional isolation and a lack of supportive relationships is apparent and potentially a detrimental influence on staff and nurse educators. As a consequence of role ambiguity, the potential also exists for the nurse educator role to become invisible within

the clinical arena. Unless this conflict is resolved the role will continue to be undervalued and negatively effect job satisfaction and staff retention. The advancement of nurse education practice and importantly clinical outcomes is contingent upon the clarification of role boundaries and exploration and articulation of the role.

Although there is an increasing focus on primary health care, the acute care environment will continue to remain a focus for care delivery. This study will focus on the nurse educator in the acute care environment - an environment characterised by a predominance of older patients requiring chronic and complex care, diminished length of stay, high patient acuity, maximum student thresholds and an increasingly diversified skillmix within an ageing workforce. These demographics alone require skilled nurse educators to facilitate the achievement of safe clinical outcomes through appropriate nurse education interventions including engagement in research, multidisciplinary education and clinical leadership roles that support the National Hospital and Health Reform Commission's recommendations.

We will provide this understanding by conducting a mixed-method study incorporating a national survey of nurse educators and in -depth interviews eliciting role requirements, and attitudes and experiences of nurse educators in acute care hospitals. These data will be used to generate insight into the role of the nurse educator in Australian acute care hospitals that will guide the collaborative design of competency standards and a model for nurse educator practice to support nurses to provide safe, quality patient care.

This research will yield a clearly articulated, industry and specialty endorsed delineation of the nurse educator role and scope of practice, supported by a flexible career pathway and will significantly contribute to the further development of the nurse educator specialty and a sustainable nurse educator workforce in Australia. Furthermore, the study may also assist, nurses, academics, management and other health professionals to gain insight into this complex, but challenging role. Through engagement in the study collaborative clinical and academic partnerships and the emergence of dynamic and innovative education and teaching practice may occur supporting the intensive learning required by nurses to develop and maintain expert clinical skills and competency.

Also, by demonstrating the relationship of the role of the nurse educator to clinical and organisational outcomes, as well as empirically devising competencies for the nurse educator in contemporary acute care settings, nurse educators may be empowered to establish and maintain effective collaborative partnerships in nurse education and actively engage in the transformation of education and nursing practice. Role development may also support nurse educators to carve a niche in the professional practice environment and their recognition as clinical leaders and strategic stakeholders within the health workforce.

Study Goal

This study aims to investigate, critically analyse and document the role, scope of practice and performance standards of nurse educators within acute care hospitals in Australia and identify the impact of the nursing role on patient outcomes and the inherent relationship between education and practice performance.

2. Function of the Nurse Educators in Acute Care Hospitals (NEACH) Steering Committee

The function of the NEACH Steering Committee is to provide expert consultation on matters associated with the study. The Committee will guide the Study Team in defining and realising benefits, and monitoring risks, quality and timeliness.

3. Role of the Steering Committee

The role of the Committee is to:

- provide advice on the study's feasibility and achievement of outcomes;
- ensure the study's scope aligns with the requirements of the stakeholder groups;
- provide guidance on issues and matters pertaining to the study;
- address any issue that has major implications for the study ;
- monitor the scope of the study as emergent issues force changes to be considered;
- provide advice regarding differences in opinion and approach.

4. Role of individual committee members

Roles of the individual members of the Steering Committee include:

- understanding the strategic implications and outcomes of initiatives being pursued through study outputs;
- appreciating the significance of the study for some or all major stakeholders and perhaps represent their interests;
- being genuinely interested in the initiative and the outcomes being pursued in the study;
- having a broad understanding of study management issues and the approach being adopted; and
- being committed to, and actively involved in pursuing the study outcomes.

In practice, this means that they:

- monitor that the study is conducted according to the agreed proposal
- establish and foster an effective relationship with the committee members based on trust and mutual respect for each other's roles;
- ensure the requirements of stakeholders are met by the study's outputs;
- provide guidance to the Study Team and users of the study's outputs;
- appraise and review ideas and issues raised from study outcomes;
- review the progress of the study and implications for stakeholders
- monitor adherence of study activities to standards of best practice and the potential to meet the needs of key stakeholder groups.

4.1 The role of the Study Team is to:

- Conduct the study according to the agreed protocol
- Ensure the study is conducted according to NHMRC Guidelines
- Provide regular study reports to Steering Committee members
- Consult Steering Committee members on issues influencing the study direction
- Be responsible for monitoring budgetary issues according to Curtin Policy
- Collect, analyse and summarise data for Steering Committee consideration
- Draft and disseminate manuscripts for comment
- Assure authorship is based upon NHMRC Guidelines

Appendix 3 Steering Committee
Meeting Report

STEERING COMMITTEE GROUP INTERVIEW REPORT

Key Issues impacting on the Nurse Educator role in Australia **Notes from Steering Committee Meeting 9/04/09**

Role is becoming increasingly invisible

- Role erosion
- Loss of identity

Education

- Need to understand what education is
- Career path not identified
- Lack of clarity on certification
- Not mandated
- Keep the NE standardised;
 - Need a framework to train NE's
 - Need systems and standardised processes to achieve it
- Devaluing of Masters? As people are having to go back and do a Cert 4.
- St Vincent's – must have a masters.
- Undergrads need a facilitator in both a clinical and academic domain
- Education is not limited to the NE.
 - Who is an educator?
- Language
 - Use of the word "training" devaluates the work.
- RN's need to recognise that teaching is a part of their role. All RN's will teach.
- Inter professional acknowledgement, linked to salary
- Inter professional learning; who can access it? Also linked to the respect for nurses.
- Disparities in salary often mean people are categorised incorrectly to get a more appropriate salary. This devaluates the original role as you are putting someone in it that is not qualified.
- Poor education to health profession about role/significance/importance of NE.

Definition of Role

- No clear definition
- How do you define the role? E.g. general or specific.
- Lack of clarity; from both NE and the workforce
- Lack of guidance, particularly from those with experience
- Lack of understanding in terms of use and expectations
- No standard across the board/state/nation
- Create own roles
- Write own job descriptions
- Clear division between NE and CNE

NEACH Steering Committee 090409

- CNE
 - Lack of structure, support, understanding of the role.
 - Often pulled out of education environment and thrown into clinical environment.
 - Report to clinical manager rather than someone who has education experience. Why don't they report to the education department?
 - Complete lack of understanding of what their role is on the ward.
 - If budget issues occur the CNE is the first to go.
- No synergy between clinical and academia.
 - No common goal
 - Implementation of inter professional education
- Defining role can become problematic
- Is the lack of structure a strength or a weakness?
 - Still need a core set of principles

Multidisciplinary Role

- Difficult to act as a multidisciplinary police officer
- Difficult to promote code of conduct and be a leader to other nurses by policing conduct of medical staff.
- Oligopoly of Health; the entrenched idea in the Australian health system that medical professionals are the team leaders
 - This constrains nursing in Australia
 - Pervades every are of the health system
 - Nurses have difficult in being autonomous

Nexus between clinical practice and education

- Role of research in NE and the expectation of educators
- Funding for research in area is non existent

Litigation and Policy

- Is becoming more of an impact factor as the area expands; can then becoming very time consuming.
- Government funding went to what was labelled "Supervisors" (i.e. NE's). Need to get the terminology right, especially in the political/policy sphere thus expanding throughout the general community.
- If terminology is correct within policy it crystallises the role in the health community and broader community

Rural Areas

- No NE in rural district hospitals
- There is not a strong educators presence in the base areas

Budget/Finance and Funding

- Restricts role; don't have 24/7 coverage of CNE's as a result of budget constraints. Education is around the clock not just business hours.
- Increased funding needs to go into CNE roles to support undergrads and those that are returning to the workforce.
- Salary differences; how can you attract/motivate people to the role without financial stimulation?
- Salary is related to status, and status is related to power

Historical Relevance

- Historical view of the role of the nurse.
- In general, the issue has been simmering under the system. Stressors on the health system is making the issue more acute.
- Specific to NE's
 - In the 1980's the School of Nursing and Clinical worked together
 - The implementation of education through the universities saw a diversion between clinical and education.

DISCUSSION OF SURVEY

National Survey;

**Facilities
Profession
Target**

Purpose

- Find out what's out there
- Initially throw the net wide
- Pilot focus groups?

Questions/issues that arose:

- What does the workforce want?
- If looking at the role critically, does the role really need to exist?
 - Historically the role was used to train nurse, now nurses are trained
 - The fact that nursing has an educator; what message is that sending to the general community? Is it that nurses aren't trained?
- Reinvent/reconstruct the role?
- Discussion of the role is now and the way the roll will change in the 21st century.
- User value/satisfaction is still very important and significant
- Importance of culture; less tangible e.g. mentorship
- Uniformity nationally
- Discussion of Practice Development
 - General consensus against Practice Development. Has been misused and doesn't work unless everyone is on board, also need a clear role of NE.

Comments/amendments/additions on the survey:

- Keep the survey to NE's and add a question where the NE can outline other people that may act in that role
- "What percentage of your time would you spend teaching?"
- "Where do NE's see the future of the role? And what is the potential of the role" (future development)
- It is a big study; what is feasible and what is achievable?

Appendix 4 Permission to use Nurse Retention Index (NRI)

Email Granting Approval to Use the Nurse Retention Index

RE: Request to Use Nurse Retention Index in Survey

Page 1 of 2

 Reply  Reply to all  Forward |   X |   | Close |  Help

 You replied on 5/29/2009 9:35 AM.

Attachments can contain viruses that may harm your computer. Attachments may not display correctly.

From: Leanne Cowin

Sent: Thu 5/28/2009 11:55 AM

To: Jan Sayers

Cc:

Subject: RE: Request to Use Nurse Retention Index in Survey

Attachments:  NSCQ and NRI folder.pdf(170KB)

[View As Web Page](#)

Hi Jan,
Please find the file attached containing a copy of the NRI measure and other details that might be of use to you. Permission is granted to use this tool and to publish as you see fit. Please let me know if I can be of any further assistance to you

Regards
Leanne

Leanne Cowin RN PhD
Lecturer
School of Nursing & Midwifery
College of Health and Science
University of Western Sydney
Building 7, Campbelltown Campus
Locked Bag 1797
Penrith South DC NSW 1797
Telephone: 61 2 4620 3762
Fax: 61 2 4620 3161
l.cowin@uws.edu.au

Appendix 5 Permission to use
Professional Practice Environment Scale
(PPE)

Letter Granting Approval to Use the Professional Practice Environment Scale



Patient Care Services Administration
Tel: 617-726-3100
55 Fruit Street, Bulfinch 230
Boston, Massachusetts 02114-2696

Jeanette Ives Erickson, RN, MS
Senior Vice President
Chief Nurse

February 28, 2010

To whom it may concern,

Thank you for your interest in the *Professional Practice Environment (PPE) Scale*. You may use the PPE scale for research or evaluation projects provided the scale is not altered in any manner and the authors are acknowledged in any and all reports or publications.

The *PPE* scale is intended to measure the staffs' perception of eight components of the professional clinical practice environment in the acute care setting. The psychometric properties of this scale have been published in the *Journal of Nursing Scholarship*.¹

For your use of this scale, we request that you provide us with:

- an abstract of your study that includes sample size and sample characteristics,
- a table reflecting the internal consistency and, if applicable, other reliability coefficients of the subscales for your sample and
- a list of publications reporting use of the scale.

Enclosed in this packet are a copy of the current version of the scale, directions for scoring the scale and a request for information. Please complete the request for information form that describes how you plan to use the scale in your current work and return it by fax as directed on the form.

Thank you again for your interest in this work. We ask that all communications concerning the use of the scale be sent to Trish Gibbons RN, DNSc, Associate Chief for The Knight Nursing Center or you can email it to trishgibbons@partners.org.

We wish you success with your research endeavor and look forward to reading your results. Please feel free to contact with us regarding any questions you may have.

Sincerely,

A handwritten signature in cursive script that reads 'Jeanette Ives Erickson'.

Cc: Trish Gibbons, RN, DNSc

¹ Ives Erickson, J., Duffy, M., Gibbons, M. P., Fitzmaurice, J., DiTomassi, M., Jones, D. (2004, Third Quarter). Development and psychometric evaluation of the professional practice environment (PPE) scale. *Journal of Nursing Scholarship*, 279-285.

Appendix 6 Survey Advertising:

1. NEACH NEWS - Researcher-developed newsletter
2. Email distributed to Australian Nurse Teachers Society members



Nurse Educators in Acute Care Hospitals Project

Newsletter Winter 2009

Enquiries: jan.sayers@postgrad.curtin.edu.au

Nurse Educators Across Australia

Welcome to Nearch news! This newsletter will keep you informed of the progress and outcomes of research being conducted on the role of the nurse educator in acute care hospitals across Australia by Curtin University.

Background to the study

Acute care hospitals are under increasing pressure and scrutiny from both the public and administrators. In addition, the Australian nursing profession has undergone considerable restructure over the last three decades.

However, there has been minimal acknowledgement of the impact of these changes and the associated potential for role ambiguity and conflict within nursing roles. The nurse educator role is largely invisible in the contemporary discourse. Potential explanations for this situation are the blurring of the role between other nursing classifications, including clinical nurse consultants and clinical nurse specialists, as well as the delineation between the academic and clinical setting.

Why do we need guidance for the nurse educator role?

As a consequence of role ambiguity, the potential exists for the nurse educator role to become invisible not merely in scholarly discourse but importantly within the clinical arena.

What form and characteristics will such guidance have?

The guidance will be:

1. evidence driven: using key Australian studies and other relevant literature to form the basis for role development
2. a consensus statement: stakeholder input is critical to validate the nurse educator role and practice and is a key purpose of the project
3. relevant to the practice, policy and regulatory context in Australia.

Who will provide guidance?

An Expert Advisory Group has been established to 1) ensure the study's scope aligns with the requirements of the stakeholder groups; 2) provide guidance on issues and matters pertaining to the study; 3) address any issue that has major implications for the study; 4) monitor the scope of the study as emergent issues compel changes to be considered; and 5) provide advice regarding differences in opinion and approach.

The Expert Advisory Group comprises:

Professor Patricia Davidson, Curtin University of Technology; Dr. Alan Barnard, Queensland University of Technology; Ms. Michelle Crawford, St. Vincent's & Mater Health, Sydney; Dr. Michelle DiGiacomo, Curtin University of Technology, Linda Gregory, St. Vincent's Hospital Sydney; Ms. Jacqui Guy,



Nurse Educators in Acute Care Hospitals Project

Newsletter Winter 2009

Enquiries: jan.sayers@postgrad.curtin.edu.au

Expert Advisory Group (cont'd)

Australian Nurse Teacher's Society; Ms. Sarah Leathwick, St. Vincent's & Mater Health, Sydney; Ms. Dee Maguire, Westmead Hospital Sydney; Dr. Margaret McLeod, Royal College of Nursing Australia; Ms. Tracey Osmond, The College of Nursing; Ms. Jan Sayers, Curtin University of Technology, Sydney; Mr. Jon Rihari-Thomas, St. Vincent's Hospital, Sydney; Dr. Christine Taylor, Australian Nurse Teacher's Society; Ms. Susan Taylor, NSW Nurses Association

Project Stages

The stages of the project are outlined below:

Phase 1:

Broad consultation and engagement

April 2009 – April 2010

Input will be sought from Expert Advisory Group representatives to inform the study.

Phase 2:

National survey

June 2009(Pilot)

July - August 2009 National Survey

A survey of nurse educators working in the field will be conducted to identify their role, scope of practice, career intentions and professional practice environment.

Phase 3:

Consensus Conference – December 2009

Phase 4: Communication and dissemination – 2009/2010

A communication, dissemination and evaluation strategy will be implemented to raise awareness and facilitate adoption of the study findings and recommendations in Australia.

How can you be involved?

Register your interest to be part of the national survey to comment on the nurse educator role in acute care hospitals in Australia.

Register by emailing your name, organisation and professional designation to:
jan.sayers@postgrad.curtin.edu.au

Registration is open now until 30 August 2009. Surveys will be sent to the email address provided.

Provide information

The project working group is seeking relevant information, such as position descriptions, to inform role development.

If you have any relevant information/resources that you would like to forward to inform the research, please email these to:
jan.sayers@postgrad.curtin.edu.au

Please forward this newsletter to anyone who may have an interest in this project. Thank you!

Email Distributed to Australian Nurse Teachers Society Inviting Participation in the Study

From: ANTS [kjksecretariat@netspace.net.au]

Sent: Monday, 2 November 2009 7:41 AM

To: Jan Sayers

Subject: NEACH Survey

Attachments: NEACH PARTICIPANT INFORMATION 250809 SHEET.doc; Welcome to the Australian Nurse Educator Survey.doc

Hello ANTS member,

Attached is information about a research study and your valuable contributions will be greatly appreciated.

The study is investigating the role and scope of practice of nurse educators and clinical nurse educators across Australia.

Your assistance will be greatly appreciated. The 'Participant Information Sheet' and 'Welcome to the Survey note' are attached and give further information.

You can assist the researcher (Jan Sayers) by completing an on-line survey. Although it uses the term 'nurse educators' the survey applies to anyone teaching nurses in acute care hospitals.

The survey can be accessed through the following link:

https://www.surveymonkey.com/s.aspx?sm=qHFfSnIJ3L8kGehI792MiQ_3d_3d

Christine Taylor
Secretary, ANTS

Sent by KJK Secretariat
for Australian Nurse Teachers Society
Direct: 02 9715 1065 Fax: 02 9715 1071

PO Box A103 Enfield South NSW 2133

Appendix 7 Participant Information Sheet

Invitation to Contribute / Participant Information Sheet

Project goal

This study aims to investigate the role, scope of practice, and performance standards of nurse educators within acute care hospitals in Australia.

Project outcome

This work will describe the nurse educator role in Australia and provide recommendations for future nurse educator models and research.

Background

Acute care hospitals are under increasing pressure and scrutiny from both the public and administrators. In addition, the Australian nursing profession has undergone considerable restructuring over the last three decades. There has been minimal acknowledgement of the impact of these changes and the associated potential for role ambiguity and conflict within nursing roles. To date, the nurse educator role has been largely invisible in contemporary discourse. Potential explanations for this situation are the blurring of the role between other nursing classifications, including clinical nurse consultants and clinical nurse specialists as well as the delineation between the academic and clinical setting.

Why do we need guidance for the nurse educator role?

As a consequence of role ambiguity, the potential exists for the nurse educator role to become invisible not merely in scholarly discourse but importantly within the clinical arena.

What will the guidance be?

The guidance will:

1. be evidence driven: use key Australian studies and other relevant literature to form the basis for role development
2. be a consensus statement: stakeholder input is critical to validate and prioritise competencies for nurse educator practice and is a key purpose of the project
3. be relevant to the practice, policy and regulatory context in Australia to support role enactment

Who is involved?

The executive support for the project is provided by Curtin University of Technology, Sydney. Expert advisory support is provided through an Expert Advisory Group and a project working group to coordinate project activities

How will the project be implemented?

Phase 1: Broad consultation and engagement – April 2009 – April 2010

Input will be sought from Expert Advisory Group representatives to inform the study.

Phase 2: National survey– September 2009 – December 2009

A pilot survey of nurse educators working in the field will be conducted to identify their role, scope of practice, career intentions, and professional practice environment

Phase 3: Consensus Conference – February 2009

Phase 4: Communication and dissemination – 2009/2010

A communication, dissemination, and evaluation strategy will be implemented to raise awareness and facilitate adoption of the study findings and recommendations in Australia.

How can you be involved?

Register your interest to be part of a national survey to comment on the nurse educator role in acute care hospitals in Australia.

Register by emailing your name, organisation and professional designation to jansayers@postgrad.curtin.edu.au.

Registration is open from 1 April until 30 November 2009.

Surveys will be sent to the email address used to send the register of interest.

Provide information

The project working group is seeking relevant information, such as position descriptions to inform role development.

If you have any relevant information/resources that you would like to give, email jansayers@postgrad.curtin.edu.au by 31 July 2009.

Curtin University is committed to handling your personal information in accordance with the Privacy Act. We will not provide your personal information to any other individual or organization. We may use your information to send you updates and information on the NEACH study.

Please forward this project information and registration email to anyone who may have an interest in this study. For further information, please contact: jansayers@postgrad.curtin.edu.au

Appendix 8 Survey Tool

Australian Survey of Nurse Educators / Clinical Nurse Educators

1. Welcome!

Welcome to the Australian Nurse Educator / Clinical Nurse Educator Survey site.

This survey is a component of a research project investigating the role and scope of practice of nurse educators and clinical nurse educators across Australia.

Historically, nurse educators and clinical nurse educators have played a pivotal role in preparing nurses for their professional role, through the support of graduates' transition to professional practice and continuous professional development programs.

The Australian Nurse Educator Survey is a key component of a research study investigating the role, scope of practice and performance standards of nurse educators within acute care hospitals in Australia.

The study will identify the impact of the nurse educator role on patient outcomes and the relationship between education and practice performance.

Importantly the study will guide the collaborative development of a model for nurse educator practice to support nurses to provide safe, quality patient care.

As a nurse educator or clinical nurse educator, your participation in this survey marks an important contribution to the future of nurse education practice.

Your responses will be confidential and completing this survey is evidence of your consent to participate.

Australian Survey of Nurse Educators / Clinical Nurse Educators

1. Welcome!

Welcome to the Australian Survey of Nurse Educators / Clinical Nurse Educators. Prior to completing the survey, please complete the following question.

*** 1. Have you read and understood the Participant Information Sheet?**

- Yes
 No

2. Participant Information Sheet

You have indicated that you have not read and/or understood the Participation Information Sheet. So that you are informed about the decision to participate or not to participate, please take a few moments to read this document.

The Participant Information Sheet was emailed to you along with the invitation to participate in this study. If you did not receive this or would like further information regarding this study prior to responding, please contact:

Jan Sayers on
0408 168 037
jan.sayers@postgrad.curtin.edu.au

Once you have read and understood the information sheet, please complete the following question.

*** 2. Have you read and understood the Participant Information Sheet and agree to respond to this survey?**

- Yes
 No

3. Information About You

Please answer all questions. Most questions require you to tick a box(es) to indicate your answer. Choose the box(es) that best matches your answer.

*** 3. Gender:**

- Male
 Female

Australian Survey of Nurse Educators / Clinical Nurse Educators

*** 4. Age category:**

- 30 or under
 31-35
 36-40
 41-45
 46-50
 51-55
 56-60
 61 and over

*** 5. Are you an Aboriginal or Torres Strait Islander?**

- Yes
 No

*** 6. A range of position titles are applied to nurses working in a nurse education role. Please state your position title. If there is not a category that applies to you, please choose other and provide details.**

- Clinical Nurse Educator
 Clinical Support Nurse
 Clinical Development Nurse
 Clinical Coordinator
 Staff Development Educator
 Nurse Educator
 Clinical Facilitator
 Nurse Education Coordinator/Manager
 Other

*** 7. Time in position:**

Years
Months

Australian Survey of Nurse Educators / Clinical Nurse Educators

*** 8. Is your job permanent, temporary or contract?**

- Permanent
 Temporary
 Contract

*** 9. Employment status:**

- Full-time
 Part-time
 Other

If YES to Part-time or Other, please state hours/week or employment status

10. Postcode of your employment:

11. Do you work in a private or public health facility?

- Public
 Private

*** 12. Who do you directly report to?**

- Management Position (Nursing-Clinical)
 Management Position (Nursing-Education)
 Management Position (Professional Development)
 Management Position (Non-Nursing-Clinical)
 Management Position (Non-Nursing-Education)
 Other

4. Information about your nurse educator/clinical nurse educator position

*** 13. Do you have a job description?**

- Yes
 No

Australian Survey of Nurse Educators / Clinical Nurse Educators

* 14. Has your statement of duties been reviewed within the last 12 months?

- Yes
 No

* 15. Do you meet regularly (e.g. monthly) with your line manager to discuss issues specific to your role?

- Yes
 No

* 16. Have you undertaken an appraisal and performance review in the last 12 months?

- Yes
 No

Questions 17-19 relate to those who have been appraised in the last 12 months

17. In your performance and development plan were your professional development and learning needs identified?

- Yes
 No
 Not applicable

18. As part of your performance review was a plan developed to meet your professional development and learning needs?

- Yes
 No
 Not applicable

19. Is the current plan being implemented?

- Yes
 No
 Not applicable

Australian Survey of Nurse Educators / Clinical Nurse Educators

*** 20. Do you have specialist nursing (clinical) qualifications?**

- Yes
- No

21. If you have professional nursing (clinical) qualification/s please specify the type

- Hospital-based Certificate
- Graduate Certificate
- Graduate Diploma
- Masters Degree
- Professional Doctorate
- Doctor of Philosophy

*** 22. Do you think it is important to have a post-graduate clinical qualification to perform your role?**

- Yes
- No

23. Do you have specialist qualifications in education?

- Yes
- No

24. If you answered YES to Question 23, do you use this qualification in your present position?

- Yes
- No

Australian Survey of Nurse Educators / Clinical Nurse Educators

25. If you have a specialist qualification in education, please specify

- Certificate IV in Workplace Training and Assessment
- Graduate Certificate
- Graduate Diploma
- Masters Degree
- Professional Doctorate
- Doctor of Philosophy
- Other workplace training course

Please specify type of workplace training

26. Do you think it is important to have a post-graduate qualification in education to perform your role?

- Yes
- No

27. Are you currently undertaking any courses?

- Yes
- No

Australian Survey of Nurse Educators / Clinical Nurse Educators

28. If YES please mark

- critical care
- emergency
- medical nursing
- surgical nursing
- perioperative
- midwifery
- aged care
- rehabilitation
- disability
- mental health
- paediatric
- child and family health
- community health
- chronic care
- nurse education
- education
- research degree
- other

Other (please specify)

5. The work of the nurse educator/clinical nurse educator

The following questions aim to assess the activities related to your work as a nurse educator/clinical nurse educator. The items on the next few pages ask you to rate your perceived performance against the domains of the nurse educator role. (0 Never to 10 Always)

One domain will be presented on each page.

6. Engage in curriculum and program development & evaluation

The nurse educator participates in the development & evaluation of curriculum and education programs that incorporate professional standards and attitudes and values that reflect contemporary nursing practice

Australian Survey of Nurse Educators / Clinical Nurse Educators

* 29. In your role to what extent do you

	Never 0	1	2	3	4	5	6	7	8	9	10 Always
Facilitate the development, implementation and evaluation of curriculum and education programs incorporating professional standards, attitudes and values that reflect contemporary nursing practice	<input type="radio"/>										
Collaborate with others in the development and delivery of nursing and interprofessional education programs	<input type="radio"/>										
Integrate educational theory and evidence based approaches in teaching and education	<input type="radio"/>										
Engage in the development and delivery of undergraduate or postgraduate tertiary programs	<input type="radio"/>										
Participate in programs to facilitate clinical practice	<input type="radio"/>										

7. Facilitate effective learning

The nurse educator facilitates effective learning including learner development and socialisation strategies.

* 30. In your role to what extent do you:

	Never 0	1	2	3	4	5	6	7	8	9	10 Always
Recognise and identify the needs of individual learners (international, multicultural, at-risk) and provide resources and support to facilitate learning	<input type="radio"/>										
Use a variety of teaching strategies (including information technologies) appropriate to learner needs and contexts in supporting the teaching-learning process	<input type="radio"/>										
Foster opportunities for learners to develop their critical thinking and critical reasoning skills	<input type="radio"/>										
Monitor and provide feedback to learners regarding educational achievement	<input type="radio"/>										
Facilitate the development of professional behaviours and role socialisation	<input type="radio"/>										
Promote positive learning environments through effective collegial working relationships	<input type="radio"/>										
Facilitate learning activities to promote team work and interprofessional practice	<input type="radio"/>										

8. Educational and clinical leadership

The nurse educator provides leadership that engenders change and innovation and facilitates the ongoing development of education & clinical practice

Australian Survey of Nurse Educators / Clinical Nurse Educators

* 31. In your role to what extent do you:

	0	1	2	3	4	5	6	7	8	9	10
	Never										Always
Act as a role model, engaging in self reflection, modelling critical & reflective thinking	<input type="radio"/>										
Work as an expert clinician in the clinical setting	<input type="radio"/>										
Engage in mentoring and motivating novice practitioners and other staff	<input type="radio"/>										
Provide leadership in the ongoing review of education & clinical practice at a facility or regional level	<input type="radio"/>										
Undertake primary responsibility for the planning and implementation of specialist clinical education in your hospital or health service	<input type="radio"/>										
Provide leadership in the ongoing review of clinical education practice for a more complex service, such as a service provided at multiple sites	<input type="radio"/>										
Assume leadership roles, which promote broader advancement of clinical and education practice e.g. membership of curriculum external advisory committees; leadership of position papers and development of advanced nursing education practice standards	<input type="radio"/>										
Provide leadership in state, national and/or international nursing bodies and/or specialist clinical and interprofessional education groups	<input type="radio"/>										
Initiate collaborative ventures with academic colleagues, e.g. projects determining the current status and influencing future directions of nursing education & practice	<input type="radio"/>										
Contribute to formal service and strategic planning processes within your organisation	<input type="radio"/>										
Provide ongoing analyses of current education and nursing practice, and the impact of new directions on your clinical specialty or education service	<input type="radio"/>										
Plan, implement and evaluate annual plans for your nurse education service	<input type="radio"/>										
Manage complex projects relating to significant education & nursing practice change for your organisation	<input type="radio"/>										
Monitor clinical outcomes in relation to educational activity	<input type="radio"/>										

9. Continuous quality improvement

The nurse educator is committed to maintaining and improving competence in their role

Australian Survey of Nurse Educators / Clinical Nurse Educators

* 32. In your role to what extent are you:

	Never 0	1	2	3	4	5	6	7	8	9	10 Always
Aware of current professional trends through your involvement in professional organisations	<input type="radio"/>										
Involved in professional development activities to improve your performance	<input type="radio"/>										
Demonstrating cultural competence by incorporating cultural beliefs and practices in teaching and learning	<input type="radio"/>										
Using feedback from learners, peers and your manager to improve role effectiveness	<input type="radio"/>										
Using clinical practice and outcome data to inform educational interventions	<input type="radio"/>										

10. Research and scholarship

The nurse educator acknowledges that teaching is a scholarly activity and an integral component of the role together with research.

* 33. In your role to what extent do you:

	Never 0	1	2	3	4	5	6	7	8	9	10 Always
Use evidence to inform educational programs to improve nursing practice	<input type="radio"/>										
Incorporate findings from published studies in the development of evidence based teaching & evaluation	<input type="radio"/>										
Develop proposals or submissions for program development, policy and research	<input type="radio"/>										
Manage clinical practice improvement projects	<input type="radio"/>										
Initiate original research projects	<input type="radio"/>										
Disseminate your own research results through specialist publications and presentations	<input type="radio"/>										

11. Role development, educational practice and outcome assessment

* 34. Rate your performance of the educator role overall?

	Poor 0	1	2	3	4	5 Average	6	7	8	9	10 Excellent
Performance scale	<input type="radio"/>										

Australian Survey of Nurse Educators / Clinical Nurse Educators

35. Is your education role linked to specific clinical indicators or outcomes?

Yes

No

If YES please specify _____

* 36. To what extent do you consider there is a blurring and overlap of your activities with other nursing roles?

Level of overlap/ Role ambiguity

	Not at all	1	2	3	4	5	6	7	8	9	10
	0					Somewhat					Very much
	<input type="radio"/>										

* 37. What percentage of time do you spend undertaking the following activities?

	% of average hours per week
Providing direct clinical care	<input type="text"/>
Clinical teaching	<input type="text"/>
Competency assessment	<input type="text"/>
Curriculum development	<input type="text"/>
Education program planning and coordination	<input type="text"/>
Classroom teaching	<input type="text"/>
Relief of other nursing roles eg nurse manager	<input type="text"/>
Committee participation	<input type="text"/>

Australian Survey of Nurse Educators / Clinical Nurse Educators

*** 38. What percentage of the time you devote to educational activities is provided to the following groups?**

	% of average hours per week
Nurses	<input type="text"/>
Non-health professional staff	<input type="text"/>
Nursing students (baccalaureate program/university)	<input type="text"/>
Nursing students (vocational training/TAFE)	<input type="text"/>
Volunteers and community members	<input type="text"/>
Other health professionals	<input type="text"/>

*** 39. The nurse educator role is facing many challenges and opportunities. Please rate the importance of the following factors in developing and supporting the nurse educator role?**

	0 Very Low	1	2	3	4	5 Moderately important	6	7	8	9	10 Very important
Increasing the focus on interprofessional teaching and learning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Developing strategies to promote an advanced practice role	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Promoting initiatives to foster team work and multidisciplinary care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Addressing factors relating to skill mix diversification in the nursing workforce	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Endorsing the interface between health care settings and educational providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Increasing the focus on research and scholarship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Linking nurse education activities to demonstrable patient outcomes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Advancing the nurse educator role within the nursing profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

Australian Survey of Nurse Educators / Clinical Nurse Educators

12. Career Intentions

We would like to ask you about your career intentions. Please rate each item from definitely false to definitely true (Covin 2001).

*** 40. Career intentions:**

	Definitely False	False	Mostly False	More False Than True	More True Than False	Mostly True	True	Definitely True
It is my intention to continue with my nursing career in the foreseeable future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would like to stay in nursing as long as possible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As soon as it is convenient for me I plan to leave the nursing profession	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect I will keep working as a nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My plan is to remain with my nursing career as long as I am able	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would like to find other employment by leaving nursing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*** 41. Given your present feelings about your work, how likely are you to stay in this clinical area in the next 12 months?**

	Not Likely 1	2	3	4	5	6	7	8 Very Likely
rating scale:	<input type="radio"/>							

*** 42. In the next 12 months, which of the following relates to your job plans?**

- Stay in my current position
- Stay in direct patient care but in another unit/department in this hospital
- Stay in direct patient care but in another hospital/health care facility/ community
- Leave direct patient care but stay in the nursing profession
- Leave the nursing profession for another career
- Retire

Other (please specify)

13. Professional Practice Environment Scale

Please circle the ONE response that best reflects your level of agreement in relation to your current work environment (Erickson et al 2004)

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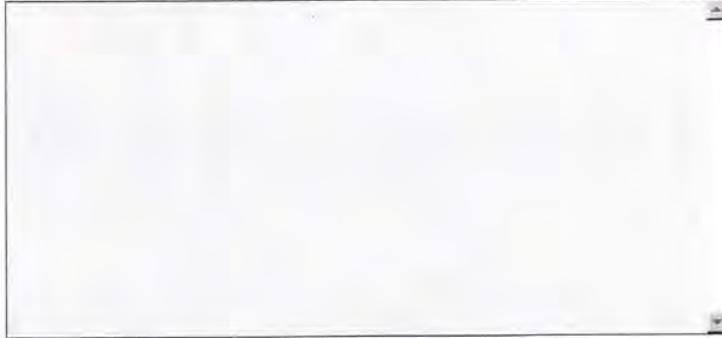
* 43. Your current work environment:

	1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree
Leadership supportive to staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My discipline (ie nursing) controls its own practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Freedom to make important patient care and work decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A lot of team work between physicians and staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient care assignments that foster continuity of care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adequate support services allow me to spend time with patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enough time and opportunity to discuss patient care problems with other staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enough staff to provide quality patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A manager who is a good manager and leader	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enough staff to get the work done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opportunity to work in a specialised work environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Manager who backs up staff in decision making, even in conflict with medical practitioner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physicians and department or unit staff have good relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being placed in a position of having to do things against my professional judgment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get information on patient's status when I need it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When patient's status changes, I get relevant information quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This unit has constructive relationships with other groups in this area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This unit doesn't get co-operation it needs from other health units and facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other units seem to have a low opinion of this unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate working relationships with other clinical areas limit effectiveness of work on this unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When staff disagree, they ignore the issue, pretending it will go away	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff withdraw from conflict	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All points of view considered in finding best solution to problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All staff work hard to arrive at best possible solution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff involved don't settle dispute until all are satisfied with decision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All contribute from their experience, expertise to effect high quality solution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Disagreements between staff are ignored or avoided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff involved settle disputes by consensus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My opinion of myself goes up when I work in this facility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel a great sense of personal satisfaction for the work I do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Australian Survey of Nurse Educators / Clinical Nurse Educators

14. Your chance to have your say

43. If there are any comments you would like to share regarding the nurse educator/ clinical nurse educator role please feel free to make comments in the section below.



Thank you for completing this survey.

Your investment of time in completing the survey will contribute to the future development of the nurse educator/clinical nurse educator in Australia.

If you are available to participate in an online focus group to further discuss these issues please email jan.sayers@postgrad.curtin.edu.au.

If you have any questions regarding this survey please contact:

Jan Sayers 0408 168 037
jan.sayers@postgrad.curtin.edu.au

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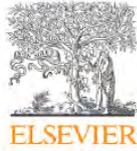
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Appendix 10 Publications arising from this thesis

1. Sayers, J., Di Giacomo, M. and Davidson, P.M. (2011). The nurse educator role in the acute care setting in Australia: important but poorly understood. *Australian Journal of Advanced Nursing*. 28, (4), 44-51
2. Sayers, J., Di Giacomo, M. (2010). The nurse educator role in Australian Hospitals: implications for policy. *Collegian*, 17, (2), July. 77-84.



The nurse educator role in Australian hospitals: Implications for health policy

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KEYWORDS

Nurse educator;
Nurse education
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Interprofessional
education;
Hospital-based
educators

Summary To date, the nurse educator role in the Australian hospital setting has been poorly described. Current pressures for health care reform have prompted reviews of nursing roles. This paper discusses the literature pertaining to the nurse educator role within the context of the Australian health care environment and current health care policy. Building on this synthesis, barriers and facilitators impacting on the nurse educator role are identified and strategic directions for policy, role clarification and advanced practice role development are highlighted. Further research identifying the impact of the hospital-based nurse educator on patient outcomes and professional nursing practice are proposed.

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Review

Background

Australia has a world class health system nonetheless a significant reform agenda has been articulated by the National Health and Hospitals Reform Commission to address present and emerging challenges (Australian Government National Health and Hospitals Reform Commission, 2009). These include health expenditure, service demands, inequities in health care access and outcomes, workforce shortages and the quality and safety of patient

care (Australian Government National Health and Hospitals Reform Commission, 2009). The role that nurses play in the health reform agenda is indisputable (Needleman, Buerhas, Matke, Stewart, & Zelevinsky, 2002) as is the premise that nursing education is the foundation for nurses to provide, safe quality care (Conway & Elwin, 2007). The hospital-based nurse educator, the focus of this discussion, is integral to addressing the Commission's initiatives of strengthening and developing a skilled and competent health workforce (Australian Government National Health and Hospitals Reform Commission, 2009). Nurse educators in the acute care setting are pivotal in supporting nurses to integrate their learning and clinical practice (Bartle, 2000; Campbell, 2003; Conway & Elwin, 2007; Mateo & Fahje, 1998).

In Australia the nurse educator role, qualifications and scope of practice varies considerably to that of nurse educators internationally and is dependent to some extent

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upon the context within which the educator is employed (Conway & Elwin, 2007). For the purposes of this paper, a nurse educator is defined as a registered nurse, who provides education to undergraduate and postgraduate students and staff within a hospital setting. The role of nurse educators in hospitals is varied and complex – some have primary responsibility for organisation wide programs, such as preceptor training, whilst others work within a specialty such as cardiac nursing providing specialty education (Conway & Elwin, 2007). Role descriptions for educators within individual hospitals may require nurse educators to have a tertiary qualification in education and/or a specialty qualification at a University or College (a tertiary institution that provides certificate or diploma courses) level. However, this is not a universal requirement nor mandated by the registering authority for nurses.

Conway and Elwin argue that the hospital-based nurse educator role is unclear and poorly described, and that there is a blurring across various categories of nurses providing education in practice environments. Whilst these anomalies continue, role description and enactment may be adversely impacted (Conway & Elwin, 2007; Dubois & Singh, 2009). In turn the success of education and training initiatives with nurses within the reform agenda may also be effected (Conway & Elwin, 2007). In the context of these issues and a concern regarding the sustainability of nurse educator positions (positions not directly responsible for patient care) it is timely to consider the role and contribution of the hospital-based nurse educator for health care policy (Conway & Elwin, 2007).

This paper presents an overview of the Australian Health Care System, population demographics informing health policy, health funding and the health workforce. The paper then focuses on the literature regarding the nurse educator role in Australian hospitals and the influence of the above drivers, health care reform and policy developments on role enactment. Building on this synthesis, the barriers and facilitators impacting on the nurse educator role are identified and strategic directions for policy, role clarification and advanced practice role development are highlighted. Further research identifying the impact of the nurse educator role on patient outcomes and professional nursing practice are proposed.

The Australian health care system

In Australia, health care is provided by both government and private sectors within a diverse range of settings in cities, suburban, rural and remote regions (Illiffe & Kearney, 2007). Commonwealth, State and Territory governments assume various roles in the provision of health care. The Commonwealth government assumes broad leadership and funding roles whilst the planning and delivery of public health services is the domain of State and Territory governments. The public hospital system provides the majority of acute health care services to Australian citizens and permanent residents over an extensive geographic area and is managed by State governments across Australia. Nurse educators work within both the public and private health care systems.

Demographics

The ageing population, escalating health care costs and health workforce shortages will significantly impact the health status of Australian society during the next half century (Senate Community Affairs Committee, 2007). The Australian Institute of Health & Welfare's (2008) report on the health of Australians for example, identified over 1 million people requiring daily assistance with self care, mobility, and communicating as a consequence of severe disability (Australian Institute of Health & Welfare, 2008). The report also identifies the major causes of death, namely cancer, cardiovascular and respiratory diseases (Australian Institute of Health & Welfare, 2008). Although Australia is considered to be a socially and economically prosperous nation, characterised by quality health care and access to education and employment opportunities, disparities for these socioeconomic indicators for health are evident within specific population groups including rural and Aboriginal and Torres Strait Islander communities (Australian Institute of Health & Welfare, 2008). Aboriginal and Torres Strait Islander health is worse than that of non-indigenous Australians (Australian Institute of Health and Welfare, 2009). They have higher levels of kidney disease and diabetes than non-indigenous Australians and high admission rates to acute care hospitals (Australian Institute of Health and Welfare, 2009). Unlike non-indigenous Australians only 3.1% of the indigenous population is aged over 65 years but they have a young population with 37.2% aged less than 15 years (Australian Institute of Health and Welfare, 2009). Providing care to a culturally diverse society comprising, a young indigenous population and an ageing non-indigenous population, all with specific complex care needs coupled with diminishing workforce participation may negatively impact capability to meet health care service demands (Conway, 2007). If these needs are to be addressed, nurse educators need to be conversant with changing population demographics and informed of the specific health needs, service delivery models and specialty nursing practices required so that they may provide relevant and timely education and support to nurses working in hospitals serving these communities (Conway & Elwin, 2007; Dubois & Singh, 2009). These challenges are not unique to the Australian system but in order to achieve health reforms, they must be considered within the local policy environment and health system funding.

Health funding

Although the focus of care is increasingly moving to the community, hospitals remain an important focus of care and are associated with significant costs. Australia supports a system of universal health care coverage i.e. employees pay a tax levy to support government funding of public health care. In turn all Australians are entitled to receive free public hospital care. This funding is administered through a complex and layered system of Commonwealth, State and local governments and public and private providers. At each level of government there are both health care providers who are government employees and private providers and there is a coexistence of private insurance, co-payment

(where private health insurance pays part of the service costs and the patient pays the remainder) and universal coverage. Funding for the health workforce, including nurse educator positions is provided through the levels of government described above (Davidson, Driscoll, Clark, Newton, & Stewart, 2008). Importantly, the Federal Government has recently committed \$157 million for clinical teaching and education infrastructure to develop an educated and competent workforce to facilitate the delivery of safe patient care.

Registered nurses seeking a career as a nurse educator are able to access funding for courses in education or a clinical specialty. This funding is provided by the Commonwealth and State Governments and professional organisations. Nurse educators are also eligible to apply for scholarships through these competitive funding sources (National Nursing and Nursing Education Taskforce, 2005). However further research is required to identify whether or not nurse educators are aware of and utilise this funding to undertake postgraduate study. It is equally important to know their uptake of scholarships for both professional and continuing education and whether or not sufficient scholarships are available (National Nursing and Nursing Education Taskforce, 2005).

Changing models of care – interprofessional learning and practice

Care environments are constantly changing in response to decreasing lengths of stay, fewer acute care beds, increased patient acuity and associated co-morbidities coupled with an unprecedented growth in day only surgery (Davidson et al., 2001). As the demand for health services changes (Aitken, Faulkner, Buchnall, & Parker, 2001) changes in care provision, including nursing and interdisciplinary models of care have also occurred (Senate Community Affairs Committee, 2007). Nurses need to have an understanding of these models of care and their appropriateness given the changing contexts of their work as cited above but also in light of the divergent skill mix of staff providing care within the multidisciplinary team (NSW Health, 2006). It is within this context that nurses and other health care workers in hospitals may be supported by the nurse educator, through fostering interdisciplinary collaboration, clinical leadership, knowledge and skill development and in turn influencing patient safety and outcomes (Conway & Elwin, 2007).

Australia's health workforce

Nurses in Australia (including nurse educators) comprise 52% of the health workforce, whilst doctors, allied health and other staff comprise the remainder (Productivity Commission, 2005). Our health workforce is also ageing with 29.8% of registered nurses aged over 50 years (Productivity Commission, 2005). Illiffe (2007) forecasts that 50% of the health workforce may retire in the next 10–20 years. This cohort will include significant numbers of nurse educators with specialist qualifications, knowledge and skills. Whilst the government has sought to increase undergraduate places to address workforce shortages, in part through international undergraduate students and graduates, Illiffe (2007)

argues that the impact of these efforts are marred by an apparent failure to develop a national methodological response to workforce planning and hence a shortfall in the number of graduate nurses available. In response to these shortfalls, a workforce comprising increasingly divergent skills and experience has emerged and is expanding through the initiation of health worker education courses at the college level (Conway, 2007). Whilst a divergent workforce may provide short-term relief to staffing deficits, the potential however also exists for the varying knowledge, skills and expertise of these workers to negatively impact, quality patient outcomes (Daly, Macleod Clark, Lancaster, Bednash, & Orchard, 2008; Sheilds & Watson, 2008). These shifts in workforce composition and experience influence the registered nurse role as the scope of practice for nurses and other health workers changes (Conway, 2007). Consequently, the registered nurse may be responsible for delegating and supervising care rather than being the direct care provider (Conway, 2007). These changes in delegation of care may impact on the quality of care provided. Dubois and Singh (2009) identify that some attempts to address workforce shortages, are focussed on staff types, as opposed to the staff member's skills and their ability to apply these in providing care. Importantly, the health care system's ability to provide safe and effective care is reliant upon a sufficient and skilled workforce working within service models that optimise staff performance (Dubois & Singh, 2009; Dussault & Dubois, 2003).

Interface between nursing and health workforce development

The Australian Commonwealth Government has established the National Health and Hospitals Reform Commission to address health system challenges impacting care delivery and outcomes (Australian Government National Health and Hospitals Reform Commission, 2009; National Health & Hospitals Reform Commission, 2008). However the impact nurses have on health care delivery and patient outcomes is dependent upon health policy mandating education requirements for nurse education and nursing professional roles within diverse contexts of practice. The requirement for a national unified focus on the interface between nursing, health and workforce development and modifying the strata and educational requirements of health care workers significantly impacts nursing roles, future care delivery and outcomes (Heath, 2002; National Nursing and Nursing Education Taskforce, 2006). Health policy reflecting educational strategies universities may employ to facilitate knowledge and skill transfer underpinned by competency development and professional values is required (Daly et al., 2008; Heath, 2002; Henderson & Winch, 2008; National Nursing and Nursing Education Taskforce, 2006).

The pivotal role of nurse educators in the health workforce

Nursing roles are influenced by health system reform, legislation, as it applies to the regulation of the nursing, and health workforce and health care delivery (Henderson &

Table 1 Factors enhancing and constraining the nurse educator role.

Factors	Enhancing	Constraining
Health system	Current reform agenda Universal health coverage	Inadequate coordination across sectors Multiple levels of government
Legislation	Universal health care coverage Participatory government	Inflexible regulatory practices
Financial	Funding enhancements for clinical education	
Social	Positive public perception of nurses	Ageing workforce Pay and remuneration disparities Increasing educational costs
Professional issues	National focus on nursing	Fragmented roles and responsibilities
Knowledge development	Support for continuing professional development	Diverse worker skill base from those educated at vocational level to those highly qualified with Bachelor's – PhD
Education system	Baccalaureate Education Subsidised funding stream	Division between academy and industry
Workforce supply	Increasing focus on the value of nurses as part of the health care system	Diversification of nursing classifications Dilution of clinical expertise in practice settings
Public demand	Increased public scrutiny Increased professional accountability	Increased public scrutiny Increased professional accountability

Winch, 2008). Other factors influencing nursing roles are economic and social determinants, professional practice issues, knowledge development, consumers and workforce supply and demand (Henderson & Winch, 2008). hospital-based nurse educators in Australia primarily work within the clinical practice setting (Conway & Elwin, 2007). In comparison, nurse educators in America and the United Kingdom may work both within academia and the clinical environment (Conway & Elwin, 2007). The Federal Government's recent commitment of additional infrastructure funding is timely as the professional development of nurses and maintaining practice standards is contingent upon the nurse educator role – particularly in the hospital setting where the nurse educator as a clinical leader is responsible for managing and facilitating clinical education and competency (Conway & Elwin, 2007; Mateo & Fahje, 1998).

Assuring workforce competency

Clinical governance and risk management initiatives require health employers to ensure that their employees are appropriately trained, skilled and competent to provide safe care within their scope of practice thereby diminishing the risk of harm or injury to the patient. For hospitalised patients, reported rates of between 5 and 15% of adverse events, with 37 and 52% of these preventable, highlights the need for professional competence to quell further escalation of these statistics (Aiken, Clarke, Sloane, Siber, & Sloane, 2003; Tourangeau, Cranley, & Jeffs, 2006). Nurse sensitive outcomes are inextricably linked to patient mortality in the hospital setting and are influenced by communication, professional relationships, staffing, education, experience and

professional support (Tourangeau et al., 2006). Further evidence of this is provided by Aiken's finding that patient mortality rates may decline when care is provided by registered nurses holding undergraduate degrees (Aiken et al., 2003).

In the Australian context, the government has focussed some attention on employee competence to ensure optimal health care provision. The Garling Inquiry into New South Wales (NSW) Acute Care Hospitals (2008) for example has identified the importance of new graduates being supervised and supported by appropriately qualified and experienced staff. Further this report has recommended the consistent teaching of basic skills and competencies to all health professionals throughout their transition to graduate practice (Garling, 2008). This initiative requires interprofessional learning and practice to improve team work and patient centred care that is focussed on effective communication and familiarity with evidence based practice (Garling, 2008). The NSW State Government (2009) has subsequently announced a \$25 million transition to work program for health professionals (NSW Minister for Health, March 30, 2009). However, it is not clear who will provide these services, although nurse educators may have the skills and expertise required as they have managed and conducted effective new graduate transition to work programs for some years (Conway & Elwin, 2007).

Factors enhancing and constraining nurse educator role development in Australia

Sustaining and continually developing a sufficient nurse educator workforce who are highly motivated, competent, and

capable of supporting nurses working in hospitals within service models that facilitate their optimal performance is essential (Dubois & Singh, 2009; Illiffe, 2007). However, the hospital-based nurse educator faces significant challenges regarding their role, education, identity and validation of their practice.

Factors enhancing and constraining nurse educator practice are summarised in Table 1.

Barriers to the nurse educator role

Role ambiguity/conflict

Landmark reports suggest that health human resources are underutilised (Oelke et al., 2008; Royal College of Nursing Australia, 2008) although factors enhancing and constraining role optimisation are not well understood (Oelke et al., 2008). Ensuring that nurses work to their full scope of practice has been identified as a critical factor in workforce retention and is an important strategy in addressing workforce shortages (Oelke et al., 2008). The concepts of 'nursing scope of practice' and 'role enactment' and the 'professional practice environment' are used widely within the literature though they are not clearly defined (Oelke et al., 2008) in the context of the nurse educator role. In recent years, the Australian nursing profession has been restructured, however there has been minimal acknowledgement of the impact of these changes and the associated potential for role ambiguity and conflict within nursing (Conway, 2007). The impact of these changes on the nurse educator role has been significant and the role has been eroded.

A report by Conway and Elwin identified the pivotal role nurse educators assume supporting the integration of theory and clinical practice. They identified nurse educators to be expert nurses working within their clinical speciality but also acknowledged the diversity of role descriptions and boundaries within hospital, states and across the country (Conway & Elwin, 2007). Together with variances in nomenclature, not only within Australia but internationally, the clarity of the nurse educator position and role enactment is further blurred and misunderstood (Conway & Elwin, 2007). Nurse education is no longer the exclusive mandate of the nurse educator as other specialist nursing roles have emerged assuming responsibility for learning & teaching and independently engaging nurses in education in the clinical practice environment (Conway, 2007; Conway & Elwin, 2007). Conway & Elwin observed that role identity and successful role enactment may become eroded and blurred in a health system characterised by constant change and overlap between other roles supporting learning. Scott argues that the enabling of health professionals may enhance their productivity. We concur that this premise may also apply to nurse educators and their practice. Whilst the nurse educator role remains poorly defined, the threat of intra-professional discord including professional isolation and a lack of supportive relationships remains (Conway & Elwin, 2007). Unless resolved, the role may continue to be undervalued and negatively effect role enactment, job satisfaction and staff retention (Conway & Elwin, 2007). Enabling nurse educators to articulate their role and scope of practice is important if they are to facilitate the empowerment of other nurses and health workers to develop skill proficiency

and champion their development of critical thinking and reasoning skills within a supported clinical learning environment (National League of Nursing, 2005). The advancement of nurse education practice is also contingent upon the clarification of role boundaries and careful description of the role (Conway & Elwin, 2007).

Lack of education and training opportunities

Registered nurse practice in Australia is governed by competency standards developed by the Australian Nursing and Midwifery Council (Australian Nursing and Midwifery Council.). The attainment of core knowledge, skills and competence is equally important for the nurse educator to perform their role. The nursing profession in Australia does not mandate the educational preparation required for nurse educators, nor does any specific regulatory authority mandate requirements. Essential criteria for the role, including educational attainment, vary between hospitals and states (Conway & Elwin, 2007). Increasing numbers of newly qualified registered nurses entering the workforce requiring clinical education, support and mentoring, has led to the recruitment of nurse educators who have a diverse range of clinical skills and professional qualifications (Conway & Elwin, 2007). Over many years, debate as to whether or not clinical competence alone is a sufficient attribute for the nurse educator to perform successfully versus their credibility as an effective educator has occurred (Cole et al., 2004; Conway & Elwin, 2007; Mateo & Fahje, 1998). Nurses in the professional practice environment need to be effectively supported to become life long learners. They require the opportunity to learn in an educational environment where engaging learning experiences are provided and supported by nurse educators with expertise and knowledge in adult education. To perform successfully in their role nurse educators also require clinical leadership, critical thinking, reflection and effective communication skills and knowledge of and commitment to learning and teaching processes (Conway & Elwin, 2007; Mateo & Fahje, 1998; Ramage, 2004). The knowledge and expertise nurse educators acquire through educational preparation and experience are instrumental in designing and facilitating learning experiences and evaluating learner outcomes (National League of Nursing, 2003). Existing variations in the nurse educator role, together with variances in clinical competence and qualifications may complicate nurse educator preparation and subsequent role development. Support for study leave and fee registration is instrumental in participation rates in initial and continuing professional education and scholarship (National Nursing and Nursing Education Taskforce, 2005).

Global shortage of qualified nurses

The global shortage of nurses will continue, particularly as many skilled nurses and nurse educators retire over the next decade. However, the development of a nurse education career pathway may enhance nurse educator recruitment and job satisfaction, as has occurred for other nursing roles. Recruitment and retention to the role may be further enhanced through improved working conditions such as flexible career pathways facilitating nurse educators to work both within academia and hospitals. This

may also diminish the divide between academia and hospitals, theory and practice, enhancing cooperative working partnerships, collegiality and scholarship and importantly curriculum innovation and enactment.

Facilitators to the nurse educator role

Australian National Health Priorities

In response to the World Health Organization's global health strategy, seven key health issues that contribute to the burden of illness and injury in Australia have been identified (Begg et al., 2007). These issues are cancer control, cardiovascular health, diabetes, injury prevention and control, mental health, arthritis and musculoskeletal disorder and asthma (Begg et al., 2007). The influence of nursing interventions on quality of life, hospital readmission rates and consumer compliance in the management of chronic and complex disease is evident in the nursing discourse (Davidson et al., 2001). Nurse educators working in speciality areas are ideally positioned to work with nurse managers identifying and supporting the implementation of appropriate models of care, enhancing clinical decision making by informing practice and intra-professional and interprofessional collaboration, to support professional nursing practice and patient centred care (Australian Government National Health and Hospitals Reform Commission, 2009).

Consumer expectations

The relationship between nurses and health care consumers has changed in recent years as consumers become more knowledgeable regarding their health and assume greater responsibility for managing their health issues. Importantly, consumers have also actively engaged in debate regarding the provision and management of health services and clearly articulated their views regarding quality of care and health management (Jackson & Daly, 2008). Patients are no longer passive care recipients but are actively involved in care planning (Australian Government National Health and Hospitals Reform Commission, 2009; Davidson, Elliott & Daffurn, 2004).

Health care consumers hold nurses in high esteem (Davidson, Elliott & Daffurn, 2004). The expectations of the profession and consumers of care generally support the tenet that nurses must be well educated to positively impact professional nursing practice and patient outcomes. In light of recent public debate in Australia regarding the professional preparation of nurses, it may be timely to reconsider the role of the nurse educator and the educational preparation required by them to perform in the role (Jackson & Daly, 2008).

Policy in support of nurse educator practice

Nurses who are cognisant of the social, economic and political factors that impact the health system can be influential in developing nursing care and practice whilst optimising patient outcomes (Jackson & Daly, 2008). Nurse educators require these traits to assume key leadership roles collaborating with academia to develop innovative models for clinical skill development for example through simulation and targeted clinical placements for undergraduate students.

Future directions for the nurse educator within the professional practice environment

As health workforce reform gains momentum in Australia identifying a defined career pathway together with delineating the nurse educator role and expectations of performance are important considerations (Henderson & Winch, 2008). Importantly, as advanced practice nursing roles emerge, it is opportune for nurse educators to exercise leadership in developing a vision for an advanced practice role to further impact health workforce education and practice.

Implications for research

The nurse educator role, as well as being poorly described, may also be underutilised. By identifying a framework and process for the development of nurse educator standards, a vision for nurse education in the Australian acute care setting will emerge, advancing nurse education, practice expectations and demonstrating performance outcomes for the role. These initiatives will not only acknowledge the contributions the nurse educator makes to health care, propelling nursing practice forward, and influencing patient outcomes, but also identify strategies to engage academia to work alongside nurse educators to support clinical education in the professional practice environment.

Further research is required to provide an understanding of the concepts of nursing 'scope of practice' and 'role enactment' and the 'professional practice environment' as they relate to nurse educators. Research is also required to determine the adequacy of the nurse educator workforce, ascertain postgraduate education required to successfully perform in the nurse educator role, and the availability and uptake of financial support to facilitate nurse educators to undertake this study. Delineation of the role and expectations of performance will likely maximise effective utilisation of nurse educator staff within the health workforce (Australian Government National Health and Hospitals Reform Commission, 2009; Dubois & Singh, 2009; Oelke et al., 2008).

Conclusion

Australia, in parallel with other developed countries, faces health care challenges in relation to population ageing, affordability, equity as well as safety and quality in health care. Hospital-based nurse educators are recognised as experts in the educational process, facilitators of learning, mentors and inspirational clinical leaders for nurse clinicians and health staff (Conway & Elwin, 2007). However, role clarity, a defined career pathway and support for professional education and development is required so that they are supported to carve a niche in the professional practice environment (Conway & Elwin, 2007). These issues emphasise the need for discussion and policy debate regarding the hospital-based nurse educator role and the need for further research. Importantly, research identifying the relationship of the nurse educator role to patient outcomes will enhance role sustainability and the recognition of nurse educators as strategic stakeholders within the health workforce.

Competing interests

The authors declare that they have no competing interests.

Contributions

JS was the lead writer of the manuscript. MD contributed to the manuscript review. All authors reviewed and approved the final manuscript.

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The nurse educator role in the acute care setting in Australia: important but poorly described

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KEY WORDS

nurse educator, clinical nurse educator, hospital based educator

ABSTRACT

Objective

The purpose of this paper is to describe the nurse educator role in the acute care setting in Australia.

Method

A literature review using Ganong's (1987) method of analysis was undertaken. Computerised databases were searched for articles published in English between 2000 and 2008 using the key words: 'education', 'nursing', 'nurse-educator', 'teaching methods', 'clinical', 'outcomes health care' and 'Australia'. Information was summarised to identify issues impacting on the nurse educator role using a standardised data extraction tool.

Results

The search strategies generated 152 articles and reports. The review identified that the nurse educator role is fundamental in supporting clinical practice and integral to developing a skilled and competent health workforce.

Conclusion

Confusion in nursing roles and role ambiguity contribute to the challenges for nurse educators in acute care. The absence of a national, standardised approach to role description and scope of practice in Australia may adversely impact role enactment. Further discussion and debate of the nurse educator role in Australia is warranted.

INTRODUCTION

The Australian health care system has experienced significant change in recent years and faces considerable challenges in continuing to provide world class health care services. In response to these challenges, the National Health and Hospitals Reform Commission (NHHRC) has identified a challenging reform agenda (National Health and Hospitals Reform Commission 2009). Issues addressed by the NHHRC include reviewing health service demand and expenditure, increasing the emphasis on patient care safety and quality, addressing inequities in health care access and outcomes and examining workforce models (National Health and Hospitals Reform Commission 2009). As nurses' play a major role in health care delivery in primary, secondary and tertiary care nurses' contribution in achieving health reform is indisputable (Needleman et al 2002). Ensuring that nurses have the appropriate skills, knowledge, competencies and professional values to achieve reform objectives is contingent upon their engagement in evidence-based education strategies.

Historically, nurse educators have played a critical role in the professional development of nurses and maintaining and advancing nursing practice standards (Conway and Elwin 2007). Their role in contemporary service models is less well defined (Conway and Elwin 2007). The nurse educator role in Australia has evolved over time and changed significantly following the transfer of nurse education from hospitals to universities (Conway and Elwin 2007). Prior to the introduction of baccalaureate nursing programs, acute care nurse educators assumed overall responsibility for student nurses as well as providing continuing and professional education of registered nurses.

A nurse educator is defined as a registered nurse who assesses, plans, implements and evaluates nursing education and professional development programs (Australian Nursing Federation 2009). They are also responsible for advancing practice development and student support rather than having complete responsibility for nurse education as in the academy

(Conway and Elwin 2007). To date their roles, scope of practice and contribution to patient outcomes is unclear (Conway and Elwin 2007). This lack of clarity is compounded by increasing scrutiny of positions not directly responsible for patient care. Therefore it is timely to consider the role and contribution of the nurse educator to patient care outcomes and the professional development of nursing (Conway and Elwin 2007).

This paper reports on an integrative literature review of the nurse educator role with a focus on the role in acute care hospitals within the Australian health care system. It is argued that the nurse educator role is critical to the continuing professional development of the nursing and broader health workforce and influences the delivery of safe, quality patient care. The integrative review has allowed the summary and synthesis of these issues and identification of challenges to role enactment and advancement.

The Australian health care system

Australia supports a system of universal health care coverage and although there is an increasing emphasis on community-based care, acute hospitals still remain an important focus of care. Nurse educators work within acute care hospitals in public and private sectors within cities, suburban, rural and remote regions across Australia. Multidimensional system, provider and patient factors have significantly impacted professional practice and patient outcomes in recent years prompting service and system reviews at State and Federal government levels. Several reviews have debated health care relating to expenditure, service demands, inequities in health care access and outcomes, workforce shortages, patient care quality and safety and the lack of integration across State and Federal systems (National Health and Hospitals Reform Commission 2009). The Australian health care system services a culturally diverse society with significant complex care needs including Aboriginal and Torres Strait Islanders (Australian Institute of Health and Welfare 2009). Nurse educators work in acute care facilities within these communities across Australia.

Workforce Challenges

Landmark nursing workforce reports have identified the requirement for a national focus on the interface between nursing, health and workforce development (Heath 2000; National Nursing and Nursing Education Taskforce 2006). This includes modification to the profile and educational preparation of future health care workers to meet service and consumer demands for care (National Nursing and Nursing Education Taskforce 2006). These issues have driven modification of skill mix in nursing in Australia (Conway and Elwin 2007).

Although nurse education has been in the tertiary setting since the mid-1980s, there are calls to change the nursing workforce focus from a predominately baccalaureate preparation to one of much greater diversity through broadening the scope of practice of enrolled nurses and the creation of new categories of health workers (Daly et al 2008). Changes to the enrolled nurse role and scope of practice have been made including authorisation to administer medications (Conway and Elwin 2007). This change is coupled with the emergence of a health workforce of increasingly divergent knowledge and skills who some argue have limited educational preparation to address the population's changing health care needs (Conway and Elwin 2007; Daly et al 2008).

These trends have emerged not merely to address workforce shortages, but to attend to the increasing needs of individuals with chronic conditions and the elderly. The described role diversity within nursing and the broader health workforce mean that the educative and supportive role of the nurse educator is likely to become more critical to support knowledge, skill and clinical practice development (Conway and Elwin 2007).

The changing work environment

The role of the nurse educator in the acute care system has been eroded in a push towards more generic health professional and health worker education programs (Conway and Elwin 2007). Although this is advantageous in developing interprofessional relationships, it can be problematic as there is

potential to lose nursing identity and compromise patient safety and outcomes in the ongoing quest to address the global shortage of health care workers (Daly et al 2008). The introduction of the Health Training Package for example means that a new cadre of health workers with varied educational preparation who may provide "basic care" are evident in hospitals. The training package is a nationally recognised framework that provides pathways to a wide variety of health care work and qualification options and facilitates articulation of both regulated and unregulated workers to engage in health care provision (Conway and Elwin 2007). Whilst these initiatives may address staffing deficits in the short term, they have potential to negatively impact the achievement of safe, quality patient outcomes (Duffield 2007; Daly et al 2008). A direct consequence for the registered nurse of a more diverse health workforce is the potential for a role shift whereby the registered nurse may not be the direct care provider but be responsible for delegation and supervision of care as a consequence of the changing scope of practice of nurses and other health care workers (Conway and Elwin 2007).

The prediction that almost 60% of the current Australian nursing workforce will retire in the period 2006 - 2026, challenges the capacity of the nursing profession and the health care system to recruit and retain sufficient appropriately skilled staff, of the right skill mix, in the right geographic location to meet service demands and importantly achieve safe patient outcomes (Duffield et al 2007).

METHOD

An integrative review of the literature utilising Ganong's (1987) method of analysis was undertaken. An integrative literature review is a method for assessing information based on a question or hypothesis that guides the review, interpretation and synthesis of findings (Weaver and Olson 2006; Whittemore and Knafel 2005; Ganong 1987). Commonly, an integrative literature review is useful to gather and integrate information to inform scholarly debate and suggest further areas for research.

The integrative review method was selected as it provides a structured approach to the identification and interpretation of themes and differences in the literature (Weaver and Olson 2006). The Cumulative Index of Nursing and Allied Health (CINAHL), Science Direct databases, and the Google search engine were employed in the literature search of Australian publications from 2000 to 2008. Search terms were 'education', 'nursing', 'nurse-educator', 'teaching methods', 'clinical', 'outcomes health care' and 'Australia'. Reference lists of retrieved articles and reports were hand-searched for any additional references. Questions guiding the review were: (1) What is the role of the nurse educator in the contemporary Australian health care system? (2) What is the impact of the nurse educator role on patient outcomes? and (3) What are the key challenges facing the nurse educator role?

Inclusion and Exclusion

Inclusion criteria required that references focus on the nurse educator role and nurse education in the Australian acute care setting and be published in English between 2000 and 2008. References not meeting these criteria were excluded.

FINDINGS

The search strategies generated 152 articles and reports. Each paper was analysed by two reviewers using the research questions as a guide. Key themes namely, role ambiguity, educational preparation for the role and career pathways, nursing workforce shortages and partnerships with academia were generated using the method of thematic analysis which draws together common issues and concerns. A feature of the review was the limited discussion of the nurse educator role. Within the literature, the term 'nurse educator role' was used generically making it difficult to differentiate between roles in the university and health care sector.

The literature is reported beneath headings corresponding to the questions that guided the review process and emergent themes that impact the nurse educator role.

The role of the nurse educator in the contemporary Australian health care system

The role of the nurse educator is multi-faceted and dependent on the context of practice and employment (Conway and Elwin 2007). Nurse educators in America and the United Kingdom may have dual roles in academia and the hospital setting (Koh 2002; Billings 2003; Conway and Elwin 2007). In contrast, nurse educators in Australia work primarily within hospitals. They are considered to be expert nurses and their role is pivotal to the integration of theory and clinical practice (Conway and Elwin 2007). This role in Australia has evolved from one where the hospital based educator had overall responsibility for the pre-registration education of nurses and professional development in a hospital based system, to providing student support and facilitation of professional education, nursing practice and organisational goals (Conway and Elwin 2007). Some educators are responsible for organisation wide programs for example preceptor programs and others work within a clinical specialty such as cardiology (Conway and Elwin 2007). It is apparent that this is a complex and varied role (Mateo and Fahje 1998; Conway and Elwin 2007).

Conway and Elwin acknowledge the diversity of nurse educator role descriptions and boundaries (Conway and Elwin 2007). Also there is a blurring across various categories of nurses providing education in hospitals (Conway and Elwin 2007). This lack of clarity may adversely impact role description and enactment (Conway and Elwin 2007; Dubois and Singh 2009). Similar issues in defining and describing the nurse educator role are also seen internationally as roles and functions blur across practice settings (Billings 2003; Gillespie and McFetridge 2006). The nurse educator practices in accordance with the competency standards for registered nurses developed by the Australian Nursing and Midwifery Council (2005). Nurse educators may also practice in accordance with the competency standards for nurse teachers (educators either working in academia or the clinical arena) developed by the Australian Nurse Teachers Society (1998).

The impact of the nurse educator role on patient outcomes

The impact of patient acuity, decreased length of stay and increased numbers of adverse events is featured prominently in the literature, yet little attention has been paid to the impact or role of nurse educators in addressing these dilemmas. An emerging body of literature has determined the importance of a well-educated nursing workforce, particularly in the acute care setting, to improve patient outcomes (Aiken et al 2003). Nurse-sensitive patient outcomes, or the nurse-led interventions that contribute to patient outcomes, are critical in determining the impact of nursing care on the patient journey (O'Brien-Pallas et al 2004; Tourangeau et al 2005; Duffield et al 2007). Changes in healthcare, decreasing length of stay, and an increasingly divergent nursing skill mix inextricably link with higher reporting of adverse patient events and outcomes (Buerhaus et al 2007; Duffield et al 2007; Rafferty et al 2007; O'Brien-Pallas et al 2004). Duffield's (2007) recent study of hospital nursing wards in NSW has demonstrated that adverse events decrease when a nurse educator is within a ward, identifying a relationship between nurse educator practice and safe patient outcomes (Duffield et al 2007).

DISCUSSION

Key challenges facing the nurse educator role

Contemporary health care mandates the continued growth and renewal of the nursing profession to address the nexus between education and practice in the clinical context. Challenges facing the nurse educator role have been minimally explored in the literature but should be considered in the context in which nurse educators' work and practice as health systems are driven by funding, policy and regulatory issues and the relationship between patient outcomes, the work environment, skill mix and workload are indisputable. Crisis management, coupled with emerging roles for alternate health workers, who may have limited educational preparation and no professional affiliations, have been identified as workplace trends in response to workforce deficits in the clinical environment

(Daly et al 2008). In the clinical practice domain, these factors may negatively impact patient care, safety and outcomes. To prevent this, recognition of changing workforce roles and associated diversity of educational attainment among health workers is necessary to lead educational change and support new service models (Conway and Elwin 2007). Nurse educators also have an intrinsic role to play in the development of nursing, education and health research and are well placed to initiate or collaborate in research focussing on clinical practice and education. Engaging in collaborative clinical and academic research partnerships may further contribute to dynamic and innovative education and teaching practices actively supporting the intensive learning required by nurses to attain expert clinical skills and competency.

At a system level, sustaining and developing a sufficient nurse educator workforce is essential to continue the development of a competent, well educated workforce – a key health reform issue. As nursing workforce shortages continue to grow and the sustainability of this position is questioned, shortages of nurse educators may also emerge. Role, identity, nurse educator education and career pathways, were identifiable themes throughout the literature reviewed. Addressing these challenges may contribute to positive role enactment and advancement and importantly sustaining this important nursing workforce role.

Challenges

1. Role identity, ambiguity and conflict

Health workforce resources are reportedly underutilised (Oelke et al 2008; Dubois and Singh 2009), although factors influencing role optimisation are not well understood. A critical factor in addressing workforce shortages and retention is ensuring nurses work to their full scope of practice (Oelke et al 2008). Although the concepts of 'nursing scope of practice', and 'role enactment' are widely used in the literature, they are not clearly defined in terms of the nurse educator role (Oelke et al 2008). This lack of clarity has been further compounded following the restructuring of nursing in recent years and minimal

acknowledgement of the effect of these changes and the subsequent potential for role conflict and ambiguity within nursing (Conway and Elwin 2007). As other nursing specialist roles have emerged and assumed responsibility for engaging nurses in education in practice settings, nurse education is no longer the exclusive mandate of the nurse educator (Conway and Elwin 2007). Conway and Elwin (2007) acknowledge that role identity and enactment may be eroded and blurred in health environments experiencing constant change and where there is overlap between roles supporting clinical education. The described changes have significantly impacted the nurse educator role and role erosion has occurred. The threat of intra-professional discord, professional isolation and a lack of supportive relationships may remain whilst the nurse educator role remains poorly defined (Conway and Elwin 2007). Also the role may continue to be undervalued and role enactment, job satisfaction and staff retention may be negatively impacted unless role uncertainty is resolved (Conway and Elwin 2007). If nurse educators are to continue to facilitate empowerment of other nurses and health workers in developing skill proficiency, critical thinking and reasoning skills, enabling nurse educators to articulate their role and scope of practice is essential (Conway and Elwin 2007). This is important at a time when sustainability of the role is questioned (Conway and Elwin 2007) and as enabling health professionals may enhance their productivity (Scott 2009). Importantly, the advancement of nurse education practice is contingent upon clarification of role boundaries and role description (Conway and Elwin 2009). Lastly, the literature is devoid of comment regarding the interface between the various nurse educator clinical roles. A strategic, structured approach to discipline specific and interprofessional clinical education in the practice environment is required.

2. Educational preparation of the nurse educator

Registered nurses in Australia practice in accordance within competency standards developed by the Australian Nursing and Midwifery Council (2005). The nurse educator is no different from the registered

nurse, midwife or specialty nurse in requiring core knowledge, skills and competence to perform their role. It is also argued that whilst the nurse educator needs to be clinically competent, this alone is insufficient to perform successfully. The knowledge and expertise nurse educators acquire through their educational preparation and experience inform their competency when facilitating learning, designing engaging learning experiences, and evaluating learner outcomes (National League of Nursing 2003).

Educational preparation for nurse educators in Australia is not mandated by the profession or any specific regulatory authority. Role criteria and education qualifications required vary from hospital to hospital and state to state. Yet, the expectations of the profession and consumers are that nurses must be well educated to positively impact on nursing practice and patient outcomes. The ad-hoc and non-standardised educational requirements of the nurse educator role are not helpful in fostering the identity and credibility of the nurse educator. Increases in new graduate nurse numbers enter the workforce requiring clinical education, support and mentoring has resulted in nurse educators with a diverse range of skills and professional qualifications being employed (Conway and Elwin 2007). Nurses in clinical practice need to be effectively supported to develop as lifelong learners. Nurse educators are responsible for creating engaging learning environments and experiences to support this. The authors argue they require knowledge and expertise in adult education principles to inform their practice. Clinical leadership, critical thinking, reflection, communication skills and knowledge of and commitment to learning and teaching processes are also required for nurse educators to perform successfully (Conway and Elwin 2007; Iliffe 2007; Oelke et al 2008). Knowledge and expertise nurse educators gain through postgraduate study and experience is instrumental in their design and facilitation of learning experiences and evaluating learner outcomes (Royal College of Nursing 2008). Current variations in the nurse

educator role, clinical competence and qualifications may complicate nurse educator preparation and subsequent role development. Study leave and fee support however, may enhance nurse educator participation rates in initial and continuing professional education and scholarship (National Nursing and Nursing Education Taskforce 2005). In light of recent public debate regarding the professional preparation of nurses (Jackson and Daly 2008), it may be timely to reconsider the role of the nurse educator and the educational preparation required to perform in the role.

3. Career pathways

Various reports (Heath 2002; Garling 2008) highlight the importance of ensuring a well educated and supported health workforce. In particular, educational support for newly qualified staff entering the workplace and the need to support the continuing clinical education of nurses is noted (Heath 2002). In response, the Commonwealth government has funded the support of undergraduate education in the clinical environment and the establishment of new clinical nurse educator positions (National Nursing and Nursing Education Taskforce 2005). Australian nurse educators may come from a variety of backgrounds. They may have experience as a preceptor, mentor, or have been a clinical specialist, clinical educator or manager prior to embarking on a career as a nurse educator. Yet the literature reviewed is devoid of discussion regarding a specific career pathway for nurse educators. It is argued that a clearly articulated, industry and specialty endorsed delineation of the nurse educator role and scope of practice, supported by a flexible career pathway would significantly contribute to the further development of the specialty. A defined career pathway may enhance nurse educator recruitment, job satisfaction, and a sustainable educator workforce as has occurred for other nursing roles. A flexible pathway facilitating educators to work both within academia and hospitals may also enhance the role and diminish the divide between academia and practice. This in turn may influence cooperative working partnerships and importantly curriculum innovation between

academia and the clinical setting further impacting safe evidence based practice and patient care outcomes. Significantly, these measures may assist, nurses, academics, management and other health professionals to gain insight into this complex and challenging role.

4. Partnerships with academia

Education in the practice setting requires reform to address the educational needs of the current and future nursing workforce to optimise safe patient care outcomes (National Nursing and Nurse Education Taskforce 2006; Daly et al 2008). The blurring of nursing roles regarding responsibility for educational interventions may cause conflict rather than collegiality and collaboration in nurse education. Substantive partnerships between nurse academics and nurse educators within disparate healthcare settings are imperative to enable nurses to continue to develop their skills and expertise and contribute to quality patient outcomes (Heath 2002; National League of Nursing 2003). These partnerships may engender a positive climate influencing the development of nursing practice and influencing safe patient care and importantly, the nursing profession.

Implications for policy, practice, research

Changes to the nurse educator role over time, although minimally described in the literature, have led to a decrease in the influence that nurse educators have, not only in the acute setting but also more broadly within the nursing profession. This is a broad generalisation and does not imply that nurse educators do not have a sphere of influence in nursing practice and on curriculum advisory boards. In spite of this the nurse educator plays a critical and dynamic role in transforming clinical practice, maintaining practice standards and supporting the professional role of the nurse and advancing nursing.

The information summarised above reflects the poorly characterised description of the nurse educator role in the acute care setting in Australia. Further, the discussion of the nurse educator role is inconsistent and sporadic. Conversely, many sources attest to the

importance of education and support of practice that optimises clinical outcomes (Aiken et al 2001; Heath 2002; Daly et al 2008, Garling 2008). Several features of the practice environment, in particular, the diversification of the workforce, underscore the importance of focussing on the nurse educator role. On the basis of this review, we recommend further research is required to elucidate the nurse educator role. In addition, despite considerable discussion in the global literature regarding the link between nursing care and patient outcomes, comment focussing on the relationship between the nurse educator, nursing care and the patient, in the context of how such interactions may influence patient outcomes, is limited. Given the current focus on this issue, further research is warranted.

Nurse educators have a pivotal role to play in the clinical environment preparing registered nurses to develop competence in assuming increasingly complex and challenging clinical leadership roles within the described diverse multidisciplinary teams of today (Conway and Elwin 2007). Nurse educators can also be instrumental in facilitating workplace postgraduate clinically based courses and continuing education programs. These programs facilitate and support degree-qualified registered nurses to achieve their potential to build capacity, interprofessional partnerships, and initiate and lead unprecedented reform in health care delivery at the point of care (Thorne 2006; Conway and Elwin 2007). An important emerging element of nurse educator practice is the advancement of interprofessional capability through interprofessional learning (Walsh et al 2005). The nurse educator is well placed to assume a clinical leadership role in interprofessional education in the practice environment and developing a team approach to problem solving and effective clinical decision making within the health team.

CONCLUSION

The literature acknowledges nursing education as the foundation for nurses to build clinical competence to provide safe patient care and the nurse educator is integral to nurses achieving this goal. However,

blurring across nursing roles providing education in clinical practice and the absence of a national, standardised approach to role description and scope of practice may adversely impact role enactment. Explicit identification of the role within the health workforce and clarification of role boundaries and role description is required to advance nurse educator practice. Further research is also required to identify the influence of the nurse educator in achieving safe patient outcomes.

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