

A preceptorship model to facilitate clinical nursing education in Botswana

A Dube



[orcid.org/ 0000-0002-4099-6763](https://orcid.org/0000-0002-4099-6763)

Thesis submitted for the degree Doctor of Philosophy in Nursing Science
of Health Science Education at the North-West University

Promoter : Prof MA Rakhudu

Co-promoter: Dr MJ Matsipane

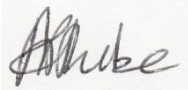
Graduation May 2018

Student number: 25757989

DECLARATION

I Antonia Dube, declare that “A Preceptorship Model to facilitate Clinical Nursing Education in Botswana” is my work and all sources used have been acknowledged and that this work has not been submitted to any other university as a requirement for any degree.

Student Number 25757989

Signed 

Date 05 December 2017

“I can do all things through Christ which strengtheneth me”

KJV: Philippians 4 verse 13

DEDICATION

I dedicate this work to my beloved mother (Helena D. Dube), my siblings (Benhilda, Antony, Simangaliso, Sithandazile, Alcon-Vee and Kholisani) and my beloved children Doreen, Arthur and Benefit for the incredible support, understanding and encouragement during the years when I was working on this research project. I appreciate the support I got especially when I was under immense pressure of family, work and study. You had to deal with so many family issues in my absence. It is a blessing and pleasure for me to be a member of this great family.

Ontlametse Marie-Eline Ramashu my granddaughter, I dedicate this thesis to you, you missed my presence, love and attention when you were born because of pressure of my studies. I love you dearly.

Special dedication my late siblings:

Hillary Polite; Menradis, Regina Dzamatira (Nee Dube); Tshakalisa, Cornelius R.E Dube. I wish they had lived long to see my final academic achievement, they were my mentors and pillars of support during my previous years of study.

My late father; Raphael Essaph Dube, for always encouraging us to pursue academic excellence, his loving memories shall forever be cherished.

“Tears might dry but memories linger forever May their departed Souls Rest in Peace

Over and above all; I give Glory, Honour and Thanks to God Almighty, for his mercies that endureth forever.”

ACKNOWLEDGEMENTS

My appreciation and gratitude goes to the following individuals, committees, institutions and organizations without whose support, cooperation and encouragement it would have not been possible to complete this thesis or achieve this degree:

- My promoter Professor, M.A Rakhudu and co-promoter Dr Matsipane thank you for the support, guidance and availability throughout this research project. Your expertise, encouragement, and patience in your supervisory role nurtured me.
- Mr S.E Moyo and A. T. Ketlogetswe, your expertise in quantitative data analysis was greatly appreciated.
- Mrs Rose Motlalepula Sianga, I thank you for agreeing to be a coder of the qualitative transcripts.
- My colleagues Ruth Setilhatlhanyo and Kago Moalosi, I thank you for the support and understading when I had to leave you with students to attend Block sessions at North West University (NWU).
- R.Kajinga and Ms Setoutwe, T.Gaobothoko, T.Nohe, I thank you for mobilizing nurse educators during my visit to collect data in your respective HITs.
- B.Jacklase, Mbiganyi, T. Matebejana, Mr Nsioki, I greatly appreciated your assistance in mobilizing preceptors at your respective clinics to facilitate data collection.
- B. Maoketsa, A. Molesu, A. Mokhutshwane, T. Julius, N. Rancharan, I thank you for all for your assistance in capturing the data.
- Health Research Unit (HRU) Ethics Committee, I thank you for granting me permission to conduct this study in Botswana.
- All Districts Health Teams (DHMTs) and managements of hospitals and clinics, I thank you for granting me permission to collect data from the preceptors in their clinical settings.
- All preceptors who participated in the study I greatly appreciated your cooperation and eagerness.
- All nurse educators who agreed to participate in the study your cooperation was highly appreciation.
- Johannes Tjihumino and Kgomotso M. Montsho, I appreciate the assistance you offered whenever I requested for your IT expertise.
- The Principals of the six health training institutions who allowed me to collect data from nurse educators in their institutions, I thank you all.
- Kanye Seventh Day Adventist College of Nursing Administrative Committee (KSDACON-Adcom), I thank you for the support offered during the period of my study.

- A special appreciation to Dr Dolly Goldenberg for granting me permission to adapt the preceptor questionnaire used for this study; not only that, but going and an extra mile to email the questionnaire to me.
- Special thanks to Agnes Magwamba and Kenneth Mukwamba for your technical assistance and support.
- NWU Ethics Committee, thank you for granting me the Ethics clearance certificate.

ABSTRACT

Background: Despite the wide use of preceptorship there is evidence that its role is not clearly understood or supported resulting in several challenges associated with the implementation of preceptorship.

Purpose: The purpose of this study was to develop a preceptorship model to facilitate clinical nursing education in Botswana based on the perceptions of the nurse educators and preceptors.

Methodology: The study was done in two phases; namely empirical and model development phases. In Phase I, a convergent parallel mixed method approach was used. For the quantitative component, n=107 preceptors and n=50 nurse were recruited using convenient sampling and A self-administered questionnaire was used for data collection from both preceptors and nurse educators. In the qualitative component, three focus group discussions were used for both educators (n=17) and preceptors (n=22). In Phase II, Dickoff, James and Wiedenbach survey list guided the development of the conceptual framework for model development. The model was developed using Chinn and Kramer's approach.

Results: The results from both quantitative and qualitative components indicated the need for a preceptorship model. The findings formed the basis for the development of a preceptorship model. The model consists of the following components: Agent, Recipient, Context, Procedure Dynamics and Terminus.

Conclusions: Preceptorship is a widely used clinical teaching strategy in nursing education in many countries including Botswana. However, a lot of challenges associated with the implementation of preceptorship have been identified by all stakeholders. Lack of resources and processes, inadequate training and support, inappropriate selection and placement of preceptors, were highlighted as impacting negatively on its effectiveness. The need for a preceptorship model to facilitate preceptorship cannot be overemphasized in this regard. This model will guide the planning and implementation of preceptorship procedures by different stakeholders to improve its effectiveness in clinical nursing education.

Recommendations: Collaborative efforts by both HTI's and clinical services in planning, implementation and evaluation of preceptorship are necessary. Management in the clinical setting and HTI's need to recognize the value of preceptorship and provide support to the preceptors for their contribution to the training and education of students. Follow up studies on the effectiveness, practicability and relevance of the model are recommended.

Key Words: Clinical nursing education, clinical setting, facilitate, preceptor, preceptorship, student and support.

LIST OF ACRONYMS

AdCom	Administrative Committee
BONU	Botswana Nurse Union
BQA	Botswana Qualification Authority
CPD	Continuing Professional Development
DHMTs	District Health Management Teams
DPSM	Department of Personnel Services Management
DTEF	Department of Tertiary Education Funding
EFTS	Effective Teaching skills
ETPs	Education and Training Providers
FDGs	Focus Group Discussions
GIP	Group 1 for Preceptors
G2P	Group 2 for Preceptors
G3P	Group 3 for Preceptors
GI NE	Group 1 for Nurse Educators
G2 NE	Group 2 for Nurse Educators
G3 NE	Group 3 for Nurse Educators
G1 P1	Group 1 Preceptor 1
G2 P1	Group 2 Preceptor 2
G3 P3	Group 1 Preceptor 3
GI NE 1	Group 1 Nurse Educator 1
G2 NE2	Group2 Nurse Educator 2
G3 NE3	Group 3 Nurse Educator 3
HPDM & E	Health Policy Department Monitoring and Evaluation
HRDC	Human Resource Development Council
HRU	Health Research Unit
HTI (s)	Health Training Institutions
IHS	Institute of Health Sciences
IT	Information Technology
KSDACON	Kanye Seventh Day Adventist College of Nursing
MMD	Mixed Methods Design
MoF	Ministry of Finance
MoHW	Ministry of Health and Wellness
MOA	Memorandum of Agreement

NMCB Nurses and Midwives Council of Botswana

QUAN Quantitative research

QUAL Qualitative research

SPO Structure, Process and Output (Donabedian's Quality Model)

UB University of Botswana

NWU North West University

Table of Contents

DECLARATION	i
DEDICATION.....	iii
ACKNOWLEDGEMENTS.....	iv
ABSTRACT.....	vi
LIST OF TABLES.....	xv
LIST OF FIGURES	xvii
CHAPTER 1	1
OVERVIEW OF THE STUDY	1
1.1 INTRODUCTION	1
1.2 BACKGROUND AND RATIONALE OF THE STUDY	1
1.3 STATEMENT OF THE PROBLEM	5
1.4 RESEARCH QUESTIONS	6
1.5 PURPOSE AND OBJECTIVES OF THE STUDY	6
1.5.1 Purpose.....	6
1.5.2 Objectives of the study.....	6
1.6 SIGNIFICANCE OF THE STUDY.....	7
1.7 DEFINITIONS OF KEY CONCEPTS	7
1.8 METHODOLOGY	8
1.8.1 Research Design.....	9
1.9 ETHICAL CONSIDERATIONS.....	10
1.10 CHAPTER OUTLINE	11
1.11 SUMMARY	11
CHAPTER 2	12
LITERATURE REVIEW	12
2.1. INTRODUCTION	12
2.2 PURPOSE OF LITERATURE REVIEW	12
2.4 DESIGN / APPROACH	12
2.5 RESULTS	14

2.5.1 Definitions of preceptorship	14
2.5.2 Brief Historical Background of Preceptorship.....	15
2.6 STRUCTURE OF PRECEPTORSHIP	16
2.6.1 Characteristics of a preceptor.....	18
2.6.2 Preceptor selection and preparation for the role	20
2.6.3 Learning environment.....	25
2.7 PROCESS OF PRECEPTORSHIP	27
2.7.1 Support for preceptors and preceptorship	27
2.7.2 Communication during preceptorship.....	34
2.8 OUTCOME OF PRECEPTORSHIP	35
2.9. CONCEPTUAL FRAMEWORK	36
2.9.1. Structure.....	37
2.9.2 Process	37
2.9.3 Outcome.....	38
2.10 CLINICAL TEACHING AND SUPERVISION MODELS IN NURSING AND HEALTH SCIENCES.....	38
2.11 SUMMARY	39
CHAPTER 3	40
METHODOLOGY	40
3.1 INTRODUCTION	40
3.2 OBJECTIVES OF THE CHAPTER.....	40
3.3 PURPOSE OF THE STUDY	40
3.4 STUDY SETTING.....	40
3.5 RESEARCH PROCESS	41
3.5.1 Phase 1: Empirical phase: Mixed Method Design.....	41
3.5.2 Phase II: Mosel Development.....	51
3.6 ETHICAL CONSIDERATIONS.....	52
3.7 SUMMARY	53
QUANTITATIVE RESEARCH FINDINGS	54
4.1 INTRODUCTION	54
4.2 QUANTITATIVE FINDINGS FOR PRECEPTORS	54

4.2.1 Preceptors' demographic characteristics.....	54
4.3 ANALYSIS AND INTERPRETATION OF FINDINGS FOR PRECEPTORS' RESPONSES	56
4.3 .1 Preceptors' perceptions on the structure of preceptorship	56
4.3.2 Preceptors' perceptions on the process of preceptorship	60
4.3.3 Preceptors' perceptions of preceptorship outcomes	63
4.4. ANALYSIS AND INTERPRETATION OF FINDINGS FOR NURSE EDUCATORS' RESPONSES	70
4.4. 1 Demographic characteristics nurse educators	71
4.4.2 Nurse educators' perceptions on the structure of preceptorship	72
4. 4.3 Nurse educators' perceptions on the process of preceptorship	75
4. 4.4 Perceptions of nurse educators on the outcome of preceptorship	78
4.5 DISCUSSION OF FINDINGS FROM PRECEPTORS AND NURSE EDUCATORS.....	85
4.5. 1 Discussion of findings on the structure of preceptorship.....	85
4.5.2 Discussion of findings on process of preceptorship	87
4.5.3 Discussion of findings on outcome of preceptorship.....	89
4.6 SUMMARY	90
CHAPTER 5	91
QUALITATIVE FINDINGS AND LITERATURE CONTROL	91
5.1 INTRODUCTION	91
5.2 RESULTS	91
5.2.1 Demographic characteristics of nurse educators.....	91
5.2.2 Demographic characteristics of preceptors	92
5.3 DISCUSSIONS OF FINDINGS AND LITERATURE CONTROL.....	93
5.3.1. Theme I: Inadequate resources for preceptorship	93
5.3.2 Theme 2: Inadequate processes to facilitate effective preceptorship.....	100
5.3.3 Theme 3: Perceived outcomes of preceptorship	110
5.3.4 Theme 4: Suggestions for the success of preceptorship	116
CHAPTER 6	123
INTERPRETATION OF MERGED FINDINGS	123

6.1 INTRODUCTION	123
6.2 FINDINGS	123
6.2.1 Demographic characteristics of participants	124
6.3 PERCEPTIONS REGARDING STRUCTURE OF PRECEPTORSHIP	126
6.3.1 Inadequate Resources for Preceptorship	129
6.4 PERCEPTIONS REGARDING THE PROCESS OF PRECEPTORSHIP	131
6.4.1 Minimal or lack of support	134
6.4.2 Ineffective communication	136
6.4.3 Unstructured Preceptorship	137
6.5 PERCEPTIONS REGARDING THE OUTCOME ON PRECEPTORSHIP	138
6.5.1 Benefits of preceptorship	140
6.5.2 Challenges to effective preceptorship	141
6.6 SUGGESTIONS FOR IMPROVEMENT OF PRECEPTORSHIP	142
6.6.1 Collaboration with key stakeholders	143
6.6.2 Partnership with accreditation bodies	144
6.7 SUMMARY	144
CHAPTER 7	145
DEVELOPMENT OF A PRECEPTORSHIP MODEL TO FACILITATE CLINICAL NURSING EDUCATION	145
7.1 INTRODUCTION	145
7.2 OBJECTIVES	145
7.3 CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT	145
7.3.1 Definition of concepts used in developing the conceptual framework	146
7.4 DESCRIPTION OF THE CONCEPTS AND THEIR APPLICATION TO MODEL DEVELOPMENT	148
7.4.1 Context: Nursing education and clinical setting	148
7.4.2 Agents and Recipients	152
7.4.3 Procedure	156
7.4.4 Dynamics:	158
7.4.5 Terminus	160
7.5 MODEL DEVELOPMENT	160

7.5.1 Overview of the Model	160
7.5.2 Purpose of the clinical model.....	161
7.5.3 Structure of the model.....	161
7.5.4 Assumptions of the model	161
7.5.5 Concepts Definition	161
7.5.6 Relationship statements	162
7.5.7 The nature of the preceptorship model	163
7. 6 EVALUTION OF THE MODEL	164
7.7 GUIDELINES FOR OPERATIONALIZATION OF THE MODEL.....	165
7.7.1 Guidelines for the Context	166
7.7.2 Guidelines for the agents	167
7.7.3 Guidelines for the Recipients.....	168
7.7.4 Guidelines for the Procedure	169
7.7.5 Guidelines for dynamics of preceptorship	169
7.7.6 Guidelines for the terminus.....	170
7.8 SUMMARY	170
CHAPTER 8	171
JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION.....	171
8.1 INTRODUCTION	171
8.2 JUST IFICATION OF THE STUDY CONTRIBUTION	171
8.2.1 Rationale of the study	171
8.2.2. Purpose of the study.....	171
8.2.3 Objectives of the study.....	171
8.2.4 Research methodology:.....	172
8.3 LIMITATIONS OF THE STUDY.....	173
8.4 RECOMMENDATIONS.....	173
8.4.1. Nursing Education	173
8.4.2 Nursing Practice.....	174
8.4.3 Nursing Research	175
8.4.4 Policy making	175
8.5 CONCLCUSION.....	176

REFERENCES	177
APPENDIX A: INFORMATION SHEET TO PARTICIPANT / RESPONDENTS.....	187
APPENDIX B CONSENT FORM	189
APPENDIX C NURSE EDUCATORS QUESTIONNAIRE	190
APPENDIX D PRECEPTORS QUESTIONNAIRE.....	195
APPENDIX E: ETHICAL CLARIFICATION TO CONDUCT RESEARCH.....	199
APPENDIX F: APPLICATION AND PERMISSION LETTERS FROM HTIs	203
APPENDIX G: APPLICATION AND PERMISSION LETTERS FROM CLINICAL SETTINGS.....	207
APPENDIX H: PRECEPTORS' SEMI - STRUCTURED INTERVIEW GUIDE.....	210
APPENDIX I: NURSE EDUCATORS' SEMI - STRUCTURED INTERVIEW GUIDE	212
APPENDIX J: NURSE EDUCATORS' TRANSCRIPT	214
APPENDIX K: PRECEPTORS' TRANSCRIPT	227
APPENDIX L: LANGUAGE EDITING LETTER.....	245

LIST OF TABLES

<i>Table 1.1 Convergent parallel mixed method design summary</i>	9
<i>Table 4. 1 Preceptors' demographics profile</i>	55
<i>Table 4. 2 Preceptors' perceptions on the structure of preceptorship</i>	57
<i>Table 4. 3 Preceptors' perceptions on the process of preceptorship</i>	61
<i>Table 4. 4 Preceptors' perceptions on the outcome of preceptorship</i>	63
<i>Table 4. 5 Independent t-test of the significant level to which gender influence preceptorship</i>	65
<i>Table 4. 6 Analysis of variance to the level to which age influence preceptorship</i>	66
<i>Table 4. 7 Analysis of variance to the level to which year of experience as preceptors influence preceptorship</i>	66
<i>Table 4. 8 Analysis of variance of level to which qualifications of preceptors influence preceptorship</i>	67
<i>Table 4. 9 Matrix of Pearson correlation of the relationship among the preceptors' related demographic information and preceptorship</i>	68
<i>Table 4. 10 Regression of support variables and demographic information on preceptorship</i>	69
<i>Table 4. 11 Regression coefficients of process variable and demographic information on preceptorship as perceived by preceptors</i>	69
<i>Table 4. 12 Regression of structural variable and demographic information on preceptorship as perceived by preceptors</i>	70
<i>Table 4. 13 Regression coefficients of structural variable and demographic information on preceptorship as perceived by preceptors</i>	70
<i>Table 4. 14 Nurse educators' demographic profile</i>	71
<i>Table 4. 15 Nurse educators' perceptions on the structure of preceptorship</i>	73
<i>Table 4. 16 Nurse educators' perceptions on the process of preceptorship</i>	76
<i>Table 4. 17 Nurse educators' perceptions on the outcome of preceptorship</i>	79
<i>Table 4. 18 Matrix of Pearson correlation of the relationship among the nurse educators' related demographic information and preceptorship</i>	81
<i>Table 4. 19 Regression of support variable and demographic information on preceptorship as perceived by nurse educators</i>	82
<i>Table 4. 20 Regression coefficients of process variable and demographic information on preceptorship as perceived by nurse educators</i>	82

<i>Table 4. 21 Regression of structure variable and demographic information on preceptorship as perceived by nurse educators.....</i>	<i>83</i>
<i>Table 4. 22 Regression coefficients of structure variable and demographic information on preceptorship as perceived by nurse educators.....</i>	<i>83</i>
<i>Table 4. 23 Regression of outcome variable and demographic information on preceptorship as perceived by nurse educators.....</i>	<i>84</i>
<i>Table 4. 24 Regression coefficients of outcome variable and demographic information on preceptorship as perceived by nurse educators.....</i>	<i>84</i>
<i>Table 5. 1 Themes, categories and subcategories.....</i>	<i>92</i>
<i>Table 6. 1 Number of participants and respondents in the MMD.....</i>	<i>123</i>
<i>Table 6. 2 Demographic profile of participants and respondents.....</i>	<i>124</i>
<i>Table 6. 3 Preceptors' and nurse educators' perceptions on the structure of preceptorship.....</i>	<i>127</i>
<i>Table 6. 4 Preceptors' and nurse educators' perceptions on the process of preceptorship.....</i>	<i>132</i>
<i>Table 6. 5 Preceptors' and nurse educators' perceptions on outcome of preceptorship.....</i>	<i>138</i>
<i>Table 7. 1 Dickoff et al. (1968: 422-423)'s survey list of activities and clarifying questions.....</i>	<i>146</i>

LIST OF FIGURES

Figure 2. 1 <i>Donabedian's Structure, Process and Outcome Model (SPO) adapted from (Stanhope and Lancaster, 2004:529-532; Donabedian, 173).</i>	37
Figure 3. 1 <i>Convergent Parallel Mixed Methods Design</i>	42
Figure 3. 3 <i>Data analysis process</i>	46
Figure 7. 1 <i>Conceptual framework for the Preceptorship model development</i>	147
Figure 7. 2 <i>Context of preceptorship</i>	149
Figure 7. 3 <i>Agents and recipients of preceptorship</i>	156
Figure 7. 4 <i>Preceptorship Procedure</i>	158
Figure 7. 5 <i>Dynamics that influence effectiveness of preceptorship</i>	160
Figure 7. 6 <i>Terminus of preceptorship</i>	160
Figure 7. 7 <i>A Preceptorship Model to facilitate Clinical Nursing Education</i>	163

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Nurse educators face challenges to prepare students to integrate successfully into diverse professional practice. Nurse educators play an important role in the transition of nursing students from the classroom to clinical practice not only in Botswana but also internationally. In the last two decades, the Botswana nursing education system has placed great value on preceptorship as a clinical teaching strategy. Since then, it experienced remarkable changes and challenges associated with the inception of preceptorship for student nurses in the Diploma in General Nursing Programme. This chapter gives a brief overview of the following: Background and rationale for the study, statement of the problem, purpose of the study, research questions and objectives, significance of the study, conceptual framework, methodology, ethical considerations and chapter outline.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

Over the years clinical nursing education has undergone a paradigm shift from the traditional faculty-student clinical supervision model to preceptorship (nurse-student) clinical supervision model. Preceptorship is a leading clinical approach and support model that is currently used in undergraduate nursing education globally to facilitate the clinical learning process Newton, Brian, Jolly, Ockerby & Cross, (2012: 2331). However, many preceptors feel they lack confidence in their role as mentors to nursing students because of inadequate preparation or formal training (Staykova, Husto & Pennington 2013: e33). A study looking at the educational needs of nurse preceptors would be invaluable to academic educators and to develop a model and guidelines of effective preceptorship in a developing country like Botswana which basically relies on preceptor accompaniment of senior (level three) diploma students in clinical learning.

Preceptorship dates back to the 15th century but in nursing education “it evolved for the first time as classified in the International Nursing Index of 1975” (Shamian & Inhaber, 1985:79). In the United States, Canada, Australia and Britain, several health care institutions have accepted and adopted preceptorship as a clinical teaching strategy (Newton et al., 2012:2331; Sedgwick & Harris, 2012: 16; Bott, Mohide & Lawlor, 2011:35). Preceptorship has since been used as a clinical teaching strategy in many countries. Although there is empirical evidence on the use of preceptorship, its benefits and challenges have also appeared in the last few decades which justify the need for development of models to guide its implementation and mitigate the identified challenges.

Preceptorship is described as a teaching and learning approach through which a well-experienced clinician (preceptor) is contracted to provide one to one clinical teaching, supervision, and role-modeling

of professional and clinical practice skills and assessments of students in a clinical setting (Billay & Myrick, 2008; Nesbit, 2008: 52-56; Billings & Halstead, 2012:327). It maximizes the benefits of clinical nursing education in terms of confidence, knowledge and professional socialization. Preceptorship uses a three way approach that involves faculty, students, and nurse-preceptors (Happell, 2009:372; Sedgwick & Harris, 2012:18; Morgan, Mattison, Stephens & Medows, 2012:35). In this approach, the preceptor is available to guide students any time during clinical instruction. Contrary to the above studies which were done in a different setting with regard to resources, preceptors in Botswana are not always available because there is no model that guides preceptorship.

Myrick, Yonge, Billy and Luhanga (2011: 134-139), contend that “the preceptorship approach to teaching-learning in the clinical environment provides an excellent modality in cultivating practical wisdom and ultimately to shape the art of nursing”. This notion supports the importance of using relevant preceptorship models to facilitate clinical learning. In a study by Cosme and Valente (2013:601), it is argued that although the preceptor plays a key role in the socialization of the student in clinical nursing education, preceptors receive no or inadequate training or preparation. Furthermore, there is evidence suggesting that the role takes time to develop and is stressful with limited resources and support (Hyrkas, Liscott & Rhudy, 2014:131-132; Horton, DePaoli, Hertach & Bower, 2012: E2; Hallin & Danielson, 2009:161). The above studies accentuate the importance of preceptor preparation which is often embraced in contextual models to facilitate preceptorship in clinical nursing education.

In a study conducted by Kristofferzon, Martensson, Mamhidir and Lofmark, (2012:1252), the authors affirm that support structures that include nurse facilitators, clinical lecturers, an appropriate environment, learning opportunities and evaluated models to facilitate clinical education are of paramount importance to the students' learning process. These findings are similar to other studies (Bourgeois, Drayton & Brown, 2011: 116-118; Gidman, McIntosh, Melling & Smith, 2011: 351–358). The study however, is limited to students and did not include preceptors and nurse educators. Furthermore, it adopted a quantitative design and was conducted in Sweden, a different setting from the Botswana context. This necessitated the need to develop a preceptorship model based on the perceptions of nurse educators and preceptors.

The mixed method design used for this study focused on the preceptors as key supervisors of a higher diploma in general nursing and the nurse educators who provide pedagogical support to students and preceptors. The preceptors and nurse educators described their perceptions of preceptorship. The findings were used to develop a preceptorship model to facilitate clinical nursing education for Botswana. Consistent with other studies, Sen Gupta, Murray, McDonnell, Murphy and Underhill (2008:7), assert that preceptor training, established working guidelines for preceptors, disclosure of students' limitations to preceptors, faculty support, training of preceptors on clinical teaching and assessment skills, and access of preceptors to information sources are key to the success of preceptorship. One can however argue that,

all these factors can only be achieved through the use of well-structured models that facilitate preceptorship implementation in the context of the setting where clinical learning activities take place.

While it is clear from the literature that Preceptorship is the ideal and leading teaching strategy to prepare nursing students for the professional nurse's role, implementation modalities to support, reduce stress, frustration and burnout associated with the preceptorship journey for all stakeholders remain unclear (Myrick et al., 2011: 134-139:). Based on the empirical evidence, it is of paramount importance that preceptorship be well structured and supported by all stakeholders in order to resolve identified challenges and maximize preceptorship benefit for student nurses. The need for a preceptorship model to facilitate in clinical nursing education is therefore inevitable.

The use of Preceptorship in clinical nursing education in Africa is increasingly evident and documented in literature. Although findings in the few cited studies in Africa depict relatively similar trends with global studies, the situation appears more complex in Africa with lack of resources and support as compounding factors. A study on training needs assessments conducted in Botswana, Lesotho, Liberia and Zambia revealed that there is inadequate student supervision during clinical allocation and practice. Inadequate clinical supervision of students was largely attributed to critical shortages of nurses and midwives, lack of incentives for preceptors, lack of empathy and student support, no formal preparation for the preceptorship role for most preceptors and that student supervision was not perceived as part of the role of practicing nurses and midwives (Lwatula, 2011:no page number).

The findings from the needs assessments by Lwatula (2011:no page.) are congruent with international studies in relation to the benefits and challenges associated with the implementation of preceptorship in clinical nursing education (Danielson, Sundin-Anderson, Hov, & Athlin, 2009:107–113; Liu, Lei, Mingxia & Haobin, 2010:804; Horton, DePaoli, Hertach, & Bower, 2012: E2). There is literature dearth in relation to follow-up studies to explain the causes of the identified challenges in the African region. This reinforces the need for the development of preceptorship models that will guide facilitate nursing education in the African context.

According to Brink (1989:62), preceptorship in the South African nursing education has been used since 1975. It was first used to refer to a group of experienced registered nurses in the health service who assisted with supervision of the University of South Africa (UNISA) students in the clinical practice. Brink highlights that, following the re-organization of nursing education into a system of tertiary education during the early 1980s, several nursing colleges in South Africa implemented the use of preceptorship for their students. The implementation of preceptorship in South Africa did not develop without challenges. Mothiba, Lekhuleni, Muputle and Nemathaga, (2012:199-203) cited the following preceptorship challenges that are consistent with preceding international studies; unavailability of preceptors, large numbers of students, nurses' lack of interest to work with students, poor interpersonal

relations between students, staff work-overload, inappropriate communication and students not accorded learning opportunities but rather assigned routine ward or clinic duties. These findings are consistent with Horton, DePaoli, Hertach, & Bower's (2012: E5) findings which indicated that, for the most part, preceptors had to carry a full load of patients and be a preceptor, and that charge nurses and other staff members did not fully appreciate this added responsibility.

In the same study, students highlighted the challenges as major setbacks making teaching and learning difficult if not nonexistent (Mothiba et al., 2012:199-203). They recommended university lecturers to advocate for preceptors who can facilitate clinical education for students. The findings indicate a need to restructure preceptorship to make it more facilitative to students' learning. From these premises, the development of a preceptorship model becomes a necessity.

Lekhuleni, van der Walt, and Ehlers (2004:24-25), conducted a study in South Africa on the "perceptions regarding the clinical accompaniment of student nurses in the Limpopo province". The findings of the study revealed that student nurses and unit supervisors perceived that nurse educators should accompany student nurses in clinical settings, but nurse educators viewed students' accompaniment to be a collaborative activity with unit supervisors and other health team members to facilitate the development of student nurses towards professional maturity. The findings are consistent with Kristofferson, Martensson, Mamhidir, & Lofmark, (2012:1253) discoveries where students indicated that the role of the lecturers in clinical supervision was vague and there was no consensus on it.

These findings further reflect role ambiguity and lack of clear guidelines and models to facilitate implementation of clinical nursing education. Preceptors in South Africa are employed by educational institutions contrary to nursing education systems in the African region wherein preceptors are part of the nursing services workforce who supervise, guide and assess student at the same time carrying a full load of patient care responsibility (Jeggles, Traut, & Africa 2013:106). The authors recommended stakeholder involvement in well-structured preceptorship training programmes. These recommendations further purport the importance of developing a contextual preceptorship model that will guide the attainment of clinical nursing education objectives.

In Botswana, all the six (6) HTIs utilize preceptorship as a clinical teaching strategy for level three student nurses during clinical internship for the Higher Diploma in General Nursing Programme. The preceptor role is considered a mandatory responsibility for every registered nurse with a minimum of two (2 years) working experience, but there is no evidence of an existing model to support the preceptor role and preceptorship. This is similar with the criterion for selection of a preceptor for nursing and midwifery in the United Kingdom which requires nurse to have been on the Register for Nurses, Midwives and Health Visitors for a minimum of one (1) year (Panzavecchia & Pearce 2014;1119). Nurses in Botswana are often appointed by their supervisors to become preceptors upon request by the HTIs. The appointment

is usually done regardless of whether the nurses have shown interest in the preceptorship role and usually with minimal preparation for the role and multiple other nursing work related responsibilities (Dube & Jooste, 2006:30). These criteria for preceptor selection compromise the quality of clinical nursing education especially if the appointed preceptor lacks interest in the role of a preceptor, skill in clinical teaching and supervision of students.

Contrary to the above study, respondents in Madisa (2012:24), cited three preceptor selection criteria whereby 5% of the preceptors were selected by students, 10% by managers, 30% by health training institution while 55% volunteered to take up the role. These findings indicate a non-structured system with no set criteria and guiding model that can have a potential negative impact on the students' clinical learning process. The resulting multiple challenges associated with the absence of a preceptorship model in Botswana were identified to include: lack of guidelines; high student to preceptor ratio, inadequate preparation of preceptors, lack of incentives, increased workload of preceptors, lack of support from stakeholders and lack of interest for the preceptor role (Monareng, Jooste & Dube, 2009:114; Lwatula, 2011 no page number; Madisa, 2012:13). Furthermore, there is no record of follow-up studies to address the challenges that have been revealed by existing studies. This empirical evidence justifies the need for the development of a model that guides the implementation of a structured preceptorship programme to maximize the benefits and improve the quality of clinical nursing education in Botswana.

1.3 STATEMENT OF THE PROBLEM

Prior to the introduction of the alternative Nursing Education System in Botswana, the traditional model of clinical teaching was used. In 1990 the Ministry of Health engaged the Kellogg Foundation Consultants to evaluate the curriculum for the Basic Diploma in General Nursing Programme. The recommendations from the Kellogg consultants' report brought about the inception of preceptorship as a clinical teaching approach in 1994. In the traditional model, the faculty members were responsible for both formal academic classroom teaching and clinical follow-up of students in the Diploma in General Nursing Programme. Due to the increase in the number of students enrolling in health training institutions, the need for a preceptor role became evident and inevitable in this regard as large numbers of students enrolled increasing the faculty- student ratio (Curriculum for Basic Diploma In General Nursing; June 1995, no page number).

In spite of the existence of preceptorship in Botswana for more than two decades, there is a paucity of studies done on preceptorship in Botswana. There is no evidence of preceptorship model to facilitate clinical nursing education in Botswana, if such a model exists, there is literature dearth thereto. The lack of a preceptorship model and guidelines are key factors that contribute to the setbacks associated with the implementation of preceptorship. This information gap is the impetus for the researcher to pursue this

inquiry and develop a contextual preceptorship model to facilitate the outcome of clinical nursing education in Botswana.

1.4 RESEARCH QUESTIONS

The questions that guided this study include the following:

1. What are the perceptions of preceptors on preceptorship in clinical nursing education?
2. What are the perceptions of nurse educators on preceptorship in clinical nursing education in Botswana?
3. What factors facilitate effective implementation of preceptorship?
4. What are the benefits of preceptorship?
5. What challenges are associated with effective implementation of preceptorship?

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

1.5.1 Purpose

The main purpose of this mixed method research was to develop a preceptorship model to facilitate clinical nursing education in Botswana.

1.5.2 Objectives of the study

The following objectives were applied to achieve the purpose of the study:

Empirical phase

- To measure preceptors' and nurse educators' perceptions of preceptorship in clinical nursing education in Botswana using an adapted Dilbert and Goldenberg (1995) 4-part questionnaire. The four parts of the questionnaire comprise: Preceptors' Perception of Benefits and Rewards Scale, Perception of Support Scale, Commitment to the Preceptor Role Scale and Demographic Characteristics Scale. The adapted questionnaire was structured and contextualized to the SPO model that guides the study.
- To explore and describe factors that facilitate for the success of preceptorship in clinical nursing education in Botswana. The objective achieved through conducting Focus Group Discussion (FGDs). Semi structured interview guide was used to direct the discussion.

Model development phase

- To construct a conceptual framework for model development using Dickoff, James and Wiedenbach survey list.
- The concepts that informed the development of the conceptual framework or model development were identified from findings of the empirical phase of the study.
- To develop a preceptorship model to facilitate clinical nursing education in Botswana using Chinn and Kramer's approach.

1.6 SIGNIFICANCE OF THE STUDY

The findings from this study have a potential to inform the best nursing education practices in Botswana that will guide the restructuring of preceptorship in clinical nursing education for the students. Furthermore, the findings of the study could maximize the benefits of preceptorship impacting the confidence; knowledge and skill of student nurses which in turn improve the quality of nursing practice upon graduation. In addition, the findings have the potential to inform the formulation of educational and clinical services policies that support preceptorship. Finally, recommendations from the study have a potential to stimulate the interest for further research on identified areas to close the existing gap in clinical nursing education.

1.7 DEFINITIONS OF KEY CONCEPTS

For the purpose of this study the key concepts used will be defined as follows:

Clinical setting: A health facility (clinical, hospital or health post) where clinical nursing education activities for higher diploma in general nursing students during internship occurs under the supervision of a preceptor.

Clinical setting management: In this study refers to nursing superintendents /matrons/ principal nursing officers I, person (s) in charge of District Health Management Teams (DHMTs) and chief registered nurse in charge of health care settings. It is worth noting that nursing superintendent and principal nursing officer I refer to a matron (nursing) one with a diploma or degree in nursing.

Clinical teaching: This study adopts Billings and Halstead's (2012:317) definition which states that; clinical teaching involves carefully designing an environment in which students have opportunities to foster mutual respect and support for each other while they are achieving identified learning outcome. The faculty is the crucial link between clinical teachers and students to promote clinical reasoning and a collegial relationship. Furthermore, in this study it will involve providing a well-designed environment that facilitates students' ability to practice and master nursing skills under the supervision and guidance of a preceptor. Clinical teaching and clinical education are use interchangeable.

Facilitate: This study adopts The Oxford Secondary Dictionary's (1991:219) definition of facilitate. Facilitate refers to making easy or to lessen the difficulty. As applied to the study facilitate refers to the preceptorship model that will make clinical nursing education easy for students for students, preceptors and nurse educators who are key stakeholders in the implementation of preceptorship activities.

Health Training Institution: The definition adapted for this study is consistent with Rakhudu, (2011:13) and states that it refers to a post-secondary school education institution which offers nursing and other health related programmes at higher and advanced diploma qualifications.

Model: Is a group of concepts that are broadly defined and systematically organized to provide a focus, rationale, and tool for integration and interpretation of information (Mosby's Dictionary of Medicine, Nursing and Health Profession, (2006:436). In this study, a model refers to a framework or support structure of interrelated concepts specially designed to facilitate the implementation of preceptorship in clinical nursing education.

Nurse educator: In this study a nurse educator is a faculty member with a basic nursing qualification and degree in nursing education or related nursing field. The nurse educator is employed by the HTI (s) and provides pedagogical expertise and guidance to nursing students and preceptors during clinical nursing education to facilitate achievement of clinical teaching and learning objectives.

Preceptor: The study adopts Löfmark , Thorkildsen, Råholm, & Natvig's, (2012: 165) definition that a preceptor is "a skilled clinician, a registered nurse who can provide students with the guidance, role modeling, feedback and experience that are authentic, can facilitate students' learning and professional socialization." For the purpose of this study the preceptor shall have a minimum experience of one semester serving as a preceptor.

Preceptorship: is a short-term process of support and guidance, whose purpose is to integrate, support and assist the development of professional competence and to enable the students to consolidate their knowledge and reflect on their practice, thus promoting independence and clinical proficiency (Nesbit, 2008:52). For the purpose of this study, preceptorship is a period of clinical teaching whereby the level three (3) students in the Higher Diploma in the General nursing programme are supervised, coached, guided, evaluated and socialized to the role of a professional nurse by a preceptor for a specified period of time.

Support: The definition was adopted from Oxford Secondary Dictionary, (1991:646) and refers "to give strength, to enable, to last long or to assist by approval." As applied to this study, support shall mean development and implementation of measures, processes and guidelines to facilitate the effectiveness of preceptorship as a clinical teaching strategy in nursing education.

Student nurse: In this study, student nurse and nursing student are used interchangeable and refer to a person or a level three (3) learner at a Health Training Institution undergoing nursing training or education for a higher diploma in general nursing under the supervision and guidance of a preceptor for a specified period of time.

1.8 METHODOLOGY

This section of the study gives a brief overview of the research design, setting of the study, population, sampling technique and sample size, data collection and analyses, quality of data, eligibility and exclusion criteria, and model development methods, ethical considerations and chapter outline.

1.8.1 Research Design

The study was conducted in two phases namely; empirical phase and Model development phase.

Phase I Empirical phase

This phase adopted a mixed method (MM) approach (Creswell, 2014:219-220) which combines elements of qualitative and quantitative research approaches for the broad purpose of increasing the breadth and depth of understanding well as corroborating the results (Schifferdecker & Reed, 2009:637; and Clark & Creswell, 2007:21). The researcher collected and analyzed data, integrated the findings, and drew inferences using both qualitative and quantitative approaches in a single study. (Tashakkori & Creswell, 2007:4). This approach was chosen because the researcher aimed at drawing on the strengths and minimizing the weaknesses of both types of research. A convergent parallel design was found to be suitable for this study. Both the quantitative and qualitative designs were weighted equally and presented as QUAN + QUAL. The data were analyzed, results compared and interpreted and conclusions were drawn. Table 1.1 outlines the summary of the MM approach used for this study.

Table 1.1 Convergent parallel mixed method design summary

COMPONENT	QUANTITATIVE APROACH	QUALITATIVE APPROACH
Design	Descriptive Survey	Explorative descriptive and contextual
Population	Preceptors in clinical settings (N=120) Nurse Educators (N=55) in health training institutions	Preceptors in clinical settings (N=120) Nurse Educators (N=55) in health training institutions
Setting	Clinical settings in eight districts and sub-districts and six HTIs offering the higher diploma in general nursing programme in Botswana	Clinical settings in eight districts and sub-districts and six HTIs in Botswana offering a higher diploma in general nursing programme
Sampling	Convenience	Purposive
Sample size	Preceptors (n=107) nurse educators (n=50)	Preceptors (n= 22) nurse educators (n=17)
Data collection method	Self-administered questionnaires QUAN	Focus Groups Discussions using a semi structured interview guide, audio-taped Field notes QUAL
Data Analysis	Statistical Package for Social Sciences (SPSS) version 24: Descriptive, comparative and inferential statistics, independent t-test, one way ANOVA Correlation and multiple regressions were used to analyze the data.	Content analysis: Inductive Transcribing Coding
Quality of data and rigor	Reliability: Pilot testing and reliability coefficient for stability. Internal consistency: Cronbach's Alpha Validity: expert agreement was used for ascertain content validity.	Measures of trustworthiness: Credibility, dependability transferability and conformability were applied to ascertain the rigor
Data presentation	Frequency tables, percentages	Themes, categories and subcategories

II: Model Development

The second phase of the study is the model development that consisted of two steps namely, concept identification and classification and model development.

• Concept identification and classification

Concepts identification and classification was done based on the results from the convergent mixed method study conducted in phase I of the study and literature review. The concepts were identified according to SPO quality model which guided the study and classified according to Dickoff, James and Wiedenbach (1968:422-423) six aspects or survey list of activities for theory development. The concepts were used to construct a conceptual framework which formed the foundation and organization for the development of a preceptorship model to facilitate clinical nursing education in Botswana. Dickoff et al, (1968:422) survey of activities and corresponding questions to classify concepts is indicated below:

1. Agent (Who is responsible that the activity be performed?)
2. Patiency or recipiency (who or what is the recipient of the activity?)
3. Framework (in what context is the activity performed?)
4. Terminus (what is the end point of the activity?)
5. Procedures (What is the guiding procedure, technique, or protocol of the activity?)
6. Dynamics (what is the energy source for the activity, physically, chemical, biological mechanical or psychological).

• Model development

The model was organized in accordance with the conceptual framework constructed in the first phase. Discussion of the model was done according to Chinn and Kramer's (2012:185-192) components of a theory namely: overview purpose, concepts definition, relationship statements, nature of the structure and assumptions. The model will be applied in the clinical context of nursing education facilitated through implementation of preceptorship as a teaching strategy.

1.9 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from North West University Ethics committee (Appendix E) and Health Research Unit, Ministry of Health; Botswana (Appendix E) Permission to carry out the study was obtained from authorities of the Clinical settings (Appendix G); Health Training Institutions (Appendix F). Participants' rights were ensured after a verbal and written explanation of the researcher's intention, purpose and objectives of the study (Appendixes A&B).

1.10 CHAPTER OUTLINE

The study is arranged into chapters according to the sequence of the mixed methods approach adopted to guide the study.

Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Quantitative findings

Chapter 5: Qualitative findings and literature control.

Chapter 6: Interpretation of merged findings

Chapter 7: Model development

Chapter 8: Justification, limitations, recommendations and conclusion

1.11 SUMMARY

The chapter outlines the study overview addressing the background and rationale of the study, statement of the problem, purpose and objectives of the study, significance of the study, definitions and key terms used in the study, methodology outline, ethical considerations, model development outline and outline of chapters in sequential order. Chapter 2 gives a detailed literature review.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

In chapter one an overview of the study was provided, outlining the background, problem statement, purpose, research questions, objectives, key concepts, and methodology. This chapter highlights the purpose and objectives of literature review, methodology used and themes from the literature review on preceptorship from the health science perspective. The chapter will focus on review of preceptorship literature globally and regionally comparing with preceptorship practices in Botswana from 2006 to-date. A few articles published before 2006 have been included based on their direct relevance and significant contribution to the purpose and objectives of this study. A Literature review is crucial in a study as it indicates what is already known about the topic under investigation, the context under which similar or related studies were conducted and the gaps emanating from recommendations of other studies on the topic that needs to be explored (DeVos, Strydom, Fouche & Delport, 2013: 134-135; Brink, Van der Walt and van Rensburg, 2014:71). Several studies have been conducted globally on preceptorship from different disciplines. Themes addressed in this literature review include: 1) Definitions of preceptorship from health and allied health sciences; 2) Brief historical background of preceptorship; 3) Characteristics of a preceptor; 4) Structure of preceptorship; 5) Process of preceptorship; 6) Outcome of preceptorship 7) Conceptual framework for the study namely Donabedian's practice model.

2.2 PURPOSE OF LITERATURE REVIEW

The purpose of this integrated literature review is to familiarize the researcher with what is already known about the topic of preceptorship in nursing and health sciences perspectives, preceptorship models that exist in nursing education and benefits and challenges entailed therein.

2.3 OBJECTIVES OF LITERATURE REVIEW

For the purpose of this study, objectives of literature review are in accordance with Brink et al., (2014:71) to:

1. Describe Preceptorship in nursing and allied health literature between 2006 and 2017
2. Identify gaps in the current literature on preceptorship in allied health literature
3. Describe the theoretical framework that will guide this study in data collection and analysis.

2.4 DESIGN / APPROACH

According to Whittmore and Knafl, (2005:546) the integrative literature review is the only approach that allows for the combination of diverse methodologies and has the potential to play a greater role in the evidence-based practice for nursing. Billay and Myrick, (2008:259-260), in their study on preceptorship,

contend that an integrative review of preceptorship is important because it explicates the concept of preceptorship for the discipline of nursing and other professional disciplines that utilize preceptorship as a practicum experience and also because of the prevalent use of preceptorship in nursing and related disciplines.

The integrated literature review adopted for this study seeks to identify gaps in preceptorship literature in relation to methodologies, study population, context of the studies and identify preceptorship models, limitations and recommendations made by other researchers on preceptorship. It will further highlight how this particular study will contribute in bridging some of the gaps identified in literature and contribute to a body of knowledge on improvement of preceptorship as a clinical teaching strategy in nursing education. The following databases were used for literature search CINHAL: SA e-Publications, Google scholar, Ebscohost, A to Z Journals, PMC, MEDLINE, SAGE Journals, ProQuest, and Web of knowledge electronic data bases and PubMed. Literature from unpublished sources and textbooks was also reviewed.

Search words and inclusion criteria used to search relevant literature for this study included: clinical education, clinical supervision, internship, mentoring, nurse educator, preceptor, preceptorship in nursing and health science, preceptorship models, student nurse, students' clinical placement, and support.

Thematic analysis was undertaken and emergent themes with similar and divergent perspectives to support the purpose and objectives of this study were explored. The organization of reviewed literature in this study is to a great extent guided by the Donabedian's quality model that focuses on structure, process and outcome (SPO) which has been used as a conceptual framework for this study. The model has been adapted because of the quality of structures and processes involved in preceptorship which determine the quality of clinical nursing education and nursing practice as ultimate outcomes of preceptorship.

Sampling of articles

The researcher viewed abstracts and titles of articles published between 2006 and 2017 based on their relevance to this study. Selection of articles for review was guided by the following; purpose and objectives of the study, population, methodological approach used, recommendations and language as not all articles were published in English or had direct relevance to the objectives of this study. This was done to identify gaps, challenges, benefits and models of preceptorship in nursing and health sciences education from different settings and compare with the practices in Botswana for the purpose of identifying the most relevant articles to address the purpose and objectives of this study. The researcher created a table of related and relevant articles to this particular study. The articles were captured under the following subheadings; the author (s), title, year of publication, research design, population, sampling, sample size, findings and recommendations and placed in a table format. The literature review table

allowed the researcher to create a pool of articles wherein sampling of literature relevant to this study was further made.

Both non-empirical and empirical literature was reviewed. The researcher reviewed the abstracts of articles more relevant to address the purpose and objectives of the study particularly articles addressing preceptorship for undergraduate students with a few on preceptorship for newly qualified nurses.

The researcher found a few articles that address preceptorship from the perspective of preceptors and nurse educators; most of the literature on preceptorship addresses students or preceptees (who may also be newly qualified nurses) and preceptors' perspectives. This was another gap identified as an impetus for the relevance of this study.

2.5 RESULTS

Over 42200 articles on preceptorship in nursing and allied health sciences exist in literature, 7010 of the articles addressed preceptorship in nursing and health sciences, 4800 were on preceptorship in nursing, 444 focused on preceptorship for nursing and health sciences, 434 addressed preceptorship in nursing and health science education while 69 addressed preceptorship models in nursing education and allied health sciences education. The abstracts of the 69 articles sampled were scrutinized for relevance to the purpose and objectives of the study. Of the sampled articles 44 (63.8 %) were of particular relevance to the objectives of this study and have significantly constituted the literature review.

2.5.1 Definitions of preceptorship

This section defines preceptorship from empirical, non-empirical and unpublished sources. Tan, Feuz, Bolderston, & Palmer, (2011:17) cited the definition of preceptorship from the Interprofessional Alberta website (2000:18-19), that is a learning opportunity for health services students in which they gain hands-on experiences in health care setting under the guidance of someone who is experienced in the field. Preceptorship facilitates the transition from the classroom to the workplace and provides support for the new practitioner into the clinical environment.

Preceptorship is also defined as a short-term process of support and guidance, whose purpose is to integrate, support and assist the development of professional competence and to enable the students to consolidate their knowledge and reflect on their practice, thus promoting independence and clinical proficiency (Nesbit, 2008:52).

Sedgwick and Harris (2012:2), cited Canadian Nurses Association (2004:2), stating preceptorship is intended to assist students in acquiring a basic level of skills and personal attributes as well as to be socialized into the profession. The Mosby Dictionary (2009), website defines preceptorship as a period of time in which two people (a nurse with a student or an experienced nurse with a new nurses) work

together so that the less experienced person can learn and apply knowledge and skills in the practice setting with the help of the more experienced person.

Segen's Medical Dictionary, (2012); defines preceptorship as a structured, supportive period of transition from learning to applying complex skills (e.g. nursing) that requires a long and rigorous period of education. Preceptorship is similar to apprentice and serves as a bridge during the transition from student to practitioner.

Similarly, Billings and Halstead (2009:293), define preceptorship as a teaching model in which the student is assigned to a preceptor who is an experienced nurse who facilitates and evaluates the student learning in the clinical area over a specified period of time. It is based on the assumption that a consistent one- to-one relationship provides opportunities for socialization into practice and bridges the gap between theory and practice.

Sharples and Elcock, (2011:7) agree that preceptorship is a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values behaviours and to continue on their journey of life- long learning. The common characteristics in the cited definitions of preceptorship by various authors are that it is both a process in terms of time period allocated for professional socialization and a teaching strategy whereby a student or less experience professional is assigned to work with and learn from a more experienced and skilled professional (a preceptor) who guides, supervises and evaluates the learning of the less experienced (preceptee), in the clinical setting to be socialized to the profession. The above cited definitions of preceptorship are an insinuation that to effectively and efficiently perform the preceptorship role, the preceptor should be an experienced nurse, and possess, leadership, teaching and assessment skills to enable facilitation of effective evaluation of students during clinical education.

2.5.2 Brief Historical Background of Preceptorship

Preceptorship is not a new concept in health sciences and nursing in particular. It backdates to the 15th century but in nursing education, "it evolved for the first time as classified in the International Nursing Index of 1975" (Shamian & Inhaber, 1985:79). The term preceptor is often used in literature synonymously with mentor although preceptorship is tantamount to clinical supervision (Hallin & Danielson, 2009:162; Liu, Mingxia & Haobin, 2010:806-807; Kristorfferzon et al, 2012: 1252-1253). The above cited authors argue that while there are various preceptorship and mentorship models in existence, such models have been developed to meet the needs of particular settings and cannot be applicable in all clinical learning environments (Hallin & Danielson, 2009:162-163). The current concepts of preceptorship evolved from the need to prepare registered nurses to become functional as soon as possible to ease the adjustment of new nurses in their work environment. The exercise helps to

promote patient safety and retain nurses in an effort to decrease the cost associated with nurse training (Kaviani & Stillwell, 2000; Murphy, 2008) cited in Horton et al., 2012 E1-E2). This notion indicates that preceptorship was initially designed for socialization of novice nurses into the professional not students. This may also account for the reason why most preceptorship studies focus on preceptees and preceptors in the exclusion of nurse educators.

In Canada, clinical nursing education is considered to be a vital component of nursing education and it is the core of nurses' professional development. The authors however, indicated that although preceptorship is a commonly utilized model of clinical nursing education, it is faced with many challenges, and a few studies have been conducted on experiences of nurse preceptors who volunteer to be preceptors for students. Findings from the studies reveal that preceptors experienced role ambiguity accompanied by stress associated with workload issues, self-efficacy concerns as role models and teachers in clinical interactions with nursing students (Sedgwick & Harris, 2012:2 & 5).

The preceptorship model enhances previous learning by enabling students to apply theoretical knowledge and skills to current clinical situations and leads to professional socialization, increased confidence and knowledge of the reality of clinical nursing (Canadian Nurses Association, 2004:1). Similarly, Myrick, Yonge, Billy and Luhanga, (2011: 134-139) assert that preceptorship in the clinical teaching-learning environment provides an excellent modality by which to cultivate practical wisdom and ultimately to shape the art of nursing. The data from the above-cited literature accentuates the importance of using contextual preceptorship models to promote best nursing education practices and subsequently improve the quality of patient care which is the core of nursing.

Despite the fact that studies on preceptorship have been conducted in different settings and contexts, findings reveal a general consensus that clinical nurses are pivotal facilitators who are in the forefront in the achievement of clinical nursing education goals and objectives. Furthermore, findings reveal several challenges entailed in the use of preceptorship as a clinical teaching strategy. It is obligatory for nurse educators to conduct in-depth literature inquiry on what is known about preceptorship in clinical nursing education and what needs to be done to facilitate its effectiveness and sustainability without causing burnout to the preceptors and frustration to the students while achieving the desired learning outcomes. The above notion highlights the need for relevant preceptorship models that support contextual clinical nursing education activities.

2.6 STRUCTURE OF PRECEPTORSHIP

According to the adapted Donabedian's Quality model of structure, process and outcome as applied in this study (Stanhope & Lancaster, 2004:529-532; Donabedian, 2005:173), structure refers to resource administration and mobilization in order to guarantee the quality of the intended outcome. Furthermore, structure refers to the resources needed for implementation of preceptorship in clinical nursing education.

Such resources include the identification of clinical settings (suitable learning environment or health care facilities) where clinical nursing education and preceptorship activities occur, availability of a model for preceptorship that facilitates clinical teaching and learning, involvement of institutional / clinical setting management, selection of preceptors and availability of nurse educators (human resource), establishment of the organizational chain of command for preceptorship and preceptorship logistics such as preceptorship guidelines.

Hallin and Danielson, (2009:161-162) in their quantitative study in Sweden affirm that the success of preceptors in the preceptorship role depends to a greater extent on the support they get, their interest in the role, preceptors' experiences in the role and the preceptorship model used. Furthermore, the researchers advocate a development of preceptorship models that are specific to the context and are flexible to accommodate different categories of nursing students, preceptors and educators. The above view is congruent with the Canadian Nurses Association, (2004:1) who emphasized the significance of a preceptorship model in enabling experiential learning by enhancing transfer of theory into practice. This further justifies the significance of my study to develop a preceptorship model to facilitate clinical nursing education in Botswana.

According to Jeggles, Traut, and Africa's (2013:1-6) report on the development and implementation of preceptorship training programme for registered nurses between the University of Western Cape (UWC) and the Provincial Government of the Western Cape (PGWC) in South Africa, several challenges on preceptorship training and support were identified. Although the aforesaid study focused on preceptorship training programme, it underscores the importance of a structured preceptorship system in the attainment of clinical learning objectives. The authors draw attention to the value of clinical supervision and its importance in developing nursing students' clinical skills in a well structure learning environment. The study further indicated that clinical supervisors have limited contact sessions with students in the clinical setting. This challenge indicates flaws in the structure of preceptorship that hinder the preceptor (s) from fully executing their role and students from attaining learning outcome or objectives.

A recommendation from the report (Jeggles et al., 2013:6) was that a preceptorship model be developed from the partnership formed between universities and clinical setting or health provinces. It was envisaged that such a model will enhance the clinical training of students and delivery of services to the recipients of health care services. According to the authors, preceptorship models proposed in literature focus on the learning environment and preceptor's preparation based on local needs and conditions. The notion asserts that preceptorship models are developed for a specific context and setting and cannot be universally applied to all settings. It is therefore crucial to have a model of preceptorship that mitigates the identified gaps in the implementation of preceptor role in each clinical nursing education setting. This assertion further justifies the importance of the researcher's study in Botswana's clinical nursing education.

Maginnis and Croxon, (2007:218) argue that the preceptorship model that assigns one student to one preceptor in the clinical setting has been found to be problematic due to shortage of preceptors and their workload. This challenge has brought about the use of cluster methods of preceptorship that assign up to eight (8) students to one preceptor. It can be argued that if the preceptor has more students and still has the same workload then the preceptor has no time to attend to the students' clinical learning needs. Findings are consistent with preceptorship practices revealed in a few studies done in Botswana which reflect that while guiding and supervising students, preceptors are still expected to take full responsibility of all routine patient activities in the units and that the workload of preceptors coupled with lack of clearly defined preceptorship guidelines and policies are major challenges faced by preceptors and students (Dube & Jooste 2006; Madisa, 2012: 48-49).

The insinuation from the previously mentioned studies is that, although the preceptorship model enhances achievement of the desired students' clinical competences and fulfillment of the preceptors in their role, preceptorship models should be contextual. There is literature dearth to the existence of a specific preceptorship model used for clinical nursing education in Botswana. No follow up studies have been done to ascertain the magnitude and develop a contextual model relevant to the country's needs and resources. This mixed method study seeks to bridge the methodology gap by addressing recommendations in (Happell, 2009:373-374; Hallin & Danielson, 2009:161) and developing a preceptorship model for Botswana's clinical nursing education which might also be appropriate to other developing countries with similar resource challenges.

2.6.1 Characteristics of a preceptor

Kristofferzon, Martensson, Mamhidir and Lofmark (2012:1253), affirm that preceptors are a crucial human resource in the success of preceptorship in clinical nursing education. The authors define a preceptor as a registered nurse, who supervises students in daily professional patient care, creates a supportive teaching environment and learning relationship, serves as a role model and assesses students' development. The characteristics identified in Kristofferson et al., (2012:1253) are consistent with the characteristics of a preceptor described by pharmacy and medical students in Young, Vos, Cantrell and Shaw, (2014:1) who state that effective preceptors should demonstrate professional expertise, actively engage students, foster a positive environment for learning, demonstrate collegiality, discuss career-related topics and concerns with students, be open to questions, give constructive feedback, demonstrate enthusiasm, review differential diagnoses, and delegate patient care responsibilities.

The above characteristics are similar to those found in Horton et al., (2012:E1) who emphasize the importance of the role of the preceptor in role modeling, socializing, protecting, educating and evaluating the nurse and facilitating easy transition into the new work environment. The above studies underscore the crucial role played by the preceptor in the teaching, evaluation and socialization of the preceptee to

the professional role. It is therefore critical that preceptorship models should clearly spell out who ought to be a preceptor.

Young et al., (2014:1) define a preceptor as an experienced, knowledgeable professional, who guides students to think critically and is required to be supportive and nurturing. While Phillips, (2006; no page number) cited in the same study further describes a preceptor as having appropriate credentials for the practice setting and displays characteristics of professionalism, mentorship and empathy for patients. Phillips (2006),’s definition emphasizes that a preceptor cannot be just any nurse who wishes to take up the role or is assigned by the supervisor indiscreetly, she/he should meet the desired characteristics. Similarly, Hilli and Leena-Melender, (2014:1) define preceptorship as a one-to-one relationship between a staff nurse and a student nurse during an intense, time-limited clinical experience with the support of the nursing faculty to facilitate student learning. The authors further indicate that from the nursing context in the Scandinavian countries the preceptorship model is commonly used in the undergraduate nursing programme and is used interchangeably with terms like supervisor or mentor.

In another qualitative study conducted in Finland and Sweden, Hil, Samu & Jonsen, (2014:565) agree with the views of other researchers on the importance of a preceptor in clinical nursing education of undergraduate students. The authors acknowledge the fundamental role played by the preceptor in the student becoming a professional nurse. The assertion in the above cited studies is the importance of the role of the preceptor in professional development for the student, provision of guidance, the ability to create a conducive learning environment and possessing skills in assessing students’ clinical learning activities.

The cited studies highlight the importance of preceptor preparation for the role. Furthermore, from the characteristics of a preceptor in the aforesaid studies, a conclusion can be made that preceptors require certain qualities that enable them to execute their preceptorship role effectively and efficiently. Preceptorship role requires more than a professional qualification as nurse, but dedication and commitment to students’ teaching and evaluation, clinical supervision and professional role modeling. Despite the different settings, context and methodologies under which the studies were conducted, findings highlight that the crucial role of the preceptor and preceptorship in clinical nursing education for undergraduate students cannot be underrated.

Young, Vos, Cantrell, and Shaw, (2014:1-6) conducted a quantitative retrospective analysis study on pharmacists students evaluations of preceptors at Iowa University college of Pharmacy in the United States of America. Students rated as excellent, preceptors who demonstrated an interest in teaching, related to students as individuals, encouraged discussion, were accessible to students, provided feedback, served as role models, were organized and spent more time with students. The conclusion derived from the aforesaid study indicates that serving as a role model and showing interest in teaching are the

strongest characteristics of being an excellent preceptor. This calls for adequate preparation and support of the preceptor for the role and the need for development of a preceptorship model that will facilitate structuring of preceptorship programmes to achieve the desired learning clinical education outcomes. The cited studies support the need for apposite structuring of preceptorship activities that include identification of relevant clinical settings, development of appropriate contextual preceptorship models, selection of suitable preceptors, provision of relevant training for preceptors, development of preceptorship objectives and implementation guidelines to facilitate the desired outcomes of clinical nursing education.

Students in Tan et al (2011:18)'s literature review of preceptorship: a model for the Medical Radiation Science study conducted in Canada support other authors' findings that qualities of a good preceptor include being relaxed, calm, confident, non-judgmental, caring, patient, providing support and encouragement, building students' self-esteem, being open minded and having good teaching skills. The authors acknowledge that although the above preceptorship attributes are crucial for the success of preceptor and preceptee relationship, collegial support by staff nurses working with preceptors is pivotal to sustain the relationship. The authors further cited Nesbit (2008), who state that a preceptor is an experienced and competent role model who has good communication skills, is knowledgeable in their field of specialty and is able to facilitate the learning process. Generally, the above cited definitions indicate the key areas of focus by nurse educators and supervisors when selecting or seeking nurses to serve as preceptors for students. It is evident from literature that not every nurse can be a good preceptor.

2.6.2 Preceptor selection and preparation for the role

Literature reveals that proper selection and preparation of a preceptor is an important measure in cultivating positive perceptions about the value of preceptorship. Despite the important role played by preceptors, literature has revealed that preceptors are often selected based only on availability, and not on interest or abilities; resulting in variability in the nature and depth of their preparation (Hyrkas, Linscott & Rhudy, 2014:120,131; Canadian Nurses Association, 2004:1) Hilli and Leena-Melender, 2014:4).

Although these studies were conducted in different parts of the world, findings are generally comparable and point not only to the significance of adequately training preceptors to equip them with the necessary knowledge and skills to diligently perform their clinical teaching and supervision role but also to the quality of preceptors and outcomes of preceptorship. From the above literature, it is appreciable that recruitment of preceptors should be clearly defined and training be made imperative. This can be achieved through use of relevant preceptorship models.

In a qualitative study conducted in Finland, recommendations indicate the need to consider how much work experience the nurse should have prior to becoming a preceptor for students (Hilli & Leena-Melender, 2014:1-4). The authors advocate further pedagogical education on regular basis to strengthen

the knowledge base for preceptors and that enough time for preceptorship should be allocated. The nurses in the study showed great interest and capacity to develop preception models based on their experiences and needs which would fit into the context of their workplace. The inference from this study is that more cooperation between nursing education institutions, health care settings and other stakeholders to increase professional education of students and narrow the gap between theory and education should be the focus of preceptorship.

The authors further indicate that a model of supervision in which different facilitators have clear roles and that is developed through cooperative discussion can be a successful model. This allusion is consistent with findings and recommendations by Hilli and Leena- Melender, (2014:-8). This qualitative study was conducted in Finland, a different setting with different resources for clinical nursing education from Botswana. This observation supports Kristofferzon et al., (2012:1253) who state that literature evidence support that many preceptors do not feel adequately prepared for their role, particularly in the areas of teaching and evaluating.

Other authors have also indicated that one of the limiting factors in preceptorship is that many clinical nurses are unprepared for their preceptor role and often lack support from the nursing faculty (Luhanga, Koren, Yonge and Myrick,(2015:89) reported having received no formal preparation for their role.

Kristorfferson et al. (2012:1252-1257), conducted a cross-sectional survey study with a descriptive, comparative and correlative design in Sweden. The study had three (3) objectives namely; 1) To investigate to what extent nursing students are satisfied with the supervision provided by facilitators (preceptors, head preceptors and clinical lecturers. 2) To compare nursing students' ratings of facilitators' contribution to supervision as supportive and challenging. 3) To examine relationships between facilitators' supportive and challenging behavior in supervision and nursing students' perception of fulfillment of expected learning outcomes in clinical educations. The findings indicate the need for meaningful and appropriate clinical learning opportunities, and supply of evaluated models of facilitators that encompass the range of experiences necessary for the graduate nurse.

Similarly, in Horton et al (2012:E2)'s study several studies have been cited that emphasize the importance of formal preparation, education and support of preceptors to enable them to effectively execute the preceptorship role as a cornerstone of clinical nursing education and students 'supervision (Byrd et al., 1997; Dibert & Goldenberg, 1995;1144; Kaviani & Stillwell, 2000; Speers, Strzyzewski, & Ziolkowski, 2004). In the same study, findings reveal that inadequate preparation of preceptors has a negative impact on clinical performance making it difficult for preceptors to assess. Most preceptors have little or no experience with being assessors. Boyer, (2008: E5-E6) concurs with other researcher that preparation of preceptors for the role of teaching as well as provisions of resource materials and policies that instructional work is pivotal in meeting challenges inherent to preceptors .

Furthermore, most preceptorship literature cited emphasizes the importance of preceptors to possess nursing knowledge necessary to establish clinical objectives, carry out evaluation and feedback techniques, identify role responsibilities, use positive communication skills, employ principles of adult education, and develop teaching/learning strategies (Beeman, 2001; Burns & Northcutt, 2009; Hautala, Saylor, & O'Leary-Kelley, 2007; Kaviani & Stillwell, 2000; Reid, Krahn, Trojan, Haase, & Yonge, 2002 cited in Horton et al, 2012:E2). Based on the above findings, a conclusion can be made that if preceptors are inadequately prepared for their role and encounter challenges in students' evaluation, then clinical nursing education objectives are likely to be unmet and students' socialization to the professional role of a nurse is greatly compromised.

The findings from the above mentioned studies are akin to Botswana's preceptor selection criteria where mostly registered nurses are appointed to be preceptors by their supervisors upon request from health training institutions, often times with very little preparation for the role without considering the nurse's interest and ability for the role expectations. The selection criteria and lack of preparation for preceptors compromise the clinical nursing education outcomes and quality of practice for future professional nurses. The importance of relevant preceptorship models and prudent mobilization of resources cannot be underestimated during clinical nursing education. The purpose and objectives of this mixed method study seeks to address this challenge from the Botswana context of preceptorship.

Hyrkas, Linscott and Rhudy (2014:120, 131), conducted a descriptive correlational study involving preceptors and preceptees who had completed six months of the preceptorship programme at a tertiary medical centre in the north-eastern part of the United States. The findings indicated that many preceptors were not adequately prepared for their role. These findings are consistent with other studies from different settings and contexts (Kristorffezon et al., 2012: 1253; Horton et al, 2012:E2).

The researchers suggest the need for establishment of systems that make preceptors perceive their preceptorship role as rewarding and supported. In my view such systems should include development and implementation of preceptorship models that facilitate effective teaching and learning during clinical nursing education. However, it is worth noting that Hyrkas et al, (2014:120, 131) used a non-probability sampling technique which was a limitation as findings cannot be generalized empirically. Furthermore, the study was conducted in the United States of America a different setting with more resources than Botswana and it focused on preceptors and newly employed nurses as preceptees. To close the methodological gap, the current mixed method study which employs both quantitative and qualitative convergent designs and non-probability sampling focuses on preceptors and nurse educators not students. Nurse educators have been included in this study because they play a pivotal role in guiding both students and preceptors during clinical teaching and learning. The nurse educator assumes responsibility in ensuring that preceptors are trained for the role, particularly with regard to assessment, evaluation of clinical learning activities, professional socialization and providing feedback. In the context of clinical

teaching, a preceptor can be viewed as a nurse who assumes an educator role. Summers, (2017:263-264) states that learning to teach and facilitate knowledge acquisition in nursing students requires preparation that includes awareness of teaching methods, role transition, assessment and evaluation of students learning progress. Similarly, preceptors as clinical teachers need adequate preparation to be efficient and effective in executing their preceptorship role. Inadequate preparation might lead to high levels of stress, burnout leading to refusal to take up the role.

From a qualitative phenomenological study conducted in the People's Republic of China, preceptors cited insufficient knowledge on teaching methods, lack of time for teaching and patient care and insufficient guidance from faculty being some of the setbacks experienced by preceptors in their role (Liu et al, 2010:806-807). The study's findings demonstrate that preceptors experience mixed feelings (positive and negative) about preceptorship structure, their preparation for role and support systems availed. Preceptors recommended development of strategies that address the needs of clinical preceptors in an endeavor to promote positive experiences and to retain preceptors. Although the sample size is too small (20) to be generalized to other settings, the findings are in conformity with other studies (Kristofferzon et al, 2012:1253; Hyrkas et al, 2014:120, 131; Monareng et al, 2009:113; Lwatula 2011; Madisa, 2012:29) conducted in different settings including Botswana.

According to Lwatula, (2011: poster)'s study conducted in Botswana, Lesotho, Liberia and Zambia entitled, "Experience with preceptor development" both the student and preceptor should contribute to the success preceptorship. The students should recognize learning objectives and outcomes, identify learning opportunities and seek feedback from the preceptors. The Faculty should orientate preceptors to the role expectation, share objectives of clinical allocation with preceptors, establish and maintain a two-way communication with preceptors and mediate between students and preceptors.

The findings revealed that in the four countries that participated in the study, preceptors were at different levels with most of them not formally prepared for the role despite that Jhpiego was continuing to build capacity of educators and preceptors in students' supervision through training skills focusing on preceptors skills using a blended learning approach and ModCAL for Training Skills Learning Resource Package. Findings further showed that trained preceptors have improved the relationships between training institutions and clinical training sites. The author highlighted lack of knowledge about role expectation from students and lack of preparation as challenges associated with preceptorship in the four countries.

Research findings from the preceding studies are akin to other studies that lack or inadequate training of preceptorship is a global challenge in clinical nursing education. Despite the fact that the studies were conducted in different countries, settings and contexts of preceptorship, they still yield corresponding results. Use of relevant preceptorship models is imperative to alleviate the problems and challenges

associated with implementation of preceptorship as identified in literature. Such a model may bridge this largely identified gap in preceptorship literature and challenges entailed therein.

Panzavecchia and Pearce, (2014:2021) conducted a qualitative descriptive study in three hospital sites in the UK on what support is provided to preceptors in the United Kingdom (UK) and what qualities are required for them to carry out their role in supporting newly qualified professionals.

Lack of formal preparation of preceptors in their role was reported by all preceptors who participated in both interviews and the questionnaires. Furthermore, the preceptors were not aware of any available training when the preceptorship programme was first introduced although they had not questioned this lack of preparation because of lack of formal requirements to have teaching and assessing qualifications. It is documented in literature that although in the UK there are no formal requirements for preceptors to possess teaching or assessing qualification, preceptors should have sufficient knowledge to be able to identify learning needs of preceptees and need the knowledge of how students or preceptees learn in order to facilitate their development (NHS North West, 2009; DeWolfe et al, 2010; Department of Health, 2010 cited in Panzavecchia & Pearce, 2014:1120).

The researchers stress the importance of preceptor preparation for the role and the need to identify relevant content to include during the preparation of the preceptors as a cornerstone for the success of Preceptorship Frameworks. Panzavecchia and Pearce, (2014:1120) substantiate their findings with other related cited literature (Yonge et al. 2008; Henderson et al., 2006; who suggest a careful selection of preceptors; willing and enthusiastic preceptors are more effective than those who are forced into the role.

One participant [P2] in the above mentioned study had this to say “... *I had no preparation and looked on the internet, on Google and on the RCN website but there wasn't much on there..... there was no real guide to being a preceptor...*” Another participant reinforced this by suggesting that provision of formal guidelines and annual updates or support sessions would be beneficial to enhance positive role perception. Challenges experienced by preceptors in the abovementioned study could be qualified to lack of appropriate preceptorship models. Pertinent preceptorship models can be used to bridge this gap by addressing the needs of both preceptors and preceptees including resources and support systems entailed therein. The importance of preceptorship models to guide in the training and support of preceptors and students for the role is imperative to develop their professional role and to retain preceptors in the realm of clinical education. Based on synthesis of literature evidence, the extent to which preceptors are adequately supported and prepared for the role remains questionable. The inadequate preparation and lack of support in turn has implications on preceptors' ability to effectively and efficiently execute their mandate in students clinical teaching and learning. Although preceptors are often experienced nurses, this does not necessarily translate to being a good teacher, hence the need for preceptors to be equipped with teaching and assessment skills.

2.6.3 Learning environment

The importance of a conducive clinical learning environment during preceptorship is the heart of clinical nursing education. Clinical nursing education should be provided in an environment within an organizational culture that supports the learning and teaching activities for both the student and the preceptor. Such an environment can be created through collaborative efforts of all stakeholders from the health training institutions and clinical setting area and appropriate preceptorship models.

According to O' Brien (2015:17-20), clinical experiences are vital to all types of healthcare educational programs. The author further concurs with literature findings that supervised clinical experiences provide the opportunity for the learner to apply didactic knowledge and theory to real world situations and sharpen skills necessary for entry into practice. The study was conducted at University of Iowa hospitals and clinics utilized as clinical sites for students registered nurse anesthetists (SRNA s) in Australia. The clinical sites as defined in the study "are required sites and enrichment sites where students receive 50 % or more of their total clinical experience and / or a site where students obtain experiences necessary to meet the council's standards." The researcher ascertains that resources to house and educate students and evaluate the effectiveness of the clinical sites should be available. Developing a clinical site requires planning and open communication, development of goals, objectives and written agreements between clinical sites and the programs or institutions they are affiliated with (O'Brien, 2015:17-20)..

Although the study was conducted in Australia and for graduate nurse anesthetist students, the experiences and observations in this study are similar to the preceptorship structure and processes for the higher diploma in general nursing students in Botswana. In Botswana preceptorship is an experiential clinical learning experience that is a vital component to student growth and learning. From the researcher's knowledge and experience with preceptorship in Botswana, students are required to cover 100% of their total clinical education hours and competences to qualify for a Higher Diploma in General nursing which is a prerequisite for licensure by the Nursing and Midwifery Council of Botswana (Higher Diploma in General Nursing Curriculum, 2009:7). It is imperative that the clinical setting which is a clinical site should be structured or organized in such a way that it facilitates effective clinical education to allow students to acquire the required clinical competencies and outcomes to effectively perform their professional role as nurse upon completion of training. The preceptor and nurse educator should facilitate in the creation of a conducive learning environment by choosing settings with rich learning experiences and resources including well prepared preceptors and use or pertinent preceptorship models. The support provided by clinical setting and HTIs management in making the learning environment relevant cannot be underestimated.

A mixed method study on how nursing students learn on clinical placements in three cohorts of undergraduates was conducted in an Australian university (Newton, Jolly, Ockerby and Cross,

2012:2338). The population comprised second and third year nursing students who used three different clinical partnership models of clinical nursing education. The study compared two models. The MASH model that uses the preceptors only as the supervisor of students in the clinical area; the second was the non-MASH model which uses both the preceptor and clinical teacher participating in students clinical practice supervision. MASH model is the acronym which represents the names of Monash University and the health care organizations that partner with the university in the clinical placement of the second and third year undergraduate Bachelor of Nursing students.

The MASH model is underpinned in the clinical setting by preceptorship and the availability of a clinical nurse educator. Preceptors in this study were interacting with students on a one-to-one basis which differs from the Botswana context where a preceptor can supervise between six (6) and ten (10) students depending on the clinical setting, learning objectives and availability of preceptors in other clinical settings (Lwatula, 2011:1; Madisa, 2012:34).

The conclusion from the findings indicates that, while the existence and role of the preceptor in students' learning environment is remarkable, provision of opportunities for the students to engage in the workplace during preceptorship cannot be overemphasized. The significance of the results is that preceptors should facilitate for a non-threatening and enabling learning environment, which allows for information sharing during clinical education. Although the aforesaid researchers also used a mixed method approach like this study, the setting, purpose, resources and population are different from the context of this study.

Mothiba, Lekhuleni, Maputle and Nemathaga, (2012:192-205) conducted a qualitative, explorative, descriptive and phenomenological study to determine the University of Limpopo students' nurses clinical experiences in a public hospital of the Capricorn district in the Limpopo Province of South Africa. Teaching and support was one of the themes that emerged during data analysis. The researchers affirm that exposure to the clinical environment provides a unique context for the students' experiential learning and skill acquisition that cannot be easily acquired anywhere else.

The findings revealed that there are no clinical preceptors and that in the absence of preceptors, teaching and learning in the clinical area was difficult if not non-existent. This was confirmed by one participant, who said, *then each ward must have a clinical preceptor and if they don't have our university must device someone who will act as a clinical preceptor, someone whom we can be able to rely on for clarity in the clinical setting.* To validate their findings, authors cited studies by Mhlongo (1996) and Kerridge (2008) who explained that there was no clinical teaching by ward staff due to shortage of equipment and staff which was affecting the conduciveness of the clinical learning environment.

Another theme that emerged from the data was opportunities for learning. Results indicate that students have little learning opportunities as they spend most of the time doing routine work in the hospital.

Students are assigned to the wards and clinics in large numbers which limit their opportunities of learning. Some professional nurses in the wards are not interested in working with students as they perceive them to be slow as a result delaying ward routine. These sentiments were confirmed by the following statement from one of the respondents; *“what I can add is that according to what I have seen or experienced... if it was possible they should give us more time for practice than theory”*. Another participant concurred by saying *“...and they allocate us work that is not consistent with our learning objectives”* (Mothiba et. al., 2012:199-200). This further cements existence of a learning environment which is unsupportive of students learning needs. These findings reflect a problem with the structure of clinical nursing education whereby students are sent to the clinical setting area before all resources are mobilized including selection of preceptors and guidelines to facilitate students’ learning and no clinical education models. The limitation of the study is that it only involved a small sample size of students and therefore does not reflect the magnitude of the problems encountered by students.

2.7 PROCESS OF PRECEPTORSHIP

According to the Donabedian model of quality, the Structure, Process and Outcome (SPO) (Stanhope & Lancaster, 2004:529-532; Donabedian, 2005:173) was adapted as the framework for this study, process entails activities that should be done to enhance quality of the desired outcome; mainly mobilization and utilization of resources for preceptorship. Based on the above notion objectives of preceptorship can be achieved through implementation of processes that are enabling and facilitating preceptorship activities from both the clinical settings and health training institutions. In this particular study process include activities such as preceptor training and orientation, support for preceptorship, effective communication amongst stakeholder and an enabling organizational culture for clinical learning and teaching of students.

2.7.1 Support for preceptors and preceptorship

For the purpose of this study, the definition of support was adopted from Oxford Secondary Dictionary (1991:646) and means “to give strength, to enable, to last long or to assist by approval.” As applied to this study, support shall mean implementation of measures, processes and guidelines to facilitate the effectiveness of preceptorship as a clinical teaching strategy in nursing education.

Happell (2009:373), states that the success of preceptorship in nursing is determined by the strength of the preceptor-student relations. The author advocates that in order to be able to fulfill their role, preceptors need to be competent practitioners who hold a teaching, advisory, supervisory or evaluator role in the service setting who maintain communication with the educational institution. This notion is congruent with Yonge et al., (2007:6), who affirm that preceptors need to participate in the orientation of students; to the clinical environment, actively facilitate clinical learning, carry out assessment of clinical skills and provide constructive feedback to students in the service area. From the above information it is apparent that preceptors need preparation and support for their role which they should get from the collaboration of

education institutions and health care settings. Nurse educators and preceptors should spearhead the development of preceptorship models that are contextualized to the education- service setting where clinical learning and teaching takes place as recommendation in Hilli and Leena-Melender, (2014:7).

Studies show that a support structure, including facilitating nurses and clinical lecturers during clinical education, is of great importance to students' (Bourgeoise et al., 2011:114–118; Gidman et al., 2011 cited in Kristofferzon et al., (2012:1253). Interviews with students in Kristofferzon et al., (2012:1253) revealed that lecturers' visits during clinical practice were extremely useful because they not only provide students with support, but the thought of a visit by lecturers motivated students to carry out preparatory work and discuss learning outcomes.

The above findings are congruent with Sedgwick and Harris, (2012: no page)'s study which highlighted the challenges to the preceptorship model that it is imperative for nurse educators, nursing programs, and leaders in the practice environment to critically reflect on the current models of clinical practice education so that programs are able to graduate safe and competent novice registered nurses. The researchers' allusions are commensurate with the aim of this study that seeks to develop a preceptorship model that reflects and supports the views of the key stakeholders in preceptorship namely the preceptors and nurses educators. Visits by nurse educators to students and preceptors during preceptorship were viewed as crucial in supporting clinical teaching and learning expectations.

From this researcher's experiential knowledge of preceptorship in Botswana's clinical nursing education, it is through the visits made by nurse educators to the clinical setting environment that resources to enhance effectively implementation of teaching and learning activities are advocated and mobilized. It is through these visits that objectives are clarified to students and preceptors, challenges faced by preceptors and students are discussed with preceptors, students and clinical setting (s) management and remedial measures instituted, progress towards goal achievement is also monitored. Such visits also enhance psychological support for students and their preceptors.

Morgan, Mattison, Stephens, and Medows, (2012:35) concur with other researchers that without the support and interest from managers, stakeholders and professional bodies, the effort and enthusiasm of practitioners who serve as preceptors may be destroyed due to lack of recognition. This notion is supported by other researchers whose findings affirm that providing appropriate support to the preceptors can enhance success and if they feel unsupported they can become demotivated and dissatisfied hence less effective in their role (Higgins, Spencer, & Kane, 2010:409–508). The aforesaid studies indicate that preceptorship lacks support even from facilities and unit managers. Support and preparation for the role is the key to successful preceptorship that should be directed by relevant preceptorship models that are country specific. Similarly, Hallin and Danielson (2009:161-162), state that the success of preceptors in their preceptorship role depends to a greater extent on the support they get, their interest in the role,

preceptors' experiences in the role and the preceptorship model used. The quantitative descriptive cross-sectional survey was conducted in a country hospital that provides clinical education for nursing students in central Sweden. Findings from Hallin and Danielson, (2009:161-174),’s study support that a preceptorship model offers a way to support and facilitates preceptors’ training and helps develop cooperation between the university and the hospital. In addition, the researchers advocate the development of a preceptorship model that should be specific to the context and flexible to accommodate different categories of nursing students, preceptors and educators.

The researchers recommend the need for more studies both quantitative and qualitative that will act as sign posts for progress and improvement of preceptorship. The authors state that for a preceptorship model to achieve its purpose, managerial support is critical to ensure that adequate time for preceptoring is availed to both preceptors and students. Although studies cited above were conducted in different clinical settings, under different structures and processes of preceptorship, the findings are congruent with the few studies done in Botswana which indicate that preceptors lack support in executing their clinical teaching role.

Preceptors are not relieved of some of their routine duties to allow them time to perform their preceptorship role. The lack of support increases the burden of work overload and makes preceptors lose interest in the preceptorship role (Monareng et al., 2006; Lwatuala, 2011; Madisa, 2012:32). Structures and processes in each clinical setting determine the specific preceptorship model to be used to support the learning activities during clinical teaching and learning. It is imperative that contextual preceptorship models that support clinical nursing education should be used hence the purpose and significance of this study.

Similarly, Hilli and Leena-Melender (2014:4), are in agreement with other authors that the evaluation of students was considered a challenge because preceptors at times do not know what to expect from students as learning outcomes are not communicated earlier, and at times objectives are not made clear. Furthermore, preceptors in the study lamented about no time allocated for preceptorship, too many students allocated to a unit at a time and having many patients and other nursing responsibility as setbacks in their preceptorship role. These findings clearly reveal that preceptors in this study perceived that preceptorship activities are not given adequate support by both the clinical setting management and nurse educators hence compromising the quality of students’ learning. Preceptors will always give patient-care first priority over students if there is no time allocated and no support for preceptorship. Lack of support from ward managers and preceptors’ colleagues was stated by 94% of preceptors as a limitation and difficulty relating to their role which resulted in lack of direction for the preceptor role.

The implication from the aforesaid studies is that the availability of a model without stakeholder support including a facilitating clinical and educational setting culture, preceptors’ colleagues and nurse educators

will be futile. This is relevant to bridge the methodology gap as recommended in Hallin and Danielson (2009:161-162), and to develop a preceptorship model for Botswana that clearly defines the structure, process and outcomes of clinical nursing education.

In another qualitative phenomenological study Liu et al. (2010:806-807), the following themes emerged; i) teaching is learning, ii) being unable to do what one would like to do, and iii) experiencing bittersweet moments and being a role model and acting like a mother. In this study preceptor cited workload, other work related responsibilities, and lack of rewards for the role are some of the challenges and setbacks they experienced. These findings are consistent with the few studies conducted in Botswana (Monareng et al., 2009; Lwutuala 2011; Madisa, 2012) and indicate lack of preceptorship support and recognition for role performance as demoralizing. However, on a positive note, some preceptors in Liu et al. (2010:806-807), state that in spite of the lack of support from preceptorship stakeholders, they still viewed their experience in the role as a learning opportunity that compels them to keep abreast with current knowledge and trends in nursing to prevent embarrassment when asked questions by students and have no answers.

The study's findings demonstrate mixed feelings by preceptors (positive and negative) about their role and recommend for development of strategies that address the needs of clinical preceptors in an endeavor to promote positive experiences and to retain preceptors. Preceptors in this study had a full load of other responsibilities over and above the preceptor role, a situation similar to the Botswana context as cited above. This indicates lack of support from their colleagues, nurse educators and clinical setting management resulting in preceptor frustrations, reluctance to take up the role and burnout.

Since this researcher seeks to develop a preceptorship model, and preceptors in the aforementioned study expressed insufficient guidance from the faculty and many other challenges, the researcher found it befitting to include both preceptors and nurse educators in this study and compare the findings with Lui et al, (2010:804-808)'s study. The mixed method (quantitative and qualitative) approach adopted for this study is relevant as the two designs will complement each other. A detailed description and explanation of the experiences of the preceptors and nurse educators might yield rich information necessary for development of a contextual preceptorship model.

Preceptors in Panzavecchia & Pearce, (2014:2023) also indicated that they lacked support from their management or the rest of the team members. Despite the fact that the studies were conducted in the United Kingdom, like in other studies cited in this literature review, it is evident from the preceptors' views and experiences that generally, preceptorship is not fully supported by the managers and colleagues of preceptors. The lack of support might be emanating from lack of preceptorship models that clearly spell out the responsibility of all stakeholders in the clinical teaching and learning process. Preceptors in Madhavanpraphakaran, Shukri and Balachandran (2013:32)'s study indicated linked lack of support and time limitation as problems associated with preceptorship. Failure to develop and apply contextual

preceptorship models in clinical nursing education jeopardizes the quality of clinical nursing education for students and challenges associated with the process of preceptorship shall perpetually prevail.

Dobrowolskear, et al. (2015:36-46), conducted a qualitative study in 11 countries namely; Croatia, Czech Republic, England, Iceland, Ireland, Italy, Poland, Serbia, Slovenia, Spain, Switzerland, Ukraine and the United States of America. Participants in the study were an expert panel of nurses (clinical and academic). Findings indicated diversity among countries in the models of clinical training in pre-registration on nursing education. Furthermore, findings illustrate that despite some harmonization in other areas, there was diversity among countries in relation to the models of clinical training in nursing education based on governance and set standards. The researchers concluded that although there were some similarities in the use of the three models, there were some disparities in the amount of time devoted to nursing education, clinical learning, different organizational patterns of students' shifts at the clinical placements and very different student-teacher ratios. The authors' recommended further research insight into the complexity of clinical training in undergraduate programmes across countries and that countries share good practices to improve organization of clinical nursing education. The following limitations were highlighted; the cross-sectional nature of the study, the process of a country's inclusion which prevented generalization and the recruitment criteria (voluntary) of expert stakeholders could have resulted in local rather than national perspectives of the countries.

These findings and limitations stress the need for contextual models for clinical nursing education that are specific and relevant to each clinical settings based on resource availability and policies. It is also evident from the findings that application of the model is determined by the availability of resources and clinical education setting. In Dobrowolskear et al. (2015:36-46), 's study the countries that participated utilized a one- to one student-preceptor ratio which has not been practical in most African countries due to resource limitations. In this researcher's mixed methods study, the two designs complement each other in determining preceptorship practices in Botswana and gives suggestions for improvement.

In Al-Zayyat and Al-Gamal (2014: 331-332), 's descriptive, longitudinal study conducted using students from five universities in Jordan, students revealed that they experience multiple problems during clinical practice. The stressors highlighted are; i) stress from patient care, ii) stress related to teachers and nursing staff, iv) workload and assignments. Stress from the teachers and nursing staff was ranked the highest and was attributed to discrepancy between students' and teacher expectations and lack of compassion and unwillingness to help from nursing staff. There is a clear indication that students perceived lack of support from preceptors, teachers and other nursing staff which could have a negative effect in their clinical education outcome.

However, the findings do not highlight the cause of identified stresses neither were teachers and preceptors included to express their views. Furthermore, the study's setting was lecture theatres. The

setting excluded students who could have had differing views. The limitations of the above study are that it was only quantitative in nature and does not reflect the students' feelings in relation to how clinical nursing education can be improved and how students react to the stress. Furthermore, there is no indication of the type of preceptorship model (s) used by the universities that participated in the study. Although the study focused on the students, it is evident from the findings that a study involving nurse educators and preceptors may complement Al-Zayyat and Al-Gamal (2014:331-332)'s findings. The authors recommend integration of qualitative questions in future related studies. My mixed method study involving in-depth description and exploration of experiences of preceptors and nurse educators about preceptorship practices in Botswana and how it can be improved lead to the development of a preceptorship model to facilitate clinical nursing education and alleviate challenges entailed therein.

Iglesias- Parra, Garcia- Mayor, Kaknani- Uttumcahndani, Leon-Campos, Garcia- Guerrero and Morales- Asencio, (2015:1-8) conducted a qualitative, cross-sectional study at a university in Spain. (Iglesias- Parra, et al 2015:1). The study was guided by the systems of competencies assessment theoretical framework based on the evolution from novel-to-expert proposed models such as Dreyfus & Dreyfus, (2005) and Benner, (1982) which place the acquisition of highest level of proficiency at expert level that require ability to deliver intuitive judgment through deep knowledge and experience (Iglesias- Parra, et al 2015:4). Students indicated a clinical learning environment and ward organization as key issues in the level of satisfaction. Clinical tutors who work in the hospital ward and served as preceptors indicated that they were not adequately protected by their organization compared to their counterparts in primary health care settings. Lack of protection may have accounted for the disparity in the way students rated the clinical tutors from the hospitals and Primary Health care in relation to communication, respect and students reception during clinical practice.

The researchers attributed lack of support to work overload for clinical tutors. The aforementioned study accentuates the need for preceptorship models that facilitate clinical nursing education by ensuring that students, preceptors and educators are satisfied and feel protected by preceptorship structure and processes in place. This study correlates with the purpose of this research that focuses on preceptors and nurses educators as key stakeholders in facilitating clinical nursing educations to ensure that the intended learning outcomes are achieved. Inadequate protection and communication cited by the clinical tutors / preceptors and students reflects a non-supportive organizational culture for clinical education. The limitation of the study is that it was done in only one university. The conclusion drawn from the study is that adequate resources including; guidelines, relevant preceptorship models, transparent support and communication process are critical in the sustenance of preceptorship in clinical nursing education.

According to Courtney-Pratt, Fitzgerald, Ford, Marsden, & Marlow, (2012:1380) the large numbers of undergraduates nursing students being enrolled in tertiary institutions in response to the current and predicted shortages of nursing workforce results in the increase in the institutions' request for clinical

placement of nursing students in hospitals and support thereof. The authors assert that there is little known about the impact of the large numbers of students on the quality of clinical placement and quality of learning experience. The mixed method study (qualitative and quantitative designs) which seeks to establish the quality of clinical placement of students was conducted by the Tasmania University. The Tasmanian situation is consistent with the Botswana's increasing demand for health human resource which has been identified as top priority and has resulted in an increase in the number of students enrolled to train as nurses in health training institutions (Ministry of Finance Botswana, 2003:306-309; Ministry of Finance Botswana, 2009:66). This further put more demands on preceptors and preceptorship hence the need for an explicit preceptorship model.

According to the findings, students rated the level of support in teaching and learning as higher from clinical facilitators compared to the supervising nurses. Findings further reveal the need for nurse educators and nurse managers to create a conducive organizational climate and culture that empowers and supports nurses (preceptors) in order for them to support students and improve the outcome of clinical nursing education. Students in few studies conducted in Botswana and other African countries including; Liberia, Lesotho South Africa and western countries have indicated similar concerns of lack of support by preceptors and supervisors of preceptors citing overwhelming workload and patient care responsibilities as major contributing factors to preceptorship challenges (Monareng et al., 2009:114; Higgins et al., 2010:409–508; Lwatuala, 2011; Jeggles et al., 2013: 101-106; Morgan et al., 2012:35; Iglesias- Parra, et al., 2012:4). Courtney et al (2012:1382),’s study has a significant contribution to my study because of its focus on clinical learning environment which comprises the preceptorship structure and process such as support which is in accordance with the conceptual framework for this study.

In Mothiba et al. (2012: 189-199),’s study, findings revealed that students get support from some but not all members of staff in the wards. Furthermore, there were conflicting ideals in relation to clinical teaching by ward professional staff which the researcher perceived as revealing both positive and negative practices in terms of teaching students in the clinical area (Mothiba et al., 2012:198-199). One participant had this to say *“They do teach us, while others are having attitude, for example they restrict us from asking questions.”* Students are expected to accomplish learning objectives while in the clinical learning environment. The researchers argue that teaching of students and other categories is one of the fundamental responsibilities of a professional nurse and failure of the professional nurse to execute this role does not only compromise students’ learning but contributes to poor quality of patient care as well.

Another participant experienced a similar sentiment by indicating that sometimes professional nurses expect students to be competent and proficient like them in performing nursing duties and if students are not, it becomes a problem. The students requested that professional nurses should treat them like students who are there to learn and prone to make mistakes and can be corrected. The findings confirm that students are not well supported during their clinical learning and may not practice use of critical thinking

and clinical judgment skills due to fear of making mistakes. It is evident from the results that both professional nurses and students lack guidance and support which is one of the core values in clinical teaching and learning. A clearly designed preceptorship model might mitigate some of these challenges. The above cited studies support that preceptors require the support of their co-workers, nurse educators and clinical setting supervisors to execute their student teaching and supervision role. The implication from the literature is that development and utilization of a preceptorship model that will facilitate the relationship among preceptors, their coworkers, students, nurse educators and clinical setting management is pivotal in the attainment of clinical teaching and learning objectives.

2.7.2 Communication during preceptorship

Communication is essential for the sustenance of any relationship and partnership. O'Brien (2015:17-20), in a study on clinical placement of Registered Nurse Anesthetist Students (SRNAs) highlighted that open communication between the clinical coordinator and the program director or designee as essential to ensuring the success of students placement in the clinical site. The author states that all clinical sites have the responsibility of providing quality experiences for SRNAs, since they are heavily invested in educating future Certified Registered Nurse Anesthetists. This view also applies to the clinical placement of general nursing students in Botswana. Clinical setting should have rich learning experiences for nursing students to enable them to carry out the intended health services at an acceptable quality. This requires clear communication among nurse educators, clinical setting management and preceptors about objectives and, guidelines for preceptorship, robust training of preceptors and support for preceptors and students.

Preceptors in a study conducted in the People's Republic of China, Liu et al (2010:806-807), indicated ineffective communication as another impediment in their role. The ineffective communication cited in the study included change of plans for students' placement without prior communication with the preceptors. Poor communication leads to lack or inappropriate planning and supervision of clinical learning activities and subsequently inability to achieve preceptorship and learning objectives and compromising the quality of clinical nursing education.

In a study conducted in the Republic of South Africa by Mothiba, et al. (2012:202), findings revealed evidence of poor communication between ward staff and student nurses. One participant indicated that the way general nurses in the ward communicate with students is different from the way they communicate with other people. Researchers cited Mongwe (2001)'s findings which stated that poor communication in a stumbling block to effective guidance of student nurse and compromises implementation of any step in the management process. However, the cause of poor communication between student nurses and nursing staff has not been fully explained in that study.

The following recommendations emanated from the study; nurse managers to assist lectures and students by identifying interest professional nurse to serve as preceptors, nurse managers and university lecturers should support the clinical preceptors, clinical preceptors to be given incentives, involvement of nurse managers and preceptors as participants in curriculum development and drawing of clinical learning outcome for students. The researchers recommend further studies on student nurses' clinical experiences during placement settings which could assist nurse educators and nurse managers in planning effective teaching and learning for students. From the above cited studies, it can be concluded that although preceptorship has been used in many countries worldwide as a clinical teaching strategy for students in nursing and health science related disciplines, ineffective or poor communication still remains a gray area that impacts negatively on the preceptorship process. This researcher's study will address the population, methodological and context differences.

2.8 OUTCOME OF PRECEPTORSHIP

Omer, Suliman, Thomas and Joseph, (2013:156-160) conducted a descriptive survey that aimed at exploring nursing students' perception of two models of preceptorship at the College of Nursing- Jeddah and King Khaled Hospital-NGHA general hospital in Saudi Arabia. A sample of Students at different levels of study in a Bachelor of nursing degree programme were divided into two groups for the purpose of putting them in the two models i.e. A and B. Moore (2009)'s Reliable Preceptorship Evaluation Survey was used for data collection.

Results reflect that a preceptorship model that incorporates intensive mentoring (Preceptorship A model) was rated as significantly more satisfying for students than the model that promotes students' independence and self-directed learning (Preceptorship model B). In model A, the preceptor who is recruited by the Nursing College as a Clinical Teaching Assistant (CTA) provides close supervision, guidance and assistance to students during their clinical training at the hospital. The CTA chooses two patients in consultation with the faculty (course coordinator), for care with four students attached to her. The CTA and students provide holistic nursing care from 0700 hrs to 1600 hrs while using every opportunity to teach the students the safe practice of comprehensive nursing care.

On the contrary, Preceptorship Model B aims to promote and increase students' independence and enhance self-directed learning. In this model preceptors are staff nurses employed by the hospitals and have diverse qualifications. The student-preceptor ratio is 1:1 with a patient load of 6 to 7 patients. The faculty (course coordinator) assumes the responsibility to create an environment to achieve clinical learning objectives. The preceptor supports the students when it is necessary (Omer et al, 2013:156). In this model, students rated the preceptor low in both the facilitation and advocacy roles. Similarly to the context of Omer et al.'s (2013: 156) study, in Botswana preceptors are also nurses employed by hospitals or clinical settings. However, on the contrary, the student- preceptor ratio in Botswana can be as high as

1:6 or more and a much higher patient load (Monareng et al., 2009; Lwatuala, 2011; Madisa, 2012:29), preceptors might get overwhelmed and have little time for students. Furthermore, in Botswana there is no documented evidence of a preceptorship model in use to compare with Omer et al, (2013:156)'s findings despite that preceptorship has been used for over two decades. Omer et al.'s (2013) study only focused on students while this study focuses on nurse educators and preceptors as key facilitators in preceptorship activities.

The results from Dilbert and Goldenberg's (1995: 1150) study indicated the need for nursing administrators and nursing educators to ensure that adequate resources, rewards and supports are available to preceptors. Recommendations for developing more effective preceptor programmes were proposed. Although the above study was conducted many years back in a different setting, it was included in the current study because of its direct relevance. The questionnaire used in the current study was adapted from the questionnaire used in the cited study.

Shepard (2014:73) affirms that preceptorship are models of training wherein a nurse referred to as a preceptor is assigned to one nursing student, for the purpose of facilitating learning in the clinical setting. The study adopted a mixed-method sequential explanatory research design. The study was conducted in Triad Region of North California. Study results showed that students believed preceptorship enhances clinical learning. Findings from the study reinforce the notion that students perceive preceptorship experiences to be beneficial for enhancing clinical competence and professionalism. This study validates the potential contribution to my study on the benefits of preceptorship in clinical nursing education from the preceptors' and nurse educators' views since in Botswana there are very few studies reported on preceptorship and its benefits on students' learning outcomes. The model developed from this study is intended to provide guidance for curriculum development and clinical placement which could result in quality clinical nursing education and preparation of ethical and competent nurses to meet the healthcare needs of the nation.

2.9. CONCEPTUAL FRAMEWORK

The conceptual framework used for this study was adapted from Donadedian's framework for evaluating the quality of healthcare programmes. The framework uses the components of structure, process and outcome (Stanhope & Lancaster, 2004:529-532; Donabedian, 2005:173). The structure, process and outcome (SPO) model has been chosen for its relevance to this study because of its emphasis on the importance of providing quality structures and processes to achieved desired outcomes. The model was adapted for this study because it is through provision of quality structures and processes to facilitate clinical nursing education, that learning outcomes and desired students' competences can be achieved.

Figure 2.1 depicts the conceptual framework used in this study

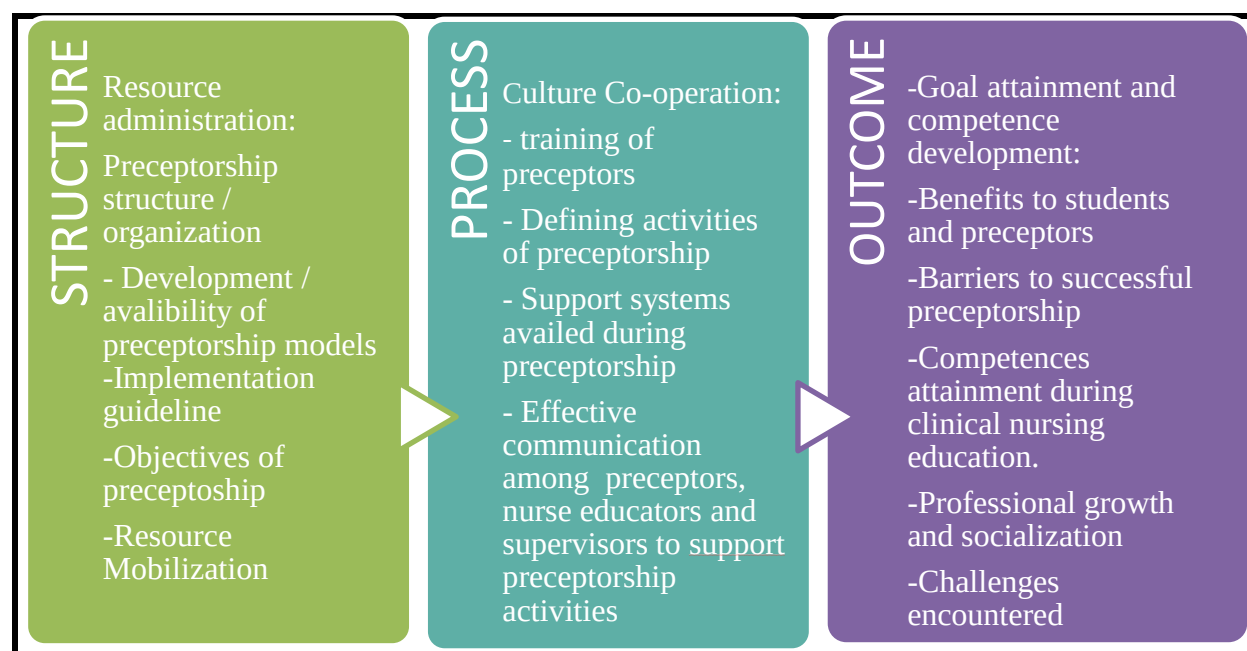


Figure 2. 1 *Donabedian's Structure, Process and Outcome Model (SPO) adapted from (Stanhope and Lancaster, 2004:529-532; Donabedian, 173).*

2.9.1. Structure

In this study, structure refers to the initial planning phase of preceptorship. All the resources needed to facilitate effective clinical nursing education during preceptorship are mobilized prior to the implementation of preceptorship. The resources include the identification of clinical settings (suitable learning environment) where preceptorship activities occur, development of model for preceptorship, availability of policies, guidelines and preceptorship objectives, involvement of institutional administration, selection of preceptors and mobilization of all other resources (human, financial, material, equipment).

2.9.2 Process

In this study, process refers to the procedures and other logistics put in place to support the implementation of preceptorship. Such procedures include; defining the concept preceptorship and preceptorship roles, preparation and training of preceptors, and provision of other didactic clinical resources (application or utilization of models, objectives and guidelines for preceptorship, communication, support from clinical settings management and nurse educators). It is worth noting some concepts under structure also fall under process when it comes to the implementation process during preceptorship. These procedures and logistics facilitate the acquisition of skills, the development of competence of student nurses and professional growth and fulfillment for preceptors. Furthermore,

support systems for preceptors and effective communication processes amongst all stakeholders are crucial components of the process of preceptorship.

2.9.3 Outcome

For the purpose of this study, outcome includes benefits and challenges to all stakeholders (the preceptors, students, nurse educators training institutions and clinical settings). Benefits include; attainment of preceptorship objectives, professional growth for both the preceptors and students, professional socialization for the students, role development, skill acquisition, competence development, improved quality of clinical nursing education and improved nursing practice and patient care. Challenges entail barriers to preceptorship. Any challenges associated with implementation of preceptorship during clinical education will be identified.

2.10 CLINICAL TEACHING AND SUPERVISION MODELS IN NURSING AND HEALTH SCIENCES

Different student clinical supervisory models exist in different countries, preceptorship being one such (Kaphagawani & Useh, 2013:183; Harvey & Radomski, 2013:2). According to Kaphagawani and Useh (ibid), learning in the clinical practice is an important component of nursing education since nursing is a practice-based profession. Harvey and Radomski (2013:12-3 identified different clinical supervision models such as the 1.) Mentoring model whereby the mentor is an independent person who does not formally supervise or assess the student. The mentor acts as a support person for students providing emotional and professional support. 2) Interprofessional Collaborative Practice model (IPCP). The IPCP model does not include students; it involves members of the health care team from different discipline to enhance quality of health care delivery. It creates interdisciplinary support and builds a culture of learning amongst team members from different discipline. 3) Parallel Consulting (Wave) model. In this model the students sees the patient in their own rooms while the clinical supervisor sees patients in the adjacent room and joins the student and patient to complete the student consultation.

The models cited in the above literature differ from the preceptorship model in that during preceptorship the student works alongside the preceptor who closely supervises the student monitors and evaluates learning activities. The preceptor offers protection to the student as a novice and to the patient who might be in danger of malpractice by an inexperienced student. It is evident from aforesaid studies that although different clinical education models exist in literature each model is context specific hence the need for development of preceptorship models based on availability of, resources such as human, financial the context where the model will be utilized or purpose of the model, study setting, population, and standards of nursing practice and education to be achieved. Furthermore, most reviewed articles on preceptorship in clinical nursing education address the preceptors and students' perspectives not nurse educators and this guided the researcher's selection of relevant articles that constituted the sample size for this study.

2.11 SUMMARY

The chapter gives a comprehensive review of articles on preceptorship and preceptorship models globally and regionally. A brief background of literature review has been outlined. The purpose, objectives and design of literature review were highlighted. A brief description of the approach used for literature review and definitions of preceptorship has been given. The reviewed articles are organized in line with the concepts of the Donabedian's structure, process and outcome (SPO) model that has been adapted as the framework to guide this study. A detailed explanation of the model application to the study has been done. Literature focus was on preceptorship in nursing, nursing education and related health sciences with emphasis on preceptorship in undergraduate programmes. A few studies on preceptorship for the newly qualified nurses were included because of their relevance to the objectives of this study. The following chapter discusses the research design and methodology of the study.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

In chapter 2 an integrated literature review on preceptorship in nursing and other health sciences related disciplines was conducted. This chapter explains and describes in detail the research process designed to meet the purpose and objectives of the study. The design of the study, setting population, sampling and sample size, data collection processes, research tools and data analysis are described in detail. The nature of the research, research questions, and the research objectives determined the research design. This study adopted a convergent parallel mixed methods (MM) approach. Quantitative and Qualitative data collection and analysis was done concurrently giving the two components of the study equal weighting (QUANT +QUAL) The results from both the quantitative and qualitative research were integrated or merged into a single study and conclusions drawn in accordance literature (Creswell, 2014:4). The design for the study was explorative descriptive and model generative in nature.

3.2 OBJECTIVES OF THE CHAPTER

The objectives of this chapter were to

- Describe the methodology of the study
- Describe the process of conceptual framework and model development and evaluation.

3.3 PURPOSE OF THE STUDY

The purpose of this study was to develop a preceptorship model to facilitate clinical nursing education in Botswana.

3.4 STUDY SETTING

The study was conducted in selected clinical settings (health facilities) utilized as clinical teaching settings for level three higher diploma in general nursing students and all six health training institutions (HTIs) that offer Higher Diploma in General nursing in Botswana. Botswana has a total national population of two million and twenty thousand nine hundred and four (Statistics Botswana, 2011:A1). The country is divided into eight (8) administrative districts and several sub-districts. The country's health care delivery system is structured and divided into different levels according to the services provided. According to Curriculum for Basic Diploma in General Nursing (Botswana,1995:3), the highest level being the referral hospitals, followed by district hospitals (mission hospital inclusive), primary hospitals, clinics with maternity services and clinics without maternity services, health posts and the lowest structures are the mobile stops. Preceptorship activities during clinical nursing education occur in any of these clinical settings where students are attached for clinical teaching and learning activities under

the supervision of preceptors. Nurse educators act as facilitators for preceptors and students during this clinical nursing education period / internship.

Preceptors were recruited from selected clinical settings (clinics, health posts and different levels of hospital in the following districts and Districts Health Management Teams (DHMTs): Southern (including Moshupa DHMT and Kanye Administrative Authority) and Kanye Adventist Hospital, Lobatse DHMT, and S'Brana Mental hospital, Jwaneng DHMT, Gaborone DHMT, Serowe DHMT; and Sekgoma Memorial Hospital, Kweneng DHMT and Scottish Livingstone hospital, Francistown DHMT and Nyangabwe Referral hospital.

Nurse educators interacting with preceptors and level three (3) students in the diploma in general nursing programme from the following HTIs were enlisted as participants: Lobatse, Gaborone, Molepolole, Serowe and Francistown all being government institutions and Kanye Seventh-Day College of Nursing being the only mission and non-government nurse training institution in the country. All health training institutions (HTIs) were included in the study because of their geographical locations that represent different districts and clinical settings where preceptorship activities take place.

3.5 RESEARCH PROCESS

This study was conducted in two phases. Phase I is the empirical phase that comprises the quantitative and qualitative designs. Phase II is the model development.

3.5.1 Phase 1: Empirical phase: Mixed Method Design

The study commenced with the convergent parallel MMD approach. The convergent parallel design (convergent/triangulation design) occurs when the researchers uses concurrent timing to implement the quantitative and qualitative studies during the same phase of the research process and analyses them separately and compares the results to see if the findings confirm or disconfirm each other (Creswell & Plano Clark 2014:219). The quantitative and qualitative studies were conducted concurrently and analyzed separately. Data collection and analysis was conducted rigorously through adequate sampling, various sources of information and data analysis steps. Following data collection and analysis, the results from the two designs were integrated through merging and interpreted as findings from a single study. Figure 3.1 illustrates the Convergence Parallel Mixed Methods use for the study (Creswell, 2014:220).

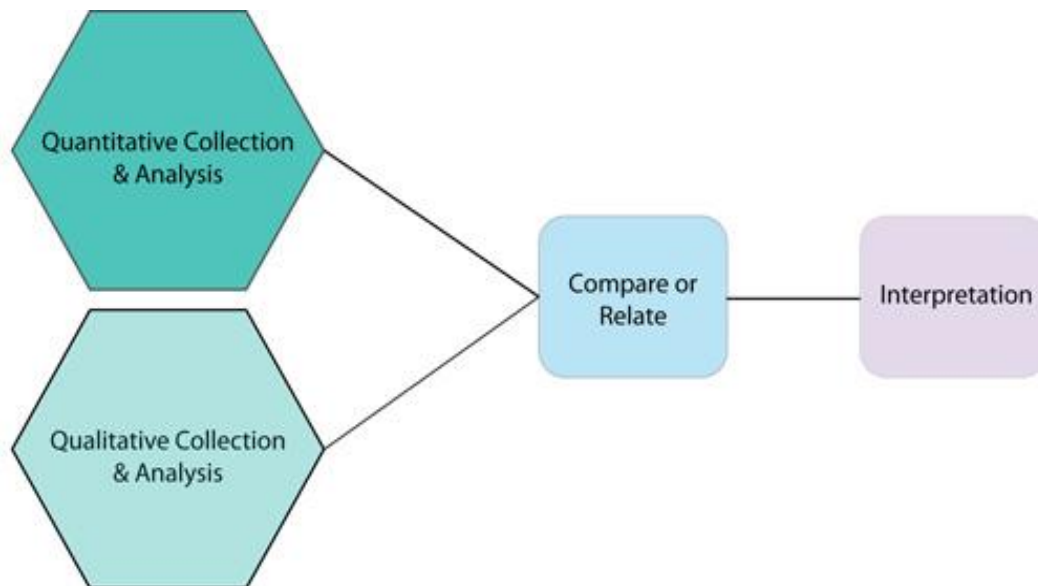


Figure 3. 1 Convergent Parallel Mixed Methods Design

The convergent design was used to best understand and develop a more complete understanding of the research problem by obtaining different but complementary data and to substantiate quantitative results with qualitative findings to develop a more complete and comprehensive understanding of preceptorship experiences in clinical nursing education. According to the literature mixed method, enhances validity, that is, when a model is supported by multiple and complementary data it gives the researcher more confidence about inferences (de Vos, et al., 2013:442; Polit & Becker, 2014:340; Creswell & Plano Clark, 2007:71). The mixed method yielded rich data that was used to construct a conceptual framework which informed the development of a preceptorship model to facilitate clinical nursing education in Botswana. Furthermore, the approach identified contradictions that emanated from the merged results.

According to de Vos et al, (2013.444) the choice of the mixed method approach is related to three decisions which were applied to this study namely:

Timing: In this mixed method research, data collection for both components were done at the same time at the settings where FGDs were also conducted. The researcher first distributed the questionnaires to either the nurse educators or preceptors the same day when FGDs were conducted. Participants were requested to complete the questionnaires before FGDs commenced making the two approaches to be conducted parallel.

Weighting: Weighting refers to determining whether the quantitative or qualitative approaches will be given equal priority or importance. In this study both designs were given the same importance and weighted equally (QUAN+ QUAL).

Mixing: of the two databases. Mixing of the results was done through merging the responses from the questionnaires with the FGDs themes and categories. The merged results were interpreted to give a more

clear understanding of the perceptions of nurse educators and preceptors on preceptorship as a clinical teaching strategy.

- **Quantitative Design**

Quantitative research is a formal, objective, systematic process to describe relationships among variables in the study and examines cause and effect interactions. Variables can be measured on instruments so that numbered data can be analyzed using statistical procedures (Burns and Grove, 2007: 747; Creswell, 2014:247). In this study, this approach was used precisely to measure respondents' perceptions in a quantifiable manner (Polit and Beck, 2014:739). It was used to address the first objective of the study.

Population

The target population was all preceptors who supervise level three (3) higher diploma in general nursing students from the six (6) HTIs during preceptorship and all nurse educators facilitating in preceptorship. The researcher obtained a list of names for both preceptors and nurse educators from heads of department for higher diploma in general nursing in the six (6) HTIs. Based on the list of preceptors from all health training institutions and information from preceptors, an estimated 120 preceptors constituted the target population of preceptors. A total of 55 names comprised the population of nurse educators.

Notably, one institution only provided the names of the clinical settings and no list of preceptors because the institution did not have names of the preceptors despite sending students to those clinical settings. The assumption was that every nurse with two years nursing experience should act as a preceptor. The researcher had to ask for the names of preceptors from each of clinical settings. Due to unavailability of a national and institutional preceptorship database for preceptors and the transfers of preceptors; there was a disparity between the list of preceptors obtained from the health training institutions and the numbers of preceptors the researcher identified in the clinical settings in selected districts, this brought the population of preceptors to 120.

Sampling

In this study recruitment of participants for the quantitative design was done through non-probability sampling techniques namely; convenience sampling. The researcher had intended to use Stratified Random sampling method for the study to obtain the sample size for preceptors while all (census) nurse educators facilitating in preceptorship were to be included in the study due to their small numbers. The researcher obtained a list of preceptors' names and clinical settings from health training institutions which was used as the baseline data to develop a sampling frame and track the preceptors in the sampled districts where possible. However, due to the colossal transfers of nurses within districts and amongst clinical settings that coincided with the data collection period, the movement of preceptors brought about a substantial discrepancy between the list of the preceptors provided by HTIs with the actual set up and numbers found by the researcher during data collection. It was also evident that some HTIs do not have a

data base of the preceptors as some preceptors found in clinical settings were not in the list provided and in other clinical settings had no preceptor and yet a name was provided. Some of the preceptors had since been posted to districts, which were not utilized as clinical settings for level three higher diploma in general nursing students, while others had resigned from nursing practice.

Due to the challenges encountered, the researcher opted to use convenience sampling technique for recruitment of preceptors. RAOSOFT sample size calculator was used to calculate the sample size for preceptors. The estimated population size for preceptors was 120. A confidence level of .95 and margin of error of 5% was used to calculate the sample size. Using the above formula the recommended sample size for preceptors was 92. The margin of error was 3.13%. Due to the small number of nurse educators the researcher had intended to include all 55 of them. Fifty (50) nurse educators and 107 preceptors finally constituted the sample size making a total sample size of 157 participants for the quantitative design. The ROASOFT sample size calculator formula used to calculate the sample size for preceptors is depicted as follows:

$$\text{Size } x = Z^{(c/100)^{2r}} (100-r)$$

$$n = N \times / (N-1) E^2 + x$$

$$E = \text{Sqrt} [(^{(N-n)} x / n (N-1)]$$

Where N is the population size, r is the fraction of responses of interest in, and $Z^{(c/100)}$ is the critical value for the confidence level c. The Margin of error is the amount of error that can be tolerated and should be 5% or less. Confidence level is the amount of uncertainty that can be tolerated. Acceptable confidence levels are 90%, 95%, and 99%. Response distribution refers to the expected results and is determined by how skewed the population is and should be maintained at 50 % if the researcher does not know the population distribution. (<http://www.raosoft.com/samplesie.html>).

Inclusion criteria

Inclusion criteria for preceptors were as follows: 1) Nurses who served as preceptors for a minimum of one semester. 2) Preceptors working in any of the selected clinical settings (hospital, clinic or health post) supervising, guiding and evaluating level three nursing students learning activities in the clinical setting. 3) Nurses serving as preceptors, and 4) Preceptors willing to participate in the study.

Inclusion criteria for nurse educators: 1) Nurse Educators from all HTI s following up and facilitating for preceptors and students for a minimum of two semesters and

2) Nurse educators willing to participate in the study

Exclusion criteria

All preceptors and nurse educators not meeting the inclusion criteria were not included in the study.

Data collection process:

Prior to commencement of data collection, written and verbal explanation of the researcher's intention and expectations from participants in relation to participating in the study was done by the researcher. It was explained that participation was voluntary. An information sheet and consent letter explaining the purposes of the study and ethical considerations pertaining to the participant's rights to participate, refusal to participate or withdrawal from the study was given to willing participants to sign as evidence of voluntary participation (Appendices A & B). Participants were informed that the results will be confidential; furthermore, the researcher would be blocked from knowing who had or had not chosen to complete the survey. This was achieved by not attaching names of respondents to questionnaires only numbers were used to code the questionnaires.

The questionnaire was distributed physically by the researcher to preceptors and nurse educators who were willing to participate. Reduced return rate is one of the inevitable disadvantages of mailed questionnaires (Keller & Warrack, 2000:151; Polit & Beck 2014:306). The researcher personally collected the completed questionnaires in an endeavor to maximize the return rate despite costs incurred due to the vast geographical area that had to be traveled to all selected clinical settings and health training institutions in pursuit of the eligible participants.

Data collection Instrument:

A self-administered questionnaire was used for quantitative data collection. The questionnaire was adapted from Goldenberg and Dilbert's (1995) 4- part questionnaire: Preceptors' Perception of Benefits and Benefit Scale, the Preceptors' Perception of Support Scale, the Commitment to the Preceptor's Role Scale and Demographic characteristics Scale. Preceptors were asked to respond to six (6) demographic characteristics, followed by 41 closed-ended statements addressing the Perception of benefits and rewards, Perception of Support and commitment to the preceptor role. The structure of the original questionnaire was adapted to categorize the scales under (SPO). Preceptors were asked to rate their perceptions of each statement on a Likert scale of 1 to 4, where four (4) indicates strongly agree and one (1) implies strongly disagree. The preceptor questionnaire was further adapted to develop the nurse educators' questionnaire. Similarly, the nurse educators' questionnaire comprised all components of the preceptors' questionnaire. It constituted nine (9) demographic characteristics, followed by 44 closed-ended statements addressing their perceptions of benefits and rewards, support and commitment to the preceptor role in relation to the structure, process and outcome of preceptorship in clinical nursing education. (See Appendices C and D and).

Quality of data and rigor

The validity and reliability of the two questionnaires was established. Reliability refers to the consistency with which the instrument measures the target attribute or the stability, equivalence and homogeneity of the research instrument (Polit & Beck, 2014:331; Burns & Grove, 2005:749).

Reliability: This tool has been used by Dilbert & Goldenberg, 1995 and has Cronbach's Alpha of .90 and .91. Reliability of the preceptors and nurse educators' adapted questionnaires was established through pilot testing.

Validity refers to whether the researcher can be able to the degree to which an instrument measures what it is intended to measure of the usefulness and meaningful deductions from sources on the data collection instrument (Creswell, 2014: 250; Streubert- Speziale & Carpenter, 2007:460). The questionnaires were given to two selected expert nurse educators with a good clinical nursing education and preceptorship background to solicit their input (expert agreement) in order to ascertain content validity to the Botswana context of preceptorship. The validity and reliability of the original questionnaire (Dilbert & Goldenberg, 1995: 1144-51) had been established. The validity ranged between $r=.53$ and $r=.75$ while the coefficient alpha was between .92 and .93.

Pilot test

The questionnaires were administered to two (2) nurse educators and four (4) preceptors meeting the inclusion criteria. The preceptors and nurse educators who participated in the pilot study were excluded from the main study. The researcher sought to establish content validity of and reliability of the instrument in relation to the preceptorship in Botswana. The results of the pilot test informed the modification of some statements and removal of a few which showed no relevance to the Botswana context of preceptorship as respondents had either not responded or indicated "not clear" Four statements were removed from the original preceptors questionnaire (Dilbert & Goldenberg, 1995). Two (2) statement were modified from the nurse educator's questionnaire adapted from the preceptor's the original questionnaire.

Data Analysis

Basic steps of analyzing quantitative data were followed which include preparing the data for analysis, exploring, presenting the analysis and validating the data. The data were captured and analyzed using Statistical Package for Social Sciences (SPSS) version 24. Frequency tables, percentages, independent t-test, one way ANOVA Correlation and multiple regressions were used to analyze and present the data. Data analysis process is presented in Figure 3.2



Figure 3. 2 Data analysis process

- **Qualitative Design**

Qualitative research is an interactive subjective approach that emphasizes belief in multiple realities, commitment to identifying an approach of understanding that supports the phenomenon understudy,

commitment to the views of participants and giving them meaning. It involves collecting data in participants' setting, analyzing data inductively, building from particular to general themes and making an interpretation of the meaning (Creswell, 2014:247; Streubert Speziale & Carpenter, 2007:20; Burns & Grove, 2005:747). Furthermore, qualitative research is not a linear process and has no fixed design or plan (de Vos, et al., 2013:327). The qualitative design selected for this study aims to validate quantitative results with qualitative findings regarding perceptions of preceptors and nurse educators on preceptorship experiences in clinical nursing education in Botswana.

In this study qualitative data was collected concurrently with quantitative data to allow participants to describe their experiences during preceptorship in clinical nursing education in more detail. Qualitative data analysis provided clarification of some quantitative responses and yielded information needed to develop a preceptorship model to facilitate clinical nursing education in Botswana.

Sampling and sample size

The sampling and sample size are discussed in the next section

- ***Sampling***

Non probability-purposive sampling was employed in the qualitative component for both preceptors and nurse educators. The researcher selected participants based on knowledge of the participants' involvement and experiences with preceptorship activities. Creswell, (2014:189) emphasizes that participants or sites in qualitative research should be purposefully selected to assist the researcher understand the problem and research questions

Key informants in this study were preceptors and nurse educators who are facilitating preceptorship in Botswana. (de Vos et al, 2011:394). The researcher requested for names of nurse educators and preceptors who facilitated in preceptorship and similarly for names of preceptors from the HTIs. It was evident in the researcher's mind that preceptors and nurse educators involved with preceptorship activities would provide rich information about preceptorship. The FGDs were representative of preceptors from all levels of the country's health care delivery system namely; referral hospitals, district hospital and clinics where clinical learning for the higher diploma in general nursing students takes place. Similarly, FGDs for nurse educators were representative of different settings where HTIs are located namely: Urban, and village settings.

- ***Sample size***

The sample size for the qualitative design FGDs was determined by data saturation. Data saturation was reached after a total of three (3) FGDs for nurse educators with a total of 17 participants and three (3) FGDs for preceptors with a total of 22 participants were conducted. The FGDs was constituted of between five (5) and eight (8) participants. A total of 39 participants constituted the qualitative sample

size. To ensure that FGDs were representative of preceptors and nurse educators nationally, FGDs constituted participants from clinical settings in three (3) districts. The clinical settings representation included two referral hospitals one district hospital and clinics from the southern, central and northern regions of the country. For nurse educators, there was one FGD that constituted representatives from all six (6) health training institutions and the other two groups; one was from a mission / district HTI in a village setting and the other from a government HTI in a city. FGDs were purposively and strategically formed to maximize adequate representation of clinical setting and HTIs in the study to increase credibility, dependability, transferability and generalizability of findings.

Inclusion criteria:

- All nurse educators interacting with preceptors and level three (3) diploma students during preceptorship in clinical nursing education.
- Nurse educators with at least two (2) semester experience facilitating in preceptorship for preceptors and students.
- All preceptors supervising level three diploma students during preceptorship in clinical nursing education.
- Preceptors with at least one (1) one semester experience in the preceptorship role

Data collection process

Data collection and analysis was done concurrently. Prior to data collection for the main study, the researcher conducted a pilot study using one FGD comprising four participants. The purpose of which was to determine if the researcher was able to use appropriate interviewing and recording skills and to establish clarity of the questions on the interview guide. Demographic statistics were analyzed from the FGDs. The researcher collected data through 2x3 FGD s which were audio taped (by use of a voice recorder) from both nurse educators and preceptors and field notes were taken. One FGD for nurse educators' comprised representatives from all the six training institutions with their different experiences based on their resources and geographical location, years of teaching experiences and educational background. The researcher had the privilege to include this group of nurse educators because the researcher was aware that they were marking and moderating examinations in one of the six health training institutions at the time of data collection. The benefits of FGDs is that the gathered information is richer and has a deeper insight into the phenomenon under study as the participants can provide historical information and their experiences about the phenomenon under study.

The researcher minimized expenses associated with conducting FGDs by recruiting preceptors for each FGD from clinical settings based on close proximity of clinical settings within the district or sub district. The researcher directed the FGDs to keep the discussions on track and to mitigate the inevitable problems of too much time consumption since data was collected during working hours or lunch time and

participants were expected to continue with their routine duties for the day. This also minimized generating volumes of undesirable data.

Questioning to allow insight

The semi-structured FGD interview guides for preceptors and nurse educators comprised semi structured opened-ended questions that were intended to elicit experiences of participants regarding preceptorship. Discussions were audio-taped with permission from participants. In this study, audio material (voice recording) was used in all FGDs because of its potential of being an unobtrusive method of collecting data and gives participants a direct opportunity to share their reality as proposed in Creswell, (2014:191). FGDs allowed capturing verbatim information from participants thus reducing the risks of bias and misrepresentation that results from other methods. Questioning was encouraged to promote discussions and provide more insight into the discussion.

Capturing and handling data

FGDs interviews lasted between 40 minutes and 50 minutes and 18 seconds. Field notes and use of a voice recorder was done to capture participants' narratives and ensure accuracy and precision of responses. Brink et al (2014:122)'s basic actions that the researcher uses during an enquiry process were applied during FGDs and data analysis. The researcher bracketed out all personal knowledge and ideas about preceptorship and only considered narratives from nurse educators and preceptors. Intuiting was achieved through attentive listening as participants related their experiences/ views/ perception and gave suggestions about preceptorship. Member checking was done through recapping of discussions sessions. The researcher kept the discussions on track by guiding the discussions. There were no incidences whereby participants displayed emotional behaviors neither were there adverse events that occurred which necessitated the researcher to handle emotions during any of the FDGs. Participants did not receive any form of compensation at the end of discussions, besides a lunch which was provided

Data analysis and coding

Inductive content analysis was used. Content analysis is the process of categorizing verbal or behavioral data to classify, summarize and tabulate the data (Streubert Speziale & Carpenter, 2007:457; De Vos et al, 2011:394). Analysis was done through reading data again and again and listening to the voice recorder until it was clear to the understanding of the researcher. During reading the researcher focused on both the literary meaning of the data and tried to form personal interpretation of the meaning of the data. This was followed by open coding. Data coding is the process of data analysis whereby statements are grouped and given a code "label" for ease of identification later in the study (Streubert Speziale & Carpenter, 2007:457). In this study statements from collected data were grouped and assigned codes based on the responses and expressions of the participants in each FDG. Code patterns were developed from the identified codes based on the trends and frequency of the individual codes. Grouping of similar and

related codes was done to generate categories. Categories were further reduced by collapsing similar categories to generate themes. The researcher involved a qualitative research expert to assist with co-coding. Co-coding was done independently. The results of the two coders were then compared to identify similar codes. Repeated codes were further reduced to form themes and categories that emerged (Flo, & Kyngas, 2008:109).

Measures to ensure the quality of data

In the qualitative design, strategies to increase trustworthiness of qualitative research according to Lincoln and Guba's (1981) model were employed during data collection and analysis because they are crucial to the research quality.

Credibility: This refers to confidence in the truth of the data. Lincoln and Guba (1981:86-87) described the two aspects of credibility, namely, carrying out the investigation in a way that believability is enhanced. In this study, the researcher adopted the following strategies to ensure the truth value: 1) Establish a trusting relationship with the nurse educators, managers and preceptors to ensure relaxation during interview; 2) The engagement of a qualitative research expert to co code. Co coding was done independently and cross checking was done by comparing the results derived by each coder.

3) Literature control was adhered to and assisted the process of validating the findings in this research with work of other researchers; 4) Reflect other multiple realities as revealed by the research participant; and 5) Lastly, the truth value that Lincoln and Guba (in Polit et al., 2006:313) refer to as credibility was obtained from observing human opinions as they are lived by the participants.

Transferability: The researcher maintained persistent observation during FGDs, Detailed and thick description of data and precise recording and reporting was done to ensure *transferability* (Mouton, 2012:276-278). Transferability is important to establish the probability with which findings have meaning to others in similar situations (Streubert Speziale & Carpenter, 2007:49). Triangulation of methods was used to enhance *dependability*. This was done by detailed descriptions and coding and re-coding conducted for approximately 10 weeks. *Conformability* was established through accurate recording of descriptions and transcription of information and playing the recorded discussion and going back to participants where responses were presented to confirm that their experiences and suggestions had been correctly captured by the researcher as proposed in (Streubert Speziale & Carpenter, 2007:49). Conformability in this study was also ensured by availing the research raw data, field notes and data analysis documents for auditing.

Member checking: Participant verification was done by summarizing FGD discussions at the end of the discussion and asking the participants to verifying if all their views and opinions had been correctly captured. One group requested the researcher to play the recorded session for them to confirm their

responses and discussion session; this was compared with the transcription. To further ensure credibility and neutrality of this study, the researcher has made all raw data, field notes, data analysis documents, the interpretation of categories, as well as interview schedules available for auditing.

Peer review: Peers reviews were done during faculty PhD compulsory research seminars where each stage of the research was presented including the results.

3.5.2 Phase II: Mosel Development

The first step in the development of the model was to construct a conceptual framework using concepts identified from the mixed method approach and literature review of this study. The concepts were classified in accordance with Dickoff et al.,(1968:422-423), six (6) aspects or survey list components of practice theory generation namely: Agency, Recipient, Context or Framework, Terminus or end point, Procedure and Dynamics as depicted in figure 7.1.

The model development was based on Chinn and Kramer's (2102:185-196) components of a theory. Chinn and Kramer, (2012:176) identified the following components as essential in theory development: 1)overview 2)purpose, 3) definition of concepts, 4)assumptions, 5)relationship statements, between concepts and 6) the nature of the structure.

Overview: A model is a schematic presentation of how preceptorship will enhance clinical teaching. This model is based on the premise that preceptorship is necessary for effective clinical learning. The empirical data from both the nurse educators and preceptors in this convergent mixed method indicate the need for preceptorship model and guidelines of implementation therefore.

Addition to this is the fact that there is great pressure on the HTI's by authorities to produce clinical competent nurses to contribute to positive health outcomes. Clinical settings can provide such environments for promoting clinical competences. Thus, the model of preceptorship for effective clinical teaching is mandatory

Purpose: Chinn and Kramer (2012:186), assert that if a theory is purposeful its purpose should be identifiable. In this study the purpose of the preceptorship model is to facilitate clinical nursing education in Botswana.

Concepts identification: According to (Chinn & Kramer, 2012:246) a concept is a complex mental formulation of experiences, forms a major component of the theory and conveys abstract ideas within the theory. Concepts making up this theory were identified, from the findings of the convergent MM study and supporting literature review was classified according to Dickoff et al (1968:422-423). All the identified major concepts were included in the development of the model as they were deemed as having a significant meaning in the facilitation of effective preceptorship.

Definitions of concepts: Conceptual definitions for operationalization of the theory were given. The concepts were defined and explained in relation to their meaning and significance to preceptorship in nursing education and model developed to establish a communing meaning.

Relationships between concepts: Concepts should be related and structured into a systematic whole to provide the overall picture or wholeness of the theory or model (Chinn and Kramer, 2008:220). In the preceptorship model developed to facilitate clinical nursing education study, the relationship of concepts in the model has been described. A schematic representation of the model gives a visual illustration of relationships between the concepts as indicated by directional arrows (Figure 7.7).

Assumption: According to Chinn and Kramer (2012:178, 245), assumptions are basic structural components of a theory or basic givens taken for granted or thought to be true without empirical evidence because they are reasonable. The assumptions underlying the model have been generated according to the findings and application of the model to the preceptorship in clinical nursing education.

Structure: The structure depicts the overall form to the conceptual relationships within the model (Chinn and Kramer, 2012:191). The nature of the preceptorship model to facilitate clinical nursing education is envisaged in the description between the two contexts of preceptorship namely: HTIs and clinical setting that house all other concepts within the model. The directional arrows further illustrate how the agent, recipient, procedure and terminus contribute to whole process of preceptorship in the contexts in which it takes place in order to produce the desired clinical learning outcome.

3.6 ETHICAL CONSIDERATIONS

Ethics clearance was granted by the North-West University's Institutional Research Ethics Regulatory Committee (NWU-IRERC); *Ethics number NWU 00250-15-A9*. Written permission to carry out the study was sought from relevant institutional and districts' research and ethics boards and committees in Botswana namely: the Health Research Unit (Ministry of Health), clinical settings, districts' health management teams of the selected clinical settings, and health training institutions respectively (**See attached Appendices G & F**). Furthermore, participants were informed verbally and in writing that participation in the study was voluntary and that they were free to withdraw from the study at any time without fear of victimization or prejudice. Participants were informed that, no reward or re-imburement would be provided for participating in the study and no deliberate harm would be inflicted. An information sheet and consent form was provided for willing participants to sign as an agreement or consent for *voluntary* participation (**See attached on Appendices A, B C, D**).

Raw data was kept in a locked cabinet in the researcher's office and also in a password locked computer whereby only the researcher had access. Only results from the analysis of group data were reported as study findings, not individual participants' responses. No names of participants appear either in the

quantitative or qualitative responses. This was done to ensure *confidentiality*. Tape recorded information and questionnaire responses will be disposed after it has been typed, transcribed, validated, analyzed and a report written and thesis submitted and approved. No drugs were used of participants nor any form of intervention or manipulation done. There was no foreseeable harm to the participants as a result of participation in this study. Only codes were used to match the numbers of the data collection tools with the sample size for quantitative approach and FGDs participants'. All measures described under this section were to ensure that Ethical Principles of Justice, Respect, Beneficence, Privacy and Confidentiality and Autonomy were observed throughout the study.

3.7 SUMMARY

The study methodology has been discussed in detail with the convergent parallel mixed methods described. The purpose and objectives of the chapter were stated. The study was conducted in two phase namely; Empirical phase which comprised quantitative and qualitative data collection and analysis done concurrently. Measures to ensure the quality of data were explained. Phase two of the study constitutes model development. The model development process was described. Ethical considerations to ensure that the rights of participants are not violated have been indicated. Chapter 4 will present quantitative data collection and analysis.

CHAPTER 4

QUANTITATIVE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the descriptive quantitative design from both the preceptors and nurse educators. Data were collected using two separate four-point Likert scale questionnaires one for the preceptors and one for the nurse educators. The findings are categorized into demographic characteristics which depict the profile of respondents and descriptive variables that determine respondents' perceptions on during preceptorship according to research objectives. The descriptive variables are further organized under; structure, process and outcome of preceptorship (SPO) model in order to contextualize the results. Data were collected from a total of 157 respondents; 107 (68.1%) preceptors and 50 (31.9%) nurse educators. The data were captured and analyzed using Statistical Package for Social Sciences (SPSS) version 24. Frequency tables, percentages, independent t-test, one way ANOVA correlation and multiple regressions were used to analyze the data.

4.2 QUANTITATIVE FINDINGS FOR PRECEPTORS

Data are presented under demographics characteristics and experiences of respondents.

4.2.1 Preceptors' demographic characteristics

Table 4.1 outlines the summary of respondents' demographic characteristics; age, gender, years of experiences and qualifications. Completed questionnaires were coded and manually numbered after which data were entered in the SPSS version 24 software to create a database for analysis.

Table 4. 1 Preceptors' demographics profile

Demographic data		Preceptors(n= 107)	
		N	f (%)
Gender	Female	78	72.90
	Male	29	27.10
Age	25- 34	47	43.92
	35 -43	41	38.32
	44 – 64	19	17.76
Years of experience	1 – 4	49	45.79
	5 -9	39	36.45
	10 -19	16	14.95
	Missing	3	2.80
Highest Qualification	Bachelor of Nursing Science	19	17.76
	Bachelor of Education (Nursing)	0	0.00
	Post Basic Diploma in Family Nurse Practitioner	4	3.74
	Diploma in General Nursing	58	54.21
	Post Basic Diploma in Midwifery	21	19.63
	Master's Degree	0	0.0
	Other	5	4.67

- Gender and age of respondents**

The dominant respondents were female preceptors (n=78; 72.9 %) while their male counterparts constituted only (n=29; 27.1%). Ages of respondents ranged between 25 and 64 years. The majority (n=88; 82.24%) were aged between 25 years and 43years; while (n=19; 17.76%) fell in the age range of between 44 and 64 years of age. This implies that preceptors are relatively young nurses who may also not be experienced in the professional role. However, there was no literature found to support the relationship between the age of the preceptors and performance of the preceptorship role.

- Years of experience as a preceptor**

Forty-nine (45.79%) of the respondents indicated that they have been preceptors for a period of between 1 and 4 years; 39 (36.45%) had 5 to 9 years' experience and 16 (14.95%) had preceptorship experience that ranged from 10 to 19 years. Three (2.80%) of the preceptors did not respond to the item. Majority 88 (82.4%) had less than 10 years' experience; of which 49 (53.4%) of the 88 preceptor have preceptorship experience of between 1 and 4 years as preceptors. The findings indicate that preceptors are relatively young as depicted in Table 4.1. Years of experience for preceptors could also reflect lack of

experience in the profession and in clinical teaching. Callaghan et al., (2009:246) posited that during preceptorship students should be assigned to practice one-on-one with experienced clinicians who serve as resource persons through providing guidance to students.

- **Highest qualifications of respondents**

The basic nursing qualification for preceptors was general nursing either at diploma or degree level. The highest qualification for the preceptors was a Bachelor of Nursing Science degree held by (n=19; 17.76%). Preceptors with the highest qualification of diploma in general nursing with no other post basic qualification dominated (n=58; 54.21%). Some preceptors had post basic qualifications in addition to the basic diploma in general nursing. Diploma in general nursing and midwifery (n=21; 19.63%); Diploma in Family Nurse Practitioner (n=4; 3.57%). Some respondents did not specify their qualification but simply indicated them as other (n=5; 4.67%).

4.3 ANALYSIS AND INTERPRETATION OF FINDINGS FOR PRECEPTORS' RESPONSES

Analysis of the results has been organized according to SPO.

4.3 .1 Preceptors' perceptions on the structure of preceptorship

Table 4.2 outlines preceptors' responses to items or statements about the structure of preceptorship practices. A four-point, Likert-type rating scale with 19 statements addressing the structure of preceptorship was used. The rating scale ranged from 1=strongly disagree, 2= Disagree, 3= Agree, 4= Strongly Agree. The means and standard deviation (SD) for each item that described the structure of preceptorship were computed.

Table 4. 2 Preceptors' perceptions on the structure of preceptorship

No of Item	Statement	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	Std. Dev
	I recommend development of a preceptorship model specific to the Botswana context of preceptorship	5 (4.7)	3 (2.8)	21 (19.6)	75 (70.1)	3.50	0.965
	Preceptorship needs a lot of restructuring for it to meet its objectives	6 (5.6)	5 (4.7)	30 (28.0)	66 (61.7)	3.46	0.827
	I understand my role as preceptor	3 (2.8)	18 (16.8)	51 (47.7)	35 (32.7)	3.10	0.776
	I am confident with students' assessments and evaluation of clinical learning activities	0 (0.0)	18 (16.8)	57 (53.3)	31 (29.0)	3.09	0.734
	Criteria for preceptor selection need to be revisited	8 (7.5)	10 (9.3)	45 (42.1)	39 (36.4)	2.98	1.09
	The guidelines for preceptorship clearly outline the responsibilities of the preceptor, student and nurse educator	7 (6.5)	23 (21.5)	49 (45.8)	25 (23.4)	2.80	0.966
	I feel I have been adequately prepared for my role as preceptor	16 (15.0)	22 (20.6)	40 (37.4)	28 (26.2)	2.72	1.04
	Nurse educators provide clear learning objectives for the students and expectations for the preceptor at the beginning of clinical placement of students	13 (12.1)	34 (31.8)	39 (36.4)	21 (19.6)	2.64	0.936
	There is a clear model to guide preceptorship in clinical nursing education	20 (18.7)	35 (32.7)	37 (34.6)	15 (14.0)	2.44	0.953
	Nursing supervisors and Nursing superintendent / Matron (s)/ Principal Nursing officers are committed to the success of the Preceptorship	21 (19.6)	36 (33.6)	38 (35.5)	12 (11.2)	2.38	0.928
	My co-workers and supervisors are conversant of the goals of the preceptorship program	15 (14.0)	45 (42.1)	35 (32.7)	11 (10.3)	2.37	0.885
	The clinical setting management provides resources needed to facilitate preceptorship in the clinical setting	18 (16.8)	47 (43.9)	29 (27.1)	12 (11.2)	2.31	0.915

I have sufficient time to provide patient care while I function as a preceptor	23 (21.5)	42 (39.3)	31 (29.0)	11 (10.3)	2.28	0.919
Nursing supervisors and Managers are available and willing to help me develop in my role as a preceptor	16 (15.0)	53 (49.5)	27 (25.2)	10 (9.3)	2.27	0.864
My other responsibilities / assignments besides patient care activities allow me time to attend to the students' learning needs	22 (20.6)	44 (41.1)	34 (31.8)	7 (6.5)	2.24	0.856
The Health training institutions' management provides me with adequate teaching and learning resource to execute my preceptor role	23 (21.5)	48 (44.9)	25 (23.4)	8 (7.5)	2.11	0.922
I have sufficient time to discussion learning objectives with each individual student on a daily basis	26 (24.3)	54 (50.5)	19 (17.8)	8 (7.5)	2.08	0.848
I was selected by my supervisor to become a preceptor	0 (0.0)	1 (1.0)	16 (16.3)	36 (36.7)	1.97	1.87
I became a preceptor by opting to become a preceptor	0 (0.0)	0 (0.0)	18 (18.4)	28 (28.6)	1.69	1.84

Findings indicate mean scores ranged from (1.69 to 3.50). In order to determine the mean scores indicating agree and strongly agreed were added together, similarly those indicating disagree and strongly disagree responses were also added together. Means below 2.5 indicated disagree and strongly disagree responses to the statements, while means of 2.5 and above indicated agree and strongly agree responses. Out of 19 statements, a total of nine (n=9; 47.4) statements were rated with means ranging (2.60-3.50; SD $\pm$ 1.78-0.965) which indicated that participants agreed with the statements.

Preceptors' agreement with statements describing the structure of preceptorship

The majority of respondents (n=96; 87.7%) agreed with the statement: "I recommend development of a preceptorship model specific to Botswana context of preceptorship," compared to only (n=8; 7.5%) who disagreed; the mean score was (3.50; SD $\pm$ 0.97). Findings indicate a critical need for the development of a preceptorship model to facilitate clinical nursing education. The participants' responses to the above statement were also congruent with their responses to the following statement: "Preceptorship needs a lot of restructuring to meet its objectives", wherein (n=96; 87.7%) agreed compared to (n=11; 10.3%) who disagreed with a mean score (3.46; SD $\pm$ 0.827). "I understand my role as a preceptor" (n=86; 80.4%) agreed compared with (n=21; 19.6%) who disagreed, the mean score was (3.10; SD $\pm$ 0.776). Eighty-four

(n=84; 78.5%) of preceptors agreed that; “criteria for selection of preceptors need to be revisited as compared to (n=18; 16.5%) who disagreed, mean score was (2.98; SD $\pm$ 1.09). Findings reflect that there is a need to restructure preceptorship, develop a contextual preceptorship model for Botswana. However, preceptors indicated that they understood their preceptorship role and were self-assured that they were competent in performing assessments and evaluations of students’ clinical learning activities during preceptorship.

A total of seventy-four (n=74; 69.2%) preceptors agreed in their responses to the statement: “Guidelines for preceptorship clearly outline the responsibilities of the student, preceptor and nurse educator” in comparison to (n=30; 28%) who disagreed, while only three (n=3; 2.8%) did not respond to the item, the mean score was (2.80; SD $\pm$ 0.966). The statement: “Nurse Educators did provide clear learning objectives for students and expectations for the preceptor at the beginning of clinical placement of students” was agreed to by (n=60; 56%) compared to (n=47; 43%) who disagreed, the mean scores “was (2.64; SD $\pm$ 0.936). Sixty-eight (n=68; 63.4%) of the respondents agreed to the statement: “I feel I have been adequately prepared for my role as a preceptor” compared to (n=38; 35.6%) who disagreed, mean score (2.72; SD $\pm$ 1.04). Only (n=1; 0.9%) did not respond. The above findings reflect that respondents agreed with only a few statements that sought to determine their perceptions on the structure of preceptorship.

Preceptors’ disagreement with statements describing the structure of preceptorship

In response to the statement: “There is a clear model to guide preceptorship in clinical nursing education” (n=55; 51.5 $\pm$ %) disagreed compared with (n=52; 48.4%) who agreed, mean score response was (2.44; SD 0.953). This response is commensurate with their responses where they strongly agreed that they would recommend development of a preceptorship model specific to Botswana context preceptorship with the highest mean scores (3.50; SD $\pm$ 0.97). The item: “I became a preceptor by being selected by my supervisor” was answered by (n=53; 49.5%) of the respondents (n=52; 48.6%) agreed, whilst one (n=1; 0.9%) disagreed and nine (n=9; 8.4%) did not respond to the statement, mean (1.97; SD $\pm$ 1.87); “I became a preceptor by opting to become a preceptor” was answered by (n=46; 43%) who all agreed with the statement. “Nursing supervisors, superintendent/matrons/principal nurse officers are committed to the success of the preceptorship” (n=57; 53.3%) disagreed compared with (50; 46.7%) who agreed, mean score was (2.38; SD $\pm$ 0.928). Sixty (n=60; 56.1%) disagreed while (n=46; 43%) agreed with the statement: “My co-workers and supervisors are conversant with the goals of the preceptorship programme” the mean score was (2.37; SD $\pm$ 0.915), one preceptor (n=0.9%) did not respond to the statement.

Sixty-five (n=65; 60.7%) disagreed that: “The clinical setting management provides resources needed to facilitate preceptorship in the clinical setting” compared to (n=41; 38.3%) who agreed, mean score was

(2.31; SD 0.915). Similarly, (n=65; 60.7% disagreed in their responses to the statement: “I have sufficient time to provide patient care while I function as a preceptor while” (n=42; 39.3%) agreed, the mean score was (2.28; SD 0.919). Sixty-eight (n=68; 64.5%) disagreed with the statement: “Nursing supervisors and managers are available and willing to help the preceptors to develop in their role as a preceptor” compared to (n=37; 34.5%) who agreed, mean score response was (2.27; SD 0.864).

In response to the statement: “My other responsibilities / assignments besides patient care allow me to attend to the students learning needs” (n=66; 61.7%) disagreed compared to (n=41; 38.3%) who agreed, the mean score was (2.24; SD $\pm$ 0.856). Seventy-one (n=71; 66.4%) disagreed as compared to (n=33; 30.9%) who agreed to statement; “the management of health training institutions provide adequate teaching and learning resources to execute my preceptor role” while (n=3; 2.8%) did not respond to the statement. Another significant majority (n=80; 74.8%) disagreed compared to (n=27; 25.3%) who agreed with the statement: “I have sufficient time to discuss learning objectives with each individual student on daily basis” with the lowest mean (2.08; SD $\pm$ 0.848) as compared to (n=27; 25.2%) who agreed. Findings indicate that preceptors perceived that preceptorship is not well-structured to facilitate clinical nursing education. Furthermore, findings confirm that structures are not in place; resources are inadequate and some key stakeholders are not conversant with the expectations.

4.3.2 Preceptors’ perceptions on the process of preceptorship

This section discusses findings describing preceptors’ perceptions of processes available to preceptors during preceptorship. Focus was on relation to communication and support for preceptors, students and preceptorship activities. A total of 10 statements that described the processes available to students and preceptors comprised this section. Table 4.3 depicts the frequency distributions of preceptors’ responses to the different statements assessing preceptors’ perceptions on processes in place to facilitate implementation of preceptorship.

Table 4. 3 Preceptors' perceptions on the process of preceptorship

No. of Item	Statement	Strong Disagree	Disagree	Agree	Strong Agree	Mean	Std. Dev
	My co-workers and supervisors are supportive of the goals of the preceptorship program	14 (13.1)	30 (28.0)	51(47.7)	11(10.3)	2.53	0.883
	There is always clear and easy communication between preceptors and nurse educators during preceptorship	12 (11.2)	41 (38.3)	41 (38.3)	13 (12.1)	2.51	0.85
	Nurse educators' visits to the clinical setting are adequate to accord me the support I need	14 (13.1)	46 (43.0)	38 (35.5)	9 (8.4)	2.39	0.821
	Nurse educators are always available for me to share information on my experiences during preceptorship	15 (14.0)	46 (43.0)	37 (34.6)	9 (8.4)	2.37	0.83
	The number of students I supervise during each clinical learning-teaching is adequate to allow for adequate student- preceptor interaction	15 (14.0)	46 (43.0)	41 (38.2)	5 (4.7)	2.34	0.776
	My supervisor and management (Nursing superintendent / Matron (s)/ Principal Nursing officer) are committed to the success of the Preceptorship	23 (21.5)	38 (35.5)	38 (35.5)	7 (6.5)	2.25	0.902
	Nursing Managers are available to help me develop in my role as a preceptor	20 (18.7)	43 (40.2)	37 (34.6)	5 (4.7)	2.22	0.869
		26 (24.3)	37 (34.6)	38 (35.5)	5 (4.7)	2.19	0.892
	I have sufficient time to discussion learning objectives with each individual student on daily basis	29 (27.1)	53 (49.5)	20 (18.7)	5 (4.7)	2.00	0.807
	I am always in students accompaniment in the clinical setting (same shifts with the students) to facilitate learning	36 (33.6)	44 (41.1)	21 (19.6)	5 (4.7)	1.93	0.871

Preceptors' agreement with processes (Communication and support) in place to facilitate effective preceptorship

Findings indicate that out of the 10 statements assessed only two (n=2; 20%) were ranked with a means above 2.5 namely: "My core-workers and supervisors are supportive of the goals of the preceptorship programme" (n=62; 58%) agreed, mean score was (2.53; SD $\pm$ 0 .883) compared to (n=44; 41.1%) who disagreed, one (n=1; 0.9%) did not respond. "There is always easy and clear communication between preceptors and nurse educators during preceptorship" (n=54; 50.5%) agreed, in comparison with (n=53;

49.5%) who disagreed, mean score was (2.52; SD $\pm$ 0.85). However, although preceptors agreed, the low mean scores could imply responses of agree not strongly agree.

Preceptors' disagreement with processes in place to facilitate preceptorship

Preceptors in this study disagreed with most (n=8; 80%) statements that described the processes available to allow effective preceptorship and ranked them with means below 2.5. Statement wherein minimal or inadequate process to support preceptorship practice was indicated were:

“Nurse educators visits’ to the clinical setting are adequate to accord me the support I need”; (n=60; 56.1%) disagreed as compared to (n=47; 43.9%) who agreed the mean was (2.39; SD $\pm$ 0.821); “nurse educators are always available for me to share information on my experiences during preceptorship” (n=61; 57%) disagreed mean (2.37; SD $\pm$ 0.83) compared to (n=46; 43%) of the preceptors who agreed. Findings reflect that preceptors do not get adequate support from nurse educators.

Visits by nurse educators to the clinical settings to meet with preceptors and students to discuss the issues with preceptors and students at clinical settings or to share information that preceptors need to facilitate effectiveness of preceptorship are inadequate. In response to the statement; “the number of students I supervise during each clinical learning-teaching is adequate to allow for adequate student-preceptor interaction” (n=61; 57%) disagreed whilst (n=46; 43%) who agreed with the statement (2.34; SD $\pm$ 0.776). The insinuation from the findings is that interaction between preceptors and students is not adequate to allow for students’ supervision by preceptors as such students’ learning needs might not be met.

The preceptors disagreed with the following statements: “My supervisor and management (Nursing superintendent / Matron (s)/ Principal Nursing officer) are committed to the success of the Preceptorship” (n=61; 57%) mean (2.25; SD $\pm$ 0.902) disagreed compared with (n=46; 43%) who agreed, one preceptor (n=1; 0.9%) did not respond; “nursing managers are available to help me develop in my role as a preceptor” (n=63; 58.9%) disagreed as compared with (n=42; 39.3%) who agreed, mean (2.22; SD $\pm$ 0.869), two (n=2; 1.87) did not respond. “My workload is appropriate to allow me to function as a preceptor” (n=63; 58.9%) mean score (2.19; SD $\pm$ 0.892) disagreed while (42; 39.3%) agreed and one (n=1; 0.9%) did not respond. Findings further validated lack of support for preceptorship.

Other statements where the majority of respondents disagreed were: “I have sufficient time to discuss learning objectives with each individual student on daily basis” (n=82; 76%) disagreed compared with (n=25; 23.4%) who agreed, with a mean score of (2.00; SD $\pm$ 0.807); “I am always in the students’ accompaniment in the clinical setting (same shifts with the students) to facilitate learning”(n=80; 74.7%) disagreed as compared to (n=26; 24.3%) who agreed, mean score (1.93; SD $\pm$ 0.871). Responses to these statements are evidence that preceptors perceived lack or minimal support from their supervisors and

management of clinical settings; wherein preceptors are expected to carry the full workload as nurses at the same time perform the preceptor role.

4.3.3 Preceptors' perceptions of preceptorship outcomes

A total of 13 statements describing preceptors' perceptions about the outcomes of preceptorship comprised this section. Outcome statements focussed on challenges and benefits of preceptorship to both preceptors and students. Table 4.4 shows the frequency distributions of responses.

Table 4. 4 Preceptors' perceptions on the outcome of preceptorship

No. of Item	Statement	Strong Disagree	Disagree	Agree	Strong Agree	Mean	Std. Dev
	Students gain competence and proficiency in clinical skills during preceptorship	1 (0.9)	5 (4.7)	44 (41.1)	56 (52.3)	3.43	0.715
	By Being a preceptor I keep up-to-date and remain stimulated in my professional role	3 (2.8)	8 (7.5)	36 (33.6)	58 (54.2)	3.36	0.882
	Socializing students to the professional role of a nursing is fulfilling for me	3 (2.8)	6 (5.6)	37 (34.6)	58 (54.2)	3.35	0.922
	Being a preceptor has improved my organizational and leadership skills	2 (1.9)	9 (8.4)	43 (40.2)	50 (46.7)	3.26	0.905
	I am motivated to put in a great deal of effort beyond what is normally expected in order to help the students' clinical learning be successful	4 (3.7)	13 (12.1)	41 (38.3)	48 (44.9)	3.22	0.872
	My analytic and critical thinking skills have greatly improved	2 (1.9)	10 (9.3)	57 (53.3)	37 (34.6)	3.19	0.754
	I gain personal satisfaction from the preceptor role	5 (4.7)	12 (11.2)	50 (46.7)	39 (36.4)	3.13	0.859
	I have improved my teaching skills by being a preceptor	3 (2.8)	11 (10.3)	54 (50.5)	37 (34.6)	3.13	0.848
	My perception of the preceptor role is different from what I 'am expected to do	26 (24.3)	40 (37.4)	28 (26.2)	10 (9.3)	2.15	0.988
	The preceptorship role is stressful and frustrating	30 (28.0)	39 (36.4)	29 (27.1)	8 (7.5)	2.12	0.939
	I find that my values and the values of the preceptor program are different	23 (21.5)	49 (45.8)	25 (23.4)	6 (5.6)	2.06	0.909
	I still do not understand what the role of a preceptor entails	33 (30.8)	45 (42.1)	17 (15.9)	9 (8.4)	1.96	0.961
	Deciding to be a preceptor was a definite mistake on my part	61 (57.0)	35 (32.7)	5 (4.7)	4 (3.7)	1.51	0.781

Preceptors agreed with as outcomes of preceptorship

Out of the 13 statements assessing perceptions on outcomes of preceptorship in Table 4.4; the majority between (n=89-100; 83.1-93.4%) of preceptors agreed with eighty (n=8; 61.5%) of them with mean scores above 2.5, indicating responses of agree to strongly agree. Statements wherein the majority of respondents' were in agreement were; "students gain competence and proficiency in clinical skills during preceptorship" (n=100; 93.4%) agreed, whilst only six (n=6; 5.6%) disagreed one (n=1; 0.9%) did not respond and mean score rating was (3.43; SD $\pm$ 0.715). "by being a preceptor I keep updated and remain

current in my professional role” (n=94; 87.8%) agreed as compared to (n=11; 10.3%) who disagreed; mean score (3.36; SD $\pm$ 0.882) and two (n=2; 1.88%) did not respond; “socializing students to the professional role of a nurse is fulfilling for me” (n=95; 88.8%) agreed whilst (n=9; 8.4%) disagreed and three (n=3; 2.8%) failed to respond, mean score was (3.33; SD $\pm$ 0.992); “being a preceptor has improved my organizational and leadership skills” (n= 93; 86.9%) agreed in comparison to (n=11; 10.3) who disagreed, mean score (3.26; SD $\pm$ 0.905), three (n=3; 2.8%) did not respond; “I am motivated to put in a great deal of effort beyond what is normally expected in order to help the students clinical learning be successful” (n=89; 83.2%) agreed as compared to (n=17; 15.8%) who disagreed, only one (n=1; 0.9%) did not respond, mean (3.22; SD $\pm$ 0.872).

Similarly, in response to the items; “My analytic and critical think skills have greatly improved (n=94; 87.9) of the preceptors agreed compared to (n=12; 11.3%) who disagreed with two (n=2; 1.9%) who did not respond to the statement, mean score was (3.19; SD $\pm$ 0.754); “I gain personal satisfaction from the preceptor role (n=89; 83.1%) agreed, whereas (n=17; 15.8%) disagreed mean was (3.13; SD $\pm$ 0.859), only one (n=1; 0.9%) did not respond. “I have improved my teaching skills by being a preceptor” (n=91; 85.1%) preceptors agreed compared to (n=14; 13.1%) who disagreed mean (3.13; SD $\pm$ 0.848) only two (n=2; 1.88%) did not provide responses. The high numbers of preceptors who agreed to the statements imply that respondents perceived preceptorship to have benefits both students and preceptors.

Preceptors disagreed with as outcomes of preceptorship

Respondents disagreed with five (n=5; 38.5%) of the items with mean score ratings of below 2.5 namely: ‘My perception of the preceptor role is different from what I’m expected to do” (n=66; 61.7%) disagreed while (n=38; 35.5%) agreed, mean was (2.15; SD $\pm$ 0.988), three (n=3; 2.8%) did not respond; “the preceptorship role is stressful and frustrating” (n=69; 64.4%) disagreed as compared to (n=37; 34.6%) who agreed, with only one (n=1; 0.9%) who did not respond, mean was (2.12; SD $\pm$ 0.939). “I find that my values and the values of the preceptorship programme are different” (n=72; 67.3%) disagreed with the statement compared to (n=31; 29%) who agreed and four (n=4; 3.7%) did not indicate their responses. “I still do not understand what my role as a preceptor entails” (n=78; 72.9%) disagreed as compared to (n=26; 24.3%) who agreed, mean score was (1.96; SD $\pm$ 0.961), three (n=3; 2.8%) did not respond; “deciding to be a preceptor was a definite mistake on my part” (n=95; 89.7%) disagreed compared to nine (n=9; 8.4%) who agreed, while three (n=3; 2.8%) did not respond, the mean was (1.51; SD $\pm$ 0.781).

Influence of preceptors’ gender on preceptorship practices

Significant differences in perceived preceptorship practices under; structure, process and outcomes were determined based on the gender variable of the respondents. This was tested by performing independent t-test analysis. Due to a limited number of respondents in the other group (nurse educator), equal variances not assumed were used for reporting the analysis (see Table 4.5). There was no significant difference in

scores for females (m =49.40, SD = 8.25; m = 22.76, SD = 5.46; m = 35.96, SD = 6.19 and males (m = 50.79, SD = 8.00; m = 22.76, SD = 5.20; m= 35.62, SD = 3.16) for structure $t(51) = -.796$, $p > .430$, for process $t(52) = 0.28$, $p > .978$ and outcome $t(95) = .378$, $p > .78$ respectively. This means gender does not have influence on the preceptorship practices in all domains.

Table 4. 5 Independent t-test of the significant level to which gender influence preceptorship

	Gender of Preceptor	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval of the Difference	
						Lower	Upper
Structure	Female	78	49.40	8.259	.935		
	Male	29	50.79	7.988	1.483		
Process	Female	78	22.76	5.456	.618		
	Male	29	22.72	5.195	.965		
Outcome	Female	78	35.96	6.194	.701		
	Male	29	35.62	3.156	.586		
			Sig.	Mean	Std.	Error	
		T	Df	(2-tailed)	Difference	Difference	
Preceptorship Structure Items		-.796	51.10	.430	-1.39567	1.75357	-4.91494 2.12360
Equal variances not assumed							
Preceptorship Process Items		.028	52.46	.978	.03227	1.14563	-2.26611 2.33066
Equal variances not assumed							
Preceptorship Outcome Items		.373	94.89	.710	.34085	.91399	-1.47367 2.15537
Equal variances not assumed							

Age, qualifications and years of experience as preceptors influence on the preceptorship practice

One way analysis of variance (ANOVA) was used to determine difference in perceived preceptorship practices (Structure, Process and Outcome) and demographic variables (age, year of experience and qualifications) of respondents. The findings in Table 4.6, Table 4.7 and Table 4.8 were not statistically significant in perceived preceptorship practices and demographic variables at .05. This implies that age, year of experience and qualifications have no influence on preceptors' perceptions of preceptorship practice.

Table 4. 6 Analysis of variance to the level to which age influence preceptorship

	Age	N	Mean	Std. Deviation	Std. Error	Source of Variance	SS	Df	MS	F	Sig
Structure	25- 34	47	50.21	6.78	.99	Between Groups	96.04	2	48.02	.715	.492
	35 -43	41	50.22	7.91	1.24	Within Groups	6984.58	104	67.16		
	44 – 64	19	47.74	11.46	2.63						
	Total	107	49.78	8.17	.790	Total	7080.62	106			
Process	25- 34	47	22.81	5.36	.78	Between Groups	13.94	2	6.967	.239	.788
	35 -43	41	23.02	4.54	.71	Within Groups	3034.25	104	29.176		
	44 – 64	19	22.00	7.04	1.61						
	Total	107	22.75	5.36	.52	Total	3048.19	106			
Outcome	25- 34	47	35.60	6.77	.98821	Between Groups	180.66	2	90.33	3.074	.050
	35 -43	41	37.24	3.68	.57465	Within Groups	3055.51	104	29.38		
	44 – 64	19	33.58	4.73	1.09						
	Total	107	35.86	5.53	.534	Total	3236.17	106			

Table 4. 7 Analysis of variance to the level to which year of experience as preceptors influence preceptorship

	Years of Experience as Preceptor	N	Mean	Std. Deviation	Std. Error	Source of Variance	SS	Df	MS	F	Sig
Structure	1 – 4	37	49.11	7.75	1.27	Between Groups	29.78	2	14.89	.220	.803
	5 -9	40	50.35	7.59	1.20	Within Groups	7050.83	104	67.79		
	10 -19	30	49.83	9.55	1.74						
	Total	107	49.78	8.17	.79	Total	7080.62	106			
Process	1 – 4	37	22.27	5.28	.87	Between Groups	24.323	2	12.16	.418	.659
	5 -9	40	23.35	5.20	.82	Within Groups	3023.86	104	29.07		
	10 -19	30	22.53	5.77	1.05						
	Total	107	22.75	5.363	.52	Total	3048.17	106			
Outcome	1 – 4	37	36.24	3.25	.54479	Between Groups	75.92	2	37.96	1.25	.290
	5 -9	40	36.52	5.03	.69329	Within Groups	3160.25	104	30.39		
	10 -19	30	34.53	3.37	.24323						
	Total	107	35.87	5.53	.53	Total	3236.17	106			

Table 4. 8 Analysis of variance of level to which qualifications of preceptors influence preceptorship

	Preceptor Qualification	N	Mean	Std. Deviation	Std. Error	Source of Variance	SS	Df	MS	F	Sig
Structure	Bachelor of Nursing Science	19	50.78	8.80	2.02	Between Groups	609.28	4	152.32	2.4	0.055
	Diploma in Family Nurse	4	44.50	3.87	1.936	Within Groups	6471.33	102	63.44		
	Diploma in General Nursing	58	50.09	6.708	0.88						
	Diploma in Nursing & Midwifery	21	47.10	10.444	2.279						
	Other	5	57.80	8.44	3.773						
	Total	107	49.79	8.173	0.79	Total	7080.61	106			
Process	Bachelor of Nursing Science	19	23.16	5.37	1.23132	Between Groups	121.62	4	30.40	1.06	0.380
	Diploma in Family Nurse	4	21	4.69	2.35	Within Group	2926.57	102	28.69		
	Diploma in General Nursing	58	22.84	5.37	0.706						
	Diploma in Nursing & Midwifery	21	21.52	5.38	1.17						
	Other	5	26.60	5.32	2.38						
	Total	107	22.75	5.36	0.52	Total	3048.187	106			
Outcome	Bachelor of Nursing Science	19	35.32	3.40	0.78	Between Groups	28.86	4	7.21	0.229	0.92
	Diploma in Family Nurse	4	37.25	4.20	2.10	Within Groups	3207.31	102	31.44		
	Diploma in General Nursing	58	35.71	6.44	0.85	Within Groups					
	Diploma in Nursing & Midwifery	21	36.19	5.31	1.15803						
	Other	5	37.4	2.30	1.03						
	Total	107	35.87	5.52	0.53	Total	3236.17	106			

Relationship between preceptorship practices and preceptors' related demographic information

The objective was to explore and describe the relationship between the level of preceptorship practices and the demographic information of the respondents. Preliminary analyses were conducted to ensure that there was no violation of the assumptions' normality, linearity, multicollinearity and homoscedasticity. Table 4.8 summarizes the relationship between preceptorship practices and selected independent

variables. The findings revealed that, the correlation values for predictors and preceptors perception on the preceptorship practices (structure, process and outcomes) at alpha level .05 were not statistically significant. This implies that there was no association found between the predictors (age, years of experience as preceptors and qualifications) and perception on preceptorship practices. None of the predictors explained the model of the regression analysis as shown in Table 4. 9.

Table 4. 9 Matrix of Pearson correlation of the relationship among the preceptors' related demographic information and preceptorship

	Outcome	Structure	Process	Age	Years of experience as a preceptor
Outcome					
Structure	.240*				
Process	.233*	.688**			
Age	-.082	-.189	-.140		
Years of experience as a preceptor	-.092	.050	.068	.219*	
Nursing Qualification	.064	.018	.018	.008	.040

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table 4.10 shows the regression of the preceptors' demographic characteristics and communication and support for preceptorship practices. The results revealed that preceptors demographic characteristics (gender of participants, age, years of experience as a preceptor, nursing qualification) and support for preceptorship practice were not significantly correlated at ($p = .05$). Though the variables were not significant, the R squared values years of experience as a preceptor and nursing qualifications for preceptors were .031 which meant that both the two factors accounted for 3.3% of the variance in the preceptor's views on the support for preceptorship practices.

Table 4. 10 Regression of support variables and demographic information on preceptorship

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	F	Sig.
1	.003 ^a	.000	-.010	5.38796	.001	.978
2	.142 ^b	.020	.001	5.35910	2.134	.147
3	.175 ^c	.031	.002	5.35643	1.104	.296
4	.175 ^d	.031	-.007	5.38203	.022	.882
a. Predictors: (Constant), Gender of Participants						
b. Predictors: (Constant), Gender of Participants, Age						
c. Predictors: (Constant), Gender of Participants, Age, Years of experience as a preceptor						
d. Predictors: (Constant), Gender of Participants, Age, Years of experience as a preceptor, Nursing qualification						
e. Dependent Variable: Process : Communication and support						

Table 4.11 regression coefficients of preceptors' demographic characteristics and communication and support for preceptorship practices. From this model in Table 4.11, gender of participants $t(104) = 0.267$, $p > .790$, age $t(104) = -1.65$, $p > .102$, years of experience as a preceptor $t(104) = 1.039$, $p > .301$ and nursing qualification, $t(104) = 0.149$, $p > .882$ are all not significant predictors of the perceived support for the preceptorship practice. This implies that each regression coefficients (b-values) did not significantly predict the outcomes when the effects of all predictors are held constant.

Table 4. 11 Regression coefficients of process variable and demographic information on preceptorship as perceived by preceptors

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	SE	B	T	
(Constant)	24.559	2.517		9.757	.000
Gender of Participants	.319	1.193	.027	.267	.790
Age	-.087	.053	-.168	-1.648	.102
Years of experience as a preceptor	.145	.140	.104	1.039	.301
Nursing qualification	.016	.109	.015	.149	.882
a. Dependent Variable: Process Support Variable , b–regression coefficient , SE – standard error, β Standardized regression coefficient (beta weight), t-statistic, P- significance level					

Table 4. 12 Regression of structural variable and demographic information on preceptorship as perceived by preceptors

Model	R	R ²	Adjusted R ²	Std. Error of the Estimate	F	Sig.
1	.076 ^a	0.006	-0.004	8.18793	0.614	0.435
2	.220 ^b	0.049	0.03	8.04829	4.675	0.033
3	.241 ^c	0.058	0.03	8.04781	1.013	0.317
4	.241 ^d	0.058	0.021	8.08659	0.014	0.904
a. Predictors: (Constant), Gender of Participants						
b. Predictors: (Constant), Gender of Participants, Age						
c. Predictors: (Constant), Gender of Participants, Age, Years of experience as a Preceptor						
d. Predictors: (Constant), Gender of Participants, Age, Years of experience as a Preceptor, Nursing qualification						
e. Dependent Variable: Preceptorship Structure						

Table 4. 13 Regression coefficients of structural variable and demographic information on preceptorship as perceived by preceptors

Model	Unstandardized Coefficients		Standardized Coefficients	T	P
	B	SE	Beta (β)		
(Constant)	52.402	3.782		13.856	.000
Gender of Participants	2.156	1.792	.118	1.203	.232
Age	-.184	.079	-.232	-2.319	.022
Years of experience as a preceptor	.209	.210	.098	.996	.322
Nursing qualification	.020	.164	.012	.120	.904
*Dependent variable: Preceptorship Structure, b – regression coefficient , SE – standard error, β standardized regression coefficient (beta weight), t –statistic, P- significance level					

4.4. ANALYSIS AND INTERPRETATION OF FINDINGS FOR NURSE EDUCATORS' RESPONSES

Fifty (n=50) nurse educators who completed and returned the self-administered questionnaires constituted 31.8% of the participants for the quantitative design of the study.

4.4. 1 Demographic characteristics nurse educators

The demographic characteristics of respondents were presented as age, gender, experience and qualifications. Table 4.14 outlines the summary of nurse educators' demographic characteristics and professional profile.

Table 4. 14 Nurse educators' demographic profile

Demographic Information		(N =50)	
		N	f (%)
Gender	Female	30	60
	Male	20	40
Age	25- 34	9	18
	35 -44	17	34
	45-54	18	36
	55 – 64	6	12
Years of experience as a Nurse Educator	1 – 4	4	8
	5 -9	15	30
	10 -19	26	52
	Missing	5	10
Duration of time following preceptors and students (years)	1-4	6	12
	5-9	17	34
	10-14	7	14
	15-19	13	26
	20-25	4	8
	Missing	1	2
Highest Nursing Qualification	Bachelor of Nursing Science	28	54
	Bachelor of Education (Nursing)	7	12
	Master Degree (in different nursing fields and public Health)	15	30

Gender and ages of nurse educators

Females dominated the nurse educators' respondents (n=30; 60%) while males constituted (n=20; 40%). The age range for nurse educators was between 30 and 57 years. The age range distribution were as follows; 25-34 years (n=9; 18%); 35-44 (n=17; 34%); 45-54 years (n=18; 36%); 55-64 years (n=6; 12%). The findings showed that (n=26; 52%) were aged between 35 and 44 years whilst the remaining (n=24;

48%) were aged between 45 and 64. The findings reflect a balance in the ages of nurse educators suggesting that both the young and elderly were involved in preceptorship activities.

Years of experience as a nurse educator

Ninety six percent (n=45; 90.0%) of nurse educators responded while five (n=5; 10%) did not respond. The experiences of the respondents ranged between 2 and 26 years. The years of experience were categorized as follows; 1-4 years (n=4; 8%); 5-9 years (n=15; 30%); 10- 14 (n=); 15- 19 (n=13). The majority (n=36; 72%) of respondents had teaching experience of between six (6) and over 26 years. The many years of experience for nurse educators might be an indication of competence in clinical nursing education and accentuate the importance of their participation in this study. As key facilitators for preceptors and students during preceptorship, the input of nurse educators is essential in the development of a contextual preceptorship model.

Duration of time following students and preceptors during preceptorship

Response rate was (n=48; 96%) with only two (n=2; 4%) who did not respond to the item. The time nurses educators have followed students and preceptors during preceptorship ranges between four (n=4) and 25 years the longest time was 23 years. Responses are as follows: 1-4years (n=6; 12%); 5-9 years (n=17; 34%); 10-14 years (n=7; 14%); 15-19 years (n=13; 26%); 20-25 years (n=4; 8%). Findings show that the majority (n=43; 86%) of nurse educators had less than 20 years' experience with preceptorship practices.

Highest qualifications of nurse educators

Nurse educators possessed varying qualification; the minimum qualification was bachelor's degree and highest a master's degree. Qualifications were categorized as follows: Bachelor of Nursing Science (n=25; 56.0%); Bachelor of Education-Nursing (n=7; 14.0%); Master's degree (n=15; 30.0%). The findings indicate that although all nurse educators are prepared at a minimum of bachelor's degree level, a few have a teaching or education qualification (see table 4.14). The implication from the findings is that lack of an education or teaching qualification can have a negative impact on the competence of nurse educators in providing pedagogical support and advice to preceptors and students.

4.4.2 Nurse educators' perceptions on the structure of preceptorship

Table 4.15 presents results from analysis of nurse educators' responses on the structure of preceptorship in relation to resources, selection and preparation of preceptors.

Table 4. 15 Nurse educators' perceptions on the structure of preceptorship

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	Std. Dev
I would recommend development of a model of preceptorship to facilitate clinical nursing education in Botswana	1 (2.0)	2 (4.0)	6 (12.0)	41 (82.0)	3.74	0.632
Selection criteria for preceptors should be revisited	3 (6.0)	5 (10.0)	9 (18.0)	33 (66.0)	3.44	0.907
Preceptorship should be re-structured if it is to meet its intended objectives	12 (24.0)	1 (2.0)	10 (20.0)	26 (52.0)	2.96	1.31
Guidelines for preceptorship are availed to preceptors and student at the beginning of internship /preceptorship	2 (4.0)	17 (34.0)	17 (34.0)	14 (28.0)	2.86	0.88
The roles of a preceptor, student, and nurse educator are clearly defined during preceptorship	5 (10.0)	21 (42.0)	17 (34.0)	7 (14.0)	2.52	0.863
I mobilize all resources needed by students and preceptors at the beginning of preceptorship	6 (12.0)	19 (38.0)	23 (46.0)	1 (2.0)	2.34	0.798
I know and understand the preceptorship model used for clinical nursing education used during preceptorship	15 (30)	11(22.0)	19 (38.0)	5 (10.0)	2.28	1.01
I experience no challenges to meet and discuss preceptorship issues and challenges with: Preceptors	14 (28.0)	22 (44.0)	12 (24.0)	2 (4.0)	2.04	0.832
I experience no challenges to meet and discuss preceptorship issues and challenges with: Preceptor's supervisors	13 (26.0)	25 (50.0)	7 (14.0)	4 (8.0)	2.00	1.96
I experience no challenges to meet and discuss preceptorship issues and challenges with: Clinical setting managers	15 (30.0)	22 (44.0)	9 (18.0)	3 (6.0)	1.96	0.902
The model of preceptorship used in Botswana's nursing education is known and well understood by all nurse educators, students and preceptors involved in preceptorship activities	14 (28.0)	29 (58.0)	7 (14.0)	0 (0.0)	1.86	0.639
Clinical setting (s) management provide preceptors with resources need for clinical teaching and learning	15 (30.0)	30 (60.0)	3 (6.0)	2(4.0)	1.84	0.71
Preceptors have adequate time to perform their nursing role and the guide students during their clinical learning	25 (50.0)	19 (38.0)	4 (8.0)	1 (2.0)	1.58	0.758
Getting nurses to serve as preceptors is not a challenge	27 (54.0)	17 (34.0)	4 (8.0)	1 (2.0)	1.54	0.761
Preceptors do not need any special preparation, any professional nurse is a competent preceptor	37 (74.0)	9 (18.0)	0 (0.0)	4 (8.0)	1.42	0.859
The workload of the preceptor allows the preceptors to execute the preceptor role efficiently	31 (62.0)	16 (32.0)	1 (2.0)	1 (2.0)	1.40	0.67

Nurse educators' agreement with statements describing the structure of preceptorship

This section comprised of a total of 16 statements that constituted items describing the structure of preceptorship. Out of 16, only five (n=5; 31.3%) had means of above 2.5 which reflected that respondents

agreed to the item namely: “I would recommend development of a model of preceptorship to facilitate clinical nursing education in Botswana” (n=47; 94%) agreed compared to (n=3; 6%) who disagreed, mean was (3.74; SD $\pm$ 0.632); “selection criteria for preceptors should be revisited” (n=42; 84%) agreed, while (n=8; 16%) disagreed, the mean score was (n=3.44; SD $\pm$ 0.907); “Preceptorship should be re-structured if it is to meet its intended objectives” (n=36; 72%) agreed in comparison to (n=13; 26%) who disagreed, mean (2.96; SD $\pm$ 1.31) and one (n=1; 2%) did not respond to the item. Responses indicate a need for development of a model to facilitated preceptorship and that the current preceptorship programme needs restructuring.

In response to; “guidelines for preceptorship are availed to preceptors and student at the beginning of internship /preceptorship” (n=31; 62%) agreed as compared to (n=19;38%) who disagreed, the mean was (n=2.86; SD $\pm$ 0.88); “the roles of a preceptor, student, and nurse educator are clearly defined during preceptorship” (n=24; 48%) agreed while (n=26; 52%) disagreed, mean rating was (2.52; SD $\pm$ 0.863). Although less than 50% (n=24; 48%) agreed with the item, the mean and standard deviation (SD) indicate that the nurse educators who agreed did not only agree, but strongly agreed with the statements. The few number statement (n=5; 31.5%) wherein respondents agreed with as structures and resources available to facilitate the implementation of preceptorship compared with (n=11; 68.8%) which they disagreed with; implies that preceptorship is not well organized.

Nurse educators’ disagreement with statements describing the structure of preceptorship

Nurse educators disagreed with the following (n=11; 68.8%) statements describing the structure of preceptorship as reflected by means below 2.5 namely; “I mobilize all resources needed by students and preceptors at the beginning of preceptorship” (n=25; 50%) disagreed while (n=24; 48%) agreed with a mean score of (2.34; SD $\pm$ 0.798); “I experience no challenges to meet and discuss preceptorship issues and challenges with preceptors” (n=36; 72) agreed compared to (n=14; 28%) who disagreed, mean was (2.04; SD $\pm$ 1.01); “I experience no challenges to meet and discuss preceptorship issues and challenges with preceptors’ supervisors (n=38; 76%) of nurse educators disagree while (n=11; 22%) agreed with the statement mean (2.00; 1.96), one (n=1; 2%) did not respond.

Other high numbers of respondents disagreed with the statements; “I experience no challenges to meet and discuss preceptorship issues and challenges with clinical setting managers” (n=37;74%) while (n=12;24%) agreed mean was (1.96; SD $\pm$ 0.902), two (n=2;4%) did not respond; “the model of preceptorship used in Botswana’s nursing education is known and well understood by all nurse educators, students and preceptors involved in preceptorship activities” (n=43; 86%) agreed as compared to (n=7; 14%) who disagreed, mean was (1.86; SD $\pm$ 0.639). “Clinical setting (s) management provide preceptors with resources need for clinical teaching and learning” (n=45; 90%) disagreed whilst five (n=5; 10%) agreed, mean score (1.84; SD $\pm$ 0.71); “preceptors have adequate time to perform their nursing roles and

guide students during their clinical learning” (n=44; 88%) disagreed in comparison with only (n=5; 10%) who agreed, while only one (n=1; 2%) did not respond, mean was (1.54; SD $\pm$ 0.758).

Nurses educators further disagreed with the following: “Getting nurses to serve as preceptors is not a challenge” (n=44; 88%) disagreed as compared to (n=5; 10%) who agreed, mean was (1.54; SD 0.761) with one missing response. These responses imply that there is a shortage of preceptors if getting nurses to preceptors is a challenge; “preceptors do not need any special preparation, any professional nurse is a competent preceptor” (n=46; 92%) disagreed while only (n=4; 8%) agreed, mean score rating was (1.42; SD $\pm$ 0.859). The majority (n=47; 94%) of respondents disagreed, while only two (n=2; 4%) agreed with statement; “the workload of the preceptor allows the preceptors to execute the preceptor role efficiently” while one (n=1; 2%) did not respond. Findings are suggestive that preceptorship is not well structured in terms of availability and adequacy of essential resources (human, time and equipment) needed to facilitate implementation of preceptorship. The large numbers of respondents who disagreed with statements describing the structure of preceptorship authenticates that the need for development of a preceptorship model to facilitate preceptorship in terms of resource mobilization is pivotal for the success of preceptorship.

4. 4.3 Nurse educators’ perceptions on the process of preceptorship

A total of 17 statements that sought to describe perceptions of nurse educators about processes in place to facilitate preceptorship comprised this section. Focus was on support for preceptors and communication during preceptorship. Table 4.16 gives frequency distribution of the findings.

Table 4. 16 Nurse educators' perceptions on the process of preceptorship

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	Std. Dev
Communication between nurse educators and preceptors is adequate to facilitates effective clinical teaching and learning	9 (18.0)	25 (50.0)	14 (28.0)	2 (4.0)	2.18	0.774
All preceptors are trained / orientated for the preceptor role	16 (32.0)	20 (40.0)	12 (24.0)	2 (4.0)	2.00	0.857
Preceptors are confident to evaluate students' clinical activities objectively	13 (26.0)	26 (52.0)	11 (22.0)	0 (0.0)	1.96	0.698
Preceptors' co-workers and supervisors are supportive of the goals of the preceptorship program	14 (28.0)	26 (52.0)	9 (18.0)	1 (2.0)	1.94	0.74
Management of health training institution provide me and preceptors with the support need to make preceptorship a success	17 (34)	21 (42.0)	11 (22.0)	1 (2.0)	1.92	0.804
The number of students allocated to a preceptor allows effective clinical teaching and supervision of students	16 (32.0)	25 (50.0)	7 (14.0)	2 (4.0)	1.90	0.789
Preceptors have autonomy to manipulate preceptorship objectives in order to align them with learning activities in the clinical setting	18 (36.0)	22 (44.0)	8 (16.0)	2 (4.0)	1.88	0.824
The visits I make to the clinical settings to meet preceptors, and students and discuss their needs, concerns and challenges are adequate to assist them achieve preceptorship objectives	18 (36.0)	25 (50.0)	5 (10.0)	2 (4.0)	1.82	0.774
Due to time constraints and workload I only follow students and preceptors for assessments and seminars	4 (8.0)	14 (28.0)	19(38.0)	13 (26.0)	1.82	0.774
The preceptor selection criteria is consistent with what is spelt out in preceptorship literature	17 (34.0)	25 (50.0)	5 (10.0)	2 (4.0)	1.80	0.808
Preceptors' co-workers and clinical setting management are conversant with preceptorship, its objectives and expectations	16 (32.0)	28 (56.0)	6 (12.0)	0 (0.0)	1.80	0.639
A great number of nurses are willing to serve as preceptors for the health training institutions	22 (44.0)	19 (38.0)	7 (14.0)	2 (4.0)	1.78	0.84
The preceptor (s) are able to plan students' learning activities appropriately	20 (40.0)	25 (50.0)	5 (10.0)	0 (0.0)	1.70	0.647
Duration of preceptor training/ orientation is adequate to equip preceptors with teaching and students' assessment skills	18 (36.0)	27 (54.0)	4 (8.0)	0 (0.0)	1.68	0.652
Preceptor training is well structured and coordinated across all health training institutions	22 (44.0)	23 (46.0)	4 (8.0)	0 (0.0)	1.60	0.67
Preceptors are always with students the clinical setting (same shifts with the students) to facilitate their learning	30 (60.0)	18 (36.0)	2 (4.0)	0 (0.0)	1.44	0.577
Preceptors' workload is reduced to allow them to carry out the preceptorship roles	35 (70.0)	13 (26.0)	2 (4.0)	0 (0.0)	1.34	0.557

Nurse educators' responses to statements describing the processes to facilitate preceptorship

Out of the 17 statements describing preceptorship processes, no statement had a mean score rating of 2.5 and above which implies that respondents disagreed with the statements. The findings indicate that the

majority of nurse educators disagreed with most of the items namely; “Communication between nurse educators and preceptors is adequate to facilitates effective clinical teaching and learning” (n=34; 68%) disagreed compared with (n=16; 32%) who agreed, mean score was (2.18; SD $\pm$ 0.774); “all preceptors are trained or oriented for the role of a preceptor” (n=36; 72%) disagreed compared with (n=14; 25%) who agreed, mean score (2.00; SD $\pm$ 0.857); “preceptors are confident to evaluate students clinical activities objectively” (n=39; 78%) disagreed, while (n=11; 22%) were in agreement, the mean rating was (1.96; SD $\pm$ 0.698); “preceptors co-workers and supervisors’ are supportive of the goals of the preceptorship programme” (n=40; 80%) disagreed in comparison with (n=10; 20%) who agreed, mean was (1.94; SD $\pm$ 0.74). “Management of health training institutions provide me and the preceptors the support needed to make preceptorship a success (n=38; 76%) disagreed, while (n=12; 24%) agreed, mean was (1.92; SD $\pm$ 0.804).

High numbers of nurse educators (n=41-48; 82-96%) disagreed with the following statements: “The number of students allocated to a preceptor allows effective clinical teaching and supervision of students” (n=41; 82%) disagreed whilst (n=9; 18%) agreed, mean score (1.90; SD $\pm$ 0.789); “preceptors have autonomy to manipulate preceptorship objectives in order to align them with learning activities in the clinical setting” (n=40; 80%) disagreed compared with (n=10; 20%) who agreed, mean score rating (1.88; SD $\pm$ 0.824); “the visits I make to the clinical settings to meet preceptors and students and discuss challenges are adequate to assist them achieve preceptorship objectives” (n=43; 86%) disagreed while (n=7; 14%) agreed, mean was (1.82; SD $\pm$ 0.774); “the preceptor selection criteria is consistent with what is spelt out in preceptorship literature” (n=42; 84%) disagreed as compared to (n=7; 14%) who disagreed, one (n=1; 2%) did not respond mean score rating (1.80; SD $\pm$ 0.808).

Another significantly high number of nurse educators; (n=45-48; 90-96%) disagreed with the following statements: “Preceptors’ co-workers and clinical setting management are conversant with preceptorship, its objectives and expectations” (n=44; 88%) disagreed as compared to (n=6; 12%) who agreed, mean score was (1.80; SD $\pm$ 0.639); “a great number of nurses are willing to serve as preceptors for health training institutions” (n=41; 82%) disagreed as opposed to (n=9; 18%) who agreed, mean was (n=1.78; SD $\pm$ 0.84); “the preceptor (s) are able to plan students’ learning activities appropriately” (n=45; 90 %) disagreed compared to five (n=5; 10%) who agreed, mean was (1.70; SD $\pm$ 0.647); “duration of preceptor training/ orientation is adequate to equip preceptors with teaching and students’ assessment skills” (n=45; 90 %) disagreed in comparison with only four (n=4; 8%) who agreed, mean score was (1.68; SD $\pm$ 0.652) one (n=1; 2%) did not respond. “Preceptor training is well structured and coordinated across all health training institutions” (n=45; 90%) disagreed compared with (n=4; 8%) who agreed, mean was (n=1.06; SD 0.67), there was one (n=1; 2%) missing response.

In response to the statements: “Preceptors are always with the students in the clinical settings (same shifts with the students) to facilitate their learning” and “preceptors’ workload is reduced to allow them to carry

out the preceptorship role” (n=48; 96%) disagreed on both items while only (n=2; 4%) agreed. The mean scores for the two responses were (n=1.44; SD 0.577 and 1.34; SD 0.557) respectively. Findings confirm that preceptors are not supported in their role. Despite nurse educators disagreeing with almost all statements; (n=32; 64%) agreed and (n=18; 36%) disagreed in their response to the statement; “due to time constraints and workload I only follow students and preceptors for assessments and seminars” mean score (1.82; SD $\pm$ 0.774). The responses to this statement are indicative that nurse educators are overwhelmed with other responsibilities such that they lack time to provide support and guidance needed by students and preceptors during preceptorship. Findings suggest that the current situation on preceptorship is not supportive to preceptors, students and nurse educators. The lack of support of or inadequate processes to facilitate implementation of preceptorship compromises the quality of clinical teaching and learning. Based on the findings; the insinuation for the development of a preceptorship model that is cognisant of adequate structures and processes to facilitate preceptorship during clinical nursing education on Botswana in line with the purpose of this study cannot be over emphasized.

4. 4.4 Perceptions of nurse educators on the outcome of preceptorship

A total of 13 statements that described perceptions of nurse educators about the outcome of preceptorship mainly, challenges and benefits constituted this section. The statements focused on perceived benefits and challenges of preceptorship. Table 4.17 illustrates frequency distribution of the findings.

Table 4. 17 Nurse educators 'perceptions on the outcome of preceptorship

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree	Mean	Std. Dev
Students and preceptors experience frustration and stress during preceptorship period	4 (8.0)	12 (24.0)	24 (48.0)	8 (16.0)	3.50	5.77
Preceptorship is an added responsibility to the nurse	2 (4.0)	5 (10.0)	17 (34.0)	26 (52.0)	3.34	0.823
Preceptors are not allocated time to perform the preceptor role	4 (8.0)	6 (12.0)	15 (30.0)	24 (48.0)	3.14	1.05
Preceptorship increases the preceptor's teaching and students' evaluation skills	1 (2.0)	8 (16.0)	29 (58.0)	11 (22.0)	2.96	0.807
Students gain competences in clinical skills and decision making	1 (2.0)	7 (14.0)	32 (64.0)	9 (18.0)	2.94	0.767
Preceptorship provides profession growth and development for preceptors	4 (8.0)	5 (10.0)	19 (38.0)	19 (38.0)	2.94	1.17
Preceptorship has more benefits for students clinical learning than the traditional faculty-student model of clinical teaching	8 (16.0)	4 (8.0)	21 (42.0)	13 (26.0)	2.62	1.26
Preceptors keep abreast with current issues and trends in nursing and education because of the demands of their role	7 (14.0)	13 (26.0)	18 (36.0)	11 (22.0)	2.62	1.06
Students who have undergone preceptorship during their training excel in the professional role upon completion of training	4 (8.0)	16 (32.0)	18 (36.0)	9 (18.0)	2.52	1.07
There is role ambiguity between preceptors and nurse educators	5 (10.0)	21 (42.0)	14 (28.0)	8 (16.0)	2.42	1.01
There are no benefits associated with preceptorship as clinical teaching and learning strategy	21 (42.0)	18 (36.0)	4 (8.0)	7 (14.0)	1.94	1.04
Preceptorship is meeting its intended objectives	15 (30)	24 (48.0)	8 (16.0)	2 (4.0)	1.90	0.839
There are no challenges associated with implementation of preceptorship	31 (62.0)	17 (34.0)	2 (4.0)	0 (0.0)	1.42	0.574

Nurse educators' agreement with statements describing the outcomes of preceptorship

Responses from analysis of statements which determined the extent to which nurse educators perceived the outcome of preceptorship are depicted in 4.6.1.1 and 4.6.1.2; findings revealed that nurse educators agreed with nine (n=9; 61.5%) of the 13 statements with mean scores rated above 2.5 namely: "Students and preceptors experience frustration and stress during preceptorship period" (n=32; 64%) agreed compared to (n=16; 32%) who disagreed, mean score (3.50; SD $\pm$ 5.77); "preceptorship is an added responsibility to the nurse educator" (n=43; 86%) agreed while (n=7; 14%) disagreed, mean score was

(3.34; SD $\pm$ 0.823); “preceptors are not allocated time to perform the preceptorship role” (n=39; 78%) agreed in comparison with (n=10; 20%) who disagreed and (n=1; 2%) who did not respond, mean rating was (3.14; SD 1.05). Preceptorship increases the preceptor’s teaching and students’ evaluation skills” (n=40; 80%) agreed as compared to (n=9; 18%) who were in disagreement, mean was (2.96; SD $\pm$ 0.807), one (n=1; 2%) did not respond; “students gain competence in clinical skills and decision making” (n=41; 82%) agreed and (n=8; 16%) disagreed, mean was (2.94; SD $\pm$ 0.767), and there was one (n=1; 4%) missing response “preceptorship provides professional growth and development for preceptors” (n=38; 76%) agreed while (n=9; 18%) disagreed and (n=3; 6%) did not respond, mean score (2.94; SD $\pm$ 1.17). Respondents further agreed that; “preceptorship has more benefits for students clinical learning than the traditional faculty- student model of clinical teaching” (n=34; 68%) agreed as compared to (n=12; 24%) who disagreed, whilst (n=4; 8%) did not respond, the mean was (2.62; SD $\pm$ 1.62); “preceptors keep abreast with current issues and trends in nursing education because of the demand of their role” (n=29; 58%) agreed in comparison with (n=20; 40%) who disagreed, mean (2.62; SD $\pm$ 1.06), one (n=1; 2%) did not respond. “Students who have undergone preceptorship training excel in their professional role upon completion of training (n=27; 54%) agreed compared with (n=20; 40%) who disagreed and (n=2; 4%) who did not respond, the mean was (2.52; SD $\pm$ 1.07). The findings are indicative that respondents agreed with most statements perceived as appropriately describing positive outcomes of preceptorship which benefit both students and preceptors.

Nurse educators’ disagreement with statements describing the outcome of preceptorship

Out of a total of 13 statements describing the extent to which nurse educators determined outcomes of preceptorship; respondents disagreed with five (n=5; 38.5%) with means scores ratings of below 2.5. Nurse educators disagreed with the following statements: “there is role ambiguity between the preceptors and nurse educator” (n=26; 52%) disagreed, while (n=22; 44%) agreed, the mean was (2.42; SD $\pm$ 1.01) and two (n=2; 4%) did not provide responses. Findings reveal that the roles of both nurse educators and preceptors are clearly spelt out. In response to the statement; “there are no benefits associated with preceptorship as a clinical teaching strategy” (n=39; 78%) disagreed compared with (n=11; 22%) who agreed, mean was (1.94; SD $\pm$ 1.04). Findings support that despite challenges encountered during preceptorship practices, preceptorship has benefits.

In response to; preceptorship is meeting its intended objective” (n=39; 78%) of the respondents disagreed while (n=10; 20 %) were in agreement, one (n=1; 2%) did not respond, mean score was (1.90; SD $\pm$ 0.839). The majority (n=48; 96%) of nurse educators disagreed that; “there are no challenges associated with implementation of preceptorship” (n=48; 96%) disagreed and only (n= 2; 4%) agreed, mean score was (1.42; SD $\pm$ 0.574). Findings are indicative of challenges inherent in the implementation of preceptorship in Botswana’s clinical nursing education. Results further authenticate the need for development of facilitating preceptorship model to mitigate challenges entailed in preceptorship.

Relationship between preceptorship practices and nurse educator related demographic information

Preliminary analyses were conducted to ensure that no violation of the assumptions' normality, linearity, multicollinearity and homoscedasticity. The findings revealed that, the correlation values for year of experience as a nurse educators and their perception on the structure of preceptorship practice at alpha level .05 was statistically significant; while other predictors (age and qualification) were not significant. This implies there was no association found between the predictors (age and qualifications) and preceptorship practices. Table 4.18 summarizes the relationship between preceptorship practices and selected independent variables.

Table 4. 18 Matrix of Pearson correlation of the relationship among the nurse educators' related demographic information and preceptorship

	Age	Years of experience as a Nursing Educator	Nursing qualification	Structure	Process	Outcome
Age	1					
Years of experience as a For Nursing Educator	-.059 .686	1				
Nursing qualification	-.199 .165	.269 .059	1			
Structure	-.101 .487	.380** .006	-.014 .924	1		
Process	-.005 .975	-.001 .994	.016 .914	.382** .006	1	
Outcome	-.062 .669	-.227 .113	-.019 .893	-.202 .160	.119 .411	1

**, Correlation is significant at the 0.01 level (2-tailed).

Table 4.19 shows the regression of the nurse educators' demographic characteristics and communication and support for preceptorship practices. The results revealed that nurse educators' demographic characteristics (gender of participants, age, years of experience as a nurse educators, nurse educators' qualification) and support for preceptorship practice were not significantly correlated at ($p = .05$). Though the variables were not significant, the R squared values year of experience as a nursing educators, gender, age and qualifications for nursing educators were .059 which meant that all the factors accounted for 5.9% of the variance in the preceptor's views on the support for preceptorship practices.

Table 4. 19 Regression of support variable and demographic information on preceptorship as perceived by nurse educators

Model	R	R Square	Adjusted R Square	Std. Error	F	Sig.
1	.056 ^a	.003	-.018	6.13174	.149	.701
2	.057 ^b	.003	-.039	6.19623	.006	.938
3	.059 ^c	.003	-.062	6.26243	.012	.915
4	.059 ^d	.003	-.069	6.26257	.013	.926
a. Predictors: (Constant), Gender of Participants						
b. Predictors: (Constant), Gender of Participants, Age						
c. Predictors: (Constant), Gender of Participants, Age, Nursing qualification						
d. Predictors: (Constant), Gender of Participants, Age, Nursing qualification, year of experience as nursing						
d. Dependent Variable: Process						

Table 4.20 presents regression coefficients of nurse educators' demographic characteristics and communication and support for preceptorship practices. From this model in Table 4.20, the gender of participants $t(49) = -0.386$, $p > .701$, age $t(49) = -0.054$, $p > .957$, years of experience as a nursing educator $t(49) = 1.039$, $p > .301$ and nurse educators' qualification, $t(49) = 0.108$, $p > .915$) are all not significant predictors of the perception for support of the preceptorship practice. This implies each regression coefficient (p-values) did not significantly predict the outcomes when the effects of all others predictors are held constant.

Table 4. 20 Regression coefficients of process variable and demographic information on preceptorship as perceived by nurse educators

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	Std. Error	Beta	T	
(Constant)	32.640	4.741		6.884	.000
Gender	-.703	1.821	-.057	-.386	.701
Age	-.004	.081	-.008	-.054	.957
Nursing qualification	.016	.145	.016	.108	.915
Years of experience as a Nursing Educator	.145	.140	.104	1.039	.301

a. Dependent Variable: Process

Table 4.21 shows the regression of the nurse educators' demographic characteristics and structure for preceptorship practices. The results revealed that nurse educators' demographic characteristics (gender of participants, age, years of experience as a nurse educators' highest qualification) and perceived structure

of preceptorship practice were not significantly correlated at ($p = .05$). Even though the variables were not significant, the R squared values year of experience as a nursing educators, gender, age and qualifications of nurse educators were 0.185 which meant that all the factors accounted for 1.85 % of the variance in the preceptor's views on the structure for preceptorship practices.

Table 4. 21 Regression of structure variable and demographic information on preceptorship as perceived by nurse educators

Model	R	R Square	Adjusted R Square	Std. Error	F	Sig.
1	.060 ^a	.004	-.017	5.23961	.175	.677
2	.124 ^b	.015	-.026	5.26355	.564	.456
3	.406 ^c	.165	.111	4.89944	8.245	.006
4	.430 ^d	.185	.112	4.89459	1.091	.302
a. Predictors: (Constant), Gender of Participants						
b. Predictors: (Constant), Gender of Participants, Age						
c. Predictors: (Constant), Gender of Participants, Age, Nursing qualification						
d. Predictors: (Constant), Gender of Participants, Age, Nursing qualification, year of experience as nursing						
d. Dependent Variable: Structure						

Table 4.22 Regression coefficients of nurse educators' demographic characteristics and structure for preceptorship. From this model in Table 4.23, gender of participants $t(49) = -0.906$, $p > .370$, age $t(49) = -0.868$, $p > .390$, and years of experience as a nurse educators' $t(49) = -1.045$, $p > .302$ are all not significant predictors of the perception for structure of preceptorship while highest qualification of nurse educators' $t(49) = 3.048$, $p < .004$ is significant. This implies that only qualification regression coefficients (b-values) was significantly predict the structure when the effects of all others predictors are held constant, while rest did not.

Table 4. 22 Regression coefficients of structure variable and demographic information on preceptorship as perceived by nurse educators

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	Std. Error	Beta	T	
(Constant)	37.211	3.765		9.883	.000
Gender of Participants	-1.299	1.434	-.124	-.906	.370
Age	-.055	.063	-.120	-.868	.390
Nursing qualification	.309	.101	.429	3.048	.004
Years of experience as a Nursing Educator	-.122	.117	-.149	-1.045	.302

a. Dependent Variable: Structure

Table 4.23 shows the regression of the nurse educators' demographic characteristics and outcome (challenges and benefits) for preceptorship practices. The results revealed that nurse educators' demographic characteristics (gender of participants, age, years of experience as a nursing educator, highest qualification) and perception about the outcome of preceptorship practice were not significantly correlated at ($p = .05$). The R squared values year of experience as a nurse educators, gender, age and highest qualifications were .062 which meant that all the factors accounted for 6.2 % of the variance in the preceptor's views on the support for preceptorship practices.

Table 4. 23 Regression of outcome variable and demographic information on preceptorship as perceived by nurse educators

Model	R	R Square	Adjusted R Square	Std. Error	F	Sig.
1	.039 ^a	.002	-.019	8.22920	.075	.786
2	.070 ^b	.005	-.037	8.30242	.157	.694
3	.077 ^c	.006	-.059	8.38762	.050	.824
4	.249 ^d	.062	-.021	8.23816	2.684	.108
a. Predictors: (Constant), Gender of Participants						
b. Predictors: (Constant), Gender of Participants, Age						
c. Predictors: (Constant), Gender of Participants, Age, Nursing qualification						
d. Predictors: (Constant), Gender of Participants, Age, Nursing qualification, year of experience as nursing						
d. Dependent Variable: Outcome						

Table 4.24 Regression coefficients of nurse educators' demographic characteristics and outcome for preceptorship practices. From this model in **Table 4.25**, gender of participants $t(49) = 0.424$, $p > .674$, age $t(49) = -0.422$, $p > .675$, years of experience as a nursing educator $t(49) = 1.638$, $p > .108$ and highest qualification for nurse educator, $t(49) = 0.212$, $p > .833$ are all not significant predictors of the perception for outcome of the preceptorship practice. This implies each regression coefficients (p-values) did not significantly predict the outcomes when the effects of all other predictors are held constant.

Table 4. 24 Regression coefficients of outcome variable and demographic information on preceptorship as perceived by nurse educators

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	Std. Error	Beta	T	
(Constant)	37.531	6.337		5.922	.000
Gender of Participants	1.023	2.414	.062	.424	.674
Age	-.045	.107	-.063	-.422	.675
Nursing qualification	.042	.197	.032	.212	.833
Years of experience as a Nursing Educator	-.279	.171	-.247	-1.638	.108

4.5 DISCUSSION OF FINDINGS FROM PRECEPTORS AND NURSE EDUCATORS

Findings from analyses of data from preceptors and nurses educators are discussed. Similarities and differences in response to similar and related statements on structure, process and outcome of preceptorship were highlighted and supported with relevant literature.

4.5. 1 Discussion of findings on the structure of preceptorship

This section discusses finding regarding the structure and resources for preceptorship from both preceptors' and nurse educators' responses. Consistence was observed in most responses of nurse educators and preceptors with a few differing perceptions.

The majority of respondents (n=96; 87.7%) preceptors and (n=47; 94%) nurse educators indicated that they would recommend a model of preceptorship to facilitate clinical nursing education in Botswana. Furthermore, both preceptors and nurse educators agreed, (n=96; 87.7%) and (n=36; 72%) respectively, that preceptorship should be restructured for it to meet its intended objective. In response to the statement "there is a clear model to guide preceptorship in clinical nursing education" preceptors (n=55; 51.5 %) and nurses educators (n=43; 86%) also disagreed that; "the model of preceptorship used in Botswana's nursing education is known and well understood by all nurse educators, students and preceptors involved in preceptorship activities."

Findings are akin to other studies (Happell, 2009:373-374; Hallin & Danielson, 2009: 161-162; Jeggles et al., 2013:106) who recommended development of contextual preceptorship models and programmes that focus on the learning environment and preceptor's preparation based on local needs, resources and conditions. Findings are supported by Rose (2008:106) who stated that goals of students' clinical preceptor experience need to be clearly identified to students, preceptors, faculty and institution, and that preceptors and students need to be oriented to basic areas like objectives and logistics prior to the experience. The implication from the findings supports restructuring preceptorship in relation to availing resources, and developing guiding policy documents such as a relevant preceptorship model for the Botswana context.

Respondents also agreed that selection criteria for preceptors should be revisited (n=84; 78.5) preceptors and (n=42; 84%) nurse educators. Findings are consistent with literature (Yonge et al.2008; Henderson et al., 2006; Bain, 1996 pages not indicated) cited in Panzavecchia and Pearce, (2014:1120) which suggest preceptors who are selected based on their willingness and enthusiasm are more effective than those who are forced into the role. Other researchers highlighted similar challenges; that preceptors are often selected based only on availability and not on interest or abilities (Hyrkas, Linscott & Rhudy, 2014:120,131; Canadian Nurses Association, 2004:1; Hilli & Leena-Melender, 2014:4). It was obvious

from the responses that there is no clear selection criterion for preceptors. Preceptors either opt to take up the role or are selected by the supervisor as deemed appropriate by each clinical setting or training institution.

Sixty five (n=65; 60.7%) of preceptors disagreed that; “the clinical setting management provides resources needed to facilitate preceptorship in the clinical setting. Similarly, (n=45; 90%) nurse educators also disagreed with the same statement. Other preceptors (n=71; 66.4%) also disagreed that the management of health training institutions provide adequate teaching and learning resources for preceptorship role. The responses correlate with responses of other preceptors (n=60; 56.1%) who indicated that; “preceptors’ co-workers and supervisors are not conversant with the goals of the preceptorship programme.” Similarly, nurse educators (n=37; 74%) indicated that they experience challenges to meet and discuss preceptorship issues and challenges with clinical setting managers which could be an indication that preceptors are either not available or busy with routine nursing duties that they are not given time by the supervisor or manager to meet with nurse educators to discuss preceptorship issues.

Findings concur with O’ Brien, (2015:17-20) that resources to house and educate students and evaluate the effectiveness of the clinical sites should be available and requires planning, development of goals, objectives and written agreements between clinical sites and the programs or institutions they are affiliated with. The insinuation from the findings is that preceptors and nurse educators are likely to encounter challenges in interacting with preceptors’ colleagues and clinical setting management in relation to preceptorship practise if they are not conversant with preceptorship and its objectives.

It was also apparent from the findings that time was a scarce resource during preceptorship wherein (n=66; 61.7%) preceptors indicated that they do not have sufficient time to provide patient care while functioning as a preceptor and that preceptors’ other responsibilities do not allow them to attend to students’ learning needs respectively. A further (n=80; 74.8%) disagreed to that they had insufficient time to discuss learning objectives with each individual student on daily basis. If preceptors do not have sufficient time to discuss students learning objectives, the probability of students’ not meeting clinical learning objectives cannot be overruled.

Nurse educators (n=44; 88%) were in support that preceptors have inadequate time to perform their nursing roles and guide students during their clinical learning. Preceptors (n=66; 61.7%) disagreed to the statement; “My other responsibilities / assignments besides patient care allow me to attend to the students learning needs. Findings corroborate with the responses of nurses’ educators to the statement: preceptors the workload of the preceptor allows the preceptor to execute the preceptorship role efficiently (n=48; 96%) disagreed. Findings from this study are similar to other related studies where both preceptors and students indicated that preceptors lacked time to be with students (Panzavecchia & Peace, (2014:1121-

1123). According to Rose, 2008:107; Croxon & Maginnis, 2009:237; Monareng et al., 2009:124) preceptors have many roles and commitments in addition to the full workload such that they do not have sufficient time to perform the preceptorship role. Similar to the findings of this study, Russell, Boson and Watts, (no date) affirmed that ongoing demand on nursing staff to precept students in addition to working full hours leads to stress and burnout and has reduced the number of nurses taking up the preceptor role.

Contrary to most literature that preceptors are not well prepared for the role, lack of teaching experience and confidence in students' assessments and evaluation (Zilembo & Monterosso, 2008:92; Botma, 2016:<http://dox.doi.org/10.14804/3-1-16>; Callaghan et al 2009:246; Tan et al 2011:18; Sharif & Masoumi, 2005 cited in Kaphagawani & Useh, 2013:183; Panzavecchia & Pearce, 2014:2021); preceptors in this study, sixty-five (n=68; 63.4%) perceived that they have been adequately prepared for the role of a preceptor and (n=88; 82.3%) agreed that they were confident with students' assessments and evaluation of clinical learning activities. However, the majority of nurse educators (n=46; 92%) had different perceptions from the preceptors and disagreed with the statement; "preceptors do not need any special preparation; any professional nurse is a competent preceptor." The responses of nurse educators are in accordance with the above cited preceptorship literature that emphasises the need for adequate preparation of preceptors for the role.

4.5.2 Discussion of findings on process of preceptorship

This section discusses findings regarding the process of preceptorship as perceived by both preceptors' and nurse educators. Support and communication processes were the core variables.

Preceptors expressed mixed feelings about the type of communication existing between preceptors and nurse educators as evident from the following results; preceptors (n=54; 50.5%) s agreed that "there is always easy and clear communication between preceptors and nurse educators during preceptorship" whilst (n=53; 49.5%) disagreed. The findings indicate no significant difference between those who agreed and those who disagreed. However, a contrary view was noted whereby a higher number of nurse educators (n=34; 68%) indicated that communication between them and preceptors was not adequate to facilitate effective clinical teaching and learning.

Literature underscores the importance of communication in preceptorship, (Liu, et al, 2010:808; Madisa, 2012:49; O'Brein, 2015:17, 20; Happel, 2009:374; Iglesias-Parra, et al 2015:4; Mothiba, et al., 2012:202; Sedgwick & Harris, 2012:4-5). The cited studies emphasized establishing frequent communication between clinical preceptors and faculty or educational institutions as a way to facilitate success for preceptorship. In this study, although the respondents agreed, it is clear from the number of preceptors who agreed that communication is not very easy and clear It is therefore worrisome that if the concept of communication during preceptorship is not perceived the same by nurse educators and preceptors; to what

extent does effective communications occur and what possible implications this variance can have on the students' clinical learning outcomes.

Unexpectedly and interestingly: (n=62; 58%) preceptors agreed whilst (n=40; 80%) nurse educators disagreed that preceptors 'core-workers and supervisors are supportive of the goals of the preceptorship programme. The preceptors' responses are contrary to most literature wherein lack of support for preceptors from their colleagues and healthcare settings where they worked has been highly elucidated (Lofmark, et al., 2012:168, Borch, Ethlin, Hov, & Dupplis, 2013:102).

However, contrary to the former response, preceptors indicted that supervisor' and management (Nursing superintendent / Matron (s)/ Principal Nursing officer) are not committed to the success of the Preceptorship" (n=61; 57%), Furthermore; preceptors (n=63; 58.9%) highlighted that "nursing managers are not available to help them develop in their role as preceptor. In like manner, participants revealed that the workload of the preceptor is not appropriate to allow them to function as preceptors (n=63; 58.9%); the conflicting responses imply that preceptors have mixed feelings about the support they received which was also evident in Liu et al (2010:806-807), 's findings.

The majority of nurse educators (n=38; 76%) concurred with preceptors that; management of health training institutions does not provide nurse educators and the preceptors the support needed to make preceptorship a success. Nurse educators also concurred with preceptors whereby (n=48; 96%) disagreed; that; the workload of preceptors is reduced to allow the preceptor to perform the preceptor role. It was also apparent that preceptors lack support even from the nurse educators whereby nurse educators (n=43; 86%) disagreed that the visits they make to the clinical settings to meet preceptors and students and discuss challenges are adequate to assist them achieve preceptorship objectives. Although a lesser number of preceptors (n=63; 58.9%) compared to nurse educators (n=48; 96%) disagreed that the workload of preceptors is appropriate to allow the preceptor to function as a preceptor; literature supports that the workload of preceptors is not reduced to allow preceptors to perform the preceptorship role (Panzechchia & Peace, 2014: 1123; Horton, et al., 2012: E5).

Findings from this study are in conformity with other studies in which preceptors, students and nurse educators highlighted that preceptors lack support from their colleagues, faculty and supervisors. The preceptorship role is not recognized, preceptor's workload is not reduced which leads to stress and burnout and reduction in the number of nurses who want to take up the role of preceptorship (Hyrkas, et al 2014: 13; Martensson et al 2013:446; Sedgwick & Harris, 2012:2; Hovland, 2011:33; Lwatula, 2011; Higgins et al, 2010:409–508).

Furthermore, the majority of nurse educators in this study disagreed with statements addressing the adequacy of preceptors' preparation for the preceptorship role; "the preceptor (s) are able to plan students' learning activities appropriately" (n=45; 90 %) disagreed; "duration of preceptor training/

orientation is adequate to equip preceptors with teaching and students' assessment skills" (n=45; 90 %) disagreed; "preceptor training is well structured and coordinated across all health training institutions" another (n=45; 90%) disagreed. Findings are supported by international literature which illuminates that preceptors are not adequately prepared for the role, they are not trained nor supported; (Horton et al, 2012:E2; Horton et al, 2012:E2; Botha et al., 2012: no page number; Callaghan et, al 2009:246; Tan et al 2011:18; Kaphagawani & Useh, 2013:183; Panzavecchia & Pearce:2014:20; Hyrkas, et.al., Rhudy, 2014:120, 131; Kristorffezon et al., 2015: 1253). It is evident from the findings that preceptors do not receive adequate support from their colleagues, managers and health training institutions nor are preceptors adequately prepared to take up the preceptor role.

4.5.3 Discussion of findings on outcome of preceptorship

This section discusses findings related to the outcome of preceptorship from both preceptors' and nurse educators' responses. There was consistence in the nurse educators' and preceptors' responses to most statements addressing outcomes of preceptors.

A total of (n=100; 93.4%) preceptors and (n=41; 82%) nurse educators unanimously agreed that, "students gain competence and proficiency in clinical skills during preceptorship. Responses are consistent with literature which affirm that preceptorship helps students attain clinical competency in the clinical skills and makes them feel confident as team members alongside their supportive preceptors (Callaghan et al, 2009:246, 249; Myrick, et al, 2011: 134-139; Tan et al, 2011:20; Tan et al, 2011:17; Kaphagawani & Useh, 2013:183; Hilli et al., 2014:565).

Preceptors (n=94; 87.8%) agreed that by being preceptors, they keep abreast with current issues and trends in nursing education because of the demand of their role, this was supported by nurse educators (n=29; 58%) who agreed although to a lesser extent compared to the preceptors. Furthermore, preceptors (n=95; 88.8%) confirmed that socializing students to the professional role of a nurse is fulfilling, and "being a preceptor has improved my organizational and leadership skills" (n= 93; 86.9%) agreed. Another, (n=89; 83.2%) preceptors agreed that they are motivated to put in a great deal of effort beyond what is normally expected in order to help the students clinical learning to be successful. Similarly, (n=91; 85.1%) agreed that; "preceptorship increases the preceptor's teaching and students' evaluation skills. This was supported by (n=40; 80%) nurse educators. Eighty-nine (n=89; 83.1%) preceptors agreed with the statement; "I gain personal satisfaction from the preceptor role" Another (n=94; 87.9%) agreed with the statement; "my analytic and critical thinking skills have greatly improved.

In support of preceptors' view of the benefits of preceptorship, nurse educators agreed with the following; "Preceptors provides professional growth and development for preceptors (n=38; 76%); "preceptorship provides professional growth and development for preceptors" (n=38; 76%); "preceptorship has more benefits for students clinical learning than the traditional faculty-student model of clinical teaching"

(n=34; 68%). To further justify the benefits of preceptorship; nurse educators (n=39; 78%) disagreed that “there are no benefits associated with preceptorship as a clinical teaching strategy. The findings support literature that preceptorship benefits for the preceptor include keeping up-to-date as they learn new technology from students, and stimulate thinking, satisfaction with the professional role, personal and professional growth (Tan et al., 2011; 17; Connor, 2015:337; Fudger, 2015:13-14; Billay & Myrick 2008: 258 Zilembo & Monterosso, 2008:93).

However, despite the many benefits of preceptorship indicated in study, the respondents indicated challenges associated with preceptorship in their responses to the following statement: “Preceptorship is meeting its intended objective” (n=39; 78%) nurse educators disagreed and only (n=10; 20 %) agreed. This response conflicts with nurses educators where a significant number (n=39; 78%) disagreed with the statement that; “there are no benefits associated with preceptorship.” The majority of nurse educators (n=48; 96%) disagreed that; “there are no challenges associated with implementation of preceptorship.” It was apparent from the findings that both preceptors and nurse educators concurred in most of their responses that despite challenges associated with inadequate structures and processes in place to facilitate preceptorship, benefits to both students and preceptors outweigh the challenges.

4.6 SUMMARY

This chapter presented findings from the quantitative phase of the study. The demographic characteristics and professional profiles of preceptors and nursing educators were presented. In addition, findings from analysis of respondents’ perceptions on statements regarding the Structure, Process and Outcome of preceptorship were presented and discussed in relation to literature. Findings revealed that resources and processes to facilitate implementation of preceptorship are mostly lacking or inadequate. Chapter 5 presents findings from the qualitative phase of the study.

CHAPTER 5

QUALITATIVE FINDINGS AND LITERATURE CONTROL

5.1 INTRODUCTION

This chapter describes in detail the analysis of raw data. The data are, reduced to codes/concepts, themes, categories and sub-categories, reflections of the participants' perceptions and views through quotations from what they had said, and discussions of the findings in light of relevant literature.

5.2 RESULTS

A total of n=39 participants were interviewed in six (6) FGDs. Three (3) FGDs were conducted with nurse educators in different health training institutions, and another three (3) FGDs were conducted with preceptors from different clinical settings in selected District Health Management Teams (DHMTs). The clinical settings comprised hospitals, clinics, and health posts offering learning opportunities for level three (3) higher diploma in general nursing students from the health training institutions under the supervision of preceptors. A total of 17 nurse educators and 22 preceptors participated in FGDs. One FGD of nurse educators comprised representatives from all the six (6) health training institution who shared their experience, challenges and suggestions to improve preceptorship. Similarities were observed in the responses and discussions amongst participant groups which indicated a general agreement in most of their responses. Very little disparity (variation) was observed in the responses and remarks of both preceptors and nurse educators.

5.2.1 Demographic characteristics of nurse educators

Ages of nurses educators ranged between 34 and 56 years. The highest qualification was master's degrees in various clinical specializations. Eight (n=8; 47.0%) were males while nine (n=9; 53.0%) were females. Only three (3) nurse educators were master's degree holders namely: Master of Nursing Science in Midwifery, Master of Arts in Child & Family Studies and Master of Arts Health Science (Psychiatric Nursing) respectively. Thirteen were Bachelor of Nursing Science degree holders with no education or teaching qualification and only one participant had a nursing education qualification.

The highest number of years of teaching experience was 24 years with a minimum of three (3) years and a mean of 9.6 years. The results further indicated that 82. 3% (n=14) of the participants had teaching experience of between seven (7) and 24 years; while 21.4% (n=3) had teaching experience of between three (3) and five (5) years. Although all nurse educators had a minimum qualification of either a bachelor or master's degree, findings reflect a conclusive evidence that most nurse educators do not possess an education qualification; they have only attended workshops on effective teaching skills. Nurse educators are entrusted with the responsibility of facilitating in preceptorship activities and providing

pedagogical support to preceptors and students during clinical nursing education despite their lack of education qualifications. The lack of education preparation or qualification could impact negatively on preceptorship outcomes.

5.2.2 Demographic characteristics of preceptors

A total of 22 preceptors participated in the FGDs sessions. Ages of preceptors ranged between 29 years to 58 years with a mean age of 42.1 years. Five (22.7%) were aged between 50 and 58, eight (36.4%) were aged between 40 years and 46 years, another eight (36.4%) were aged between 30 and 39, and only one (4.5%) was below 30 years of age. Seven (31.8%) of the participants were males while the remaining fifteen (68.2%) were females. All preceptors had a minimum qualification of general nursing at either diploma or degree level. The highest qualification for preceptors was a Bachelor of Nursing Science degree held 22.7 % (n= 5); 36.4 (n=8) held both a basic diploma in general nursing and a post basic diploma qualification in one of the nursing fields namely; midwifery, ophthalmic nursing or psychiatric nursing, and 40.9 % (n=9) held a basic diploma in general nursing with no other post basic qualification. None of the preceptors had a qualification in education or teaching.

5.2.3 Themes, Categories and Sub Categories that emerged from Content Analysis

Data analysis was guided by SPO model (Donabedian, 2005:173) which was adapted and used as the conceptual framework for the study. In this study, structure has been reflected as resources for preceptorship. Three themes emanated from Content Analysis; inadequate resources; inadequate processes for facilitation of preceptorship and outcomes of preceptorship. Table 5.1 presents the themes, categories and subcategories.

Table 5. 2 Themes, categories and subcategories

Theme	Category	Sub- Category
Inadequate resources for preceptorship	1.1 Inadequate human resource	1.1.1 Unavailability and shortage of preceptors and nurse educators 1.1.2 Unclear selection criteria for preceptors
	1.2 Increased time pressure	1.2.1 No time allocated for preceptorship 1.2.2 Lack of time for nurse educators
	1.3 Problems with preceptorship guidelines	1.3.1 No clear guidelines for preceptors 1.3.2 Inconsistence in implementation of Guidelines
Inadequate processes to facilitate preceptorship	2.1 Lack of support for Preceptors	2.1.1 Minimal support from nurse educators 2.1.2 Lack of managerial support 2.1.3 Minimal support from colleagues
	2.2 Unstructured preceptorship	2.2.1 Inadequate training and orientation 2.2.2 No consideration in clinical placement of Preceptors
	2.3 Ineffective communication	2.3.1 No regular meetings 2.3.2 Lack of feedback on preceptorship
Perceived outcomes of preceptorship	3.1 Benefits of preceptorship	3.1.1 Increased preceptor's personal and professional growth 3.1.2 Contribution to student training
	3.2 Challenges to effective Preceptorship	3.2.2 Lack of incentives for preceptors 3.2.2 Increased workload of preceptors

		3.2.5 Lack of commitment from students
Suggestions for improvement of preceptorship	4.1 Empowerment and training of preceptors	4.1.2 Increased training of preceptors 4.2.1.2 Provide incentives for preceptor
	4.2 Collaboration with key Stakeholders	4.2.1 Partnership between health training institutions and clinical settings 4.2.2 Partnership with accreditation bodies

5.3 DISCUSSIONS OF FINDINGS AND LITERATURE CONTROL

This section discusses the findings in accordance with themes, categories and sub- categories that emerged from the data. The researcher reflects participants' direct quotations and compares with literature for the purpose of validating the findings; denotes those exclusive to this study and indicate those found in literature but not corroborated by this study. The researcher started by reading each transcript carefully to get an insight of what participants had said. The data was transcribed verbatim from a voice recorder.

Inductive Content analysis was done manually by identifying recurrent themes from raw data (open coding). The steps followed in content analysis entailed reading and re-reading of the texts and listening and re-listening to voice recordings to get a clear understanding of the responses. Identification of themes or topics that emerged and reduction of several small codes into common themes was done (De Vos et al. 2013:402; Brink et al. 2014:993-194).

The emerging views and comments were written on the margins of the transcribed texts. Themes that emerged during data analysis were contextualized and discussed according to SPO.

5.3.1. Theme I: Inadequate resources for preceptorship

Both nurse educators and preceptors in this study perceived that there is inadequacy of resources needed for preceptorship although their expressions were construed in relation to the types of resources and structures that were perceived as inadequate. Similarities and some varieties were identified in the responses of the two groups of participants (nurse educators and preceptors). Positive and negative feelings were expressed by participants who verbalized some flaws in the current structure of preceptorship practice in Botswana's nursing education system. The perceptions and views of participants in this study validate Madisa's, (2012:13) findings that preceptorship for the diploma in general nursing programme in Botswana is uncoordinated and unstructured. The following categories supported this theme: Inadequate human resources; Time pressures; Problems with preceptorship guidelines.

5.3.1.1 Category 1.1 Inadequate Human Resources

Participants in this study expressed that there is inadequate human resource to facilitate effective implementation of preceptorship in the clinical teaching and learning settings and the selection of preceptors is not consistent. Literature reveals that proper selection of a preceptor is an important measure in cultivating favorable perceptions about the value of preceptorship (Croxon & Maginnis, 2009:238).

The following sub-categories that emerged from this category include; Unavailable and shortage of preceptors and nurse educators; unclear selection criteria for preceptors.

Sub-category 1.1 Shortage of preceptors and nurse educators

Findings revealed that the number of preceptors in the clinical settings is inadequate to effectively supervise students such that most of the times students are left to any other nurses in the unit while the preceptor is either off duty or in a different shift from that of the students. In like manner, nurse educators have multiple responsibilities which leave them with little or no time to follow up students and preceptors for guidance. The human resource shortages adversely affect the objectives of preceptorship in clinical nursing education. This was reflected in the expressions, narratives and quotes of the participants.

One nurse educator had this to say (G3NE1): *“My experiences are that some of the preceptors were not available during the time when we were following up the students, so it was a bit of a challenge to monitor the progress of the students, but those who were available were helpful”*.

Quote from one nurse educator (G2NE2):

“We realize that in most of our institutions we are facing this shortage of staff. So it’s more like when we get to semester six, when we allocate our students to these units; it’s more of a relief on us. We leave them to the preceptors so that we attend to other work assignments.” The allusion supports Sedgwick and Harries, (2012:1) that the preceptorship model depends heavily on availability and willingness of nurses to take the preceptorship role and faculty shortages calls for the need to question if preceptorship meets students’ learning needs and programme outcomes.

One preceptor (GIPI) had this to say:

There is another challenge...whereby the staffing and time constraint. I will not be assigned with the students. Me I’m a preceptor yes, but I’m on night duty the students will have knocked off. I am on night duty; my shift will not align with theirs. When there is no other one assigned I will not know what to do with this other student; whether yesterday he or she, was absent maybe the person who was to follow her is not there.”

An expression by another preceptor (G2P8):

“Students may come to do management which could be a week and you as a preceptor are there for 2 days implying those other days you are not there to assess even to witness the management but you are expected to sign for that student management at the end of the week of preceptorship. Where you fail to do so giving the reason that you were not there, you cannot support or sign for the student it’s like you are going against their expectations.” Findings are consistent with preceptorship literature globally (Martensson et al, 2013: 448; Mothiba et al, 2012:192-205; Tan et al., 2011:19; Croxon & Maginnis, 2009:240;) wherein lack of preceptors, and increased workload were highlighted as concerns that can

impact negatively on the learning environment by participants. The findings further accentuate the need for development of a preceptorship model to re-structure preceptorship to be more meaningful to all stakeholders.

Sub-category 1.1.2: Unclear selection criteria for preceptors

The participants' responses to the selection criteria for preceptors reflect a non-standardized structure wherein preceptors are either selected by supervisors or can volunteer to become preceptors. Observations made from the participants' quotes are that preceptors are mostly selected by supervisors based on a minimum of two years of experience as a practicing registered nurse with no consideration for interest and preparation for the role, with only a few who volunteered to take up the role out of interest in teaching. Participants expressed comments similar to the following to indicate unclear selection criteria

This was said by one preceptor (G2P2):

"Aaaa-hmm, I think basically it starts from the selection of preceptors. Ee-em—mm, I think the major problem is that we haven't had a very good criteria of selecting who is a preceptor from the first word go. I have been a preceptor for 10 years. I think that selection, needs to -ee-e-ee you know, ee-ee - - look at someone with a Botswana Qualification Authority certification of some sort; either as a trainer of trainers or as an assessor, because if you assess those students without having a lot of information what you are going to assess them on not knowing the standards in the country regarding education -ee-emm-hh you know regarding their learnership, I think it becomes a problem too."

Another nurse educator's (G1NE2's) narrative

"They are chosen I think by the management of the clinical area or the hospital. ummmm they do choose but I don't think they force, because if the individual does not want to participate and they are forced, they would not dispense their services properly because they were forced". But I think voluntary; ee-hhh-mmm-- would give the preceptors those who really want to assist the students to be taken through volunteering. It would work better because they would know that despite all the barriers which I will meet but at least I'm doing something which I like." Findings are contrary to Jooste, (2010; 167) wherein selection of preceptors is aimed at determining which individual would best suit the preceptorship role and requires a structured process to include specific selection criteria and screening interviews. This is not the case in Botswana's preceptorship whereby neither screening nor interviews are conducted. In most cases the supervisor or manager just selects a nurse to serve as a preceptor even if the nurse has no interest in teaching or has no qualities of a good teacher.

These findings are similar to those from the literature from different parts of the world indicating that preceptors are often selected without considering their interest in the role but rather basing on who is available resulting in inconsistency in the nature and intensity of their preparation for the role (Hyrkas,

Linscott & Rhudy, 2014:120,131; Canadian Nurses Association, 2004:1; Hilli and Leena-Melender, 2014:4). Literature recommends that receptors should be selected by stakeholders involved in clinical teaching namely; managers from clinical settings and academics from the training programmes (Dube & Jooste, 2006:30;Yonge et al, 2007; Smedley, 2008 cited in Botma et al, (2012) <http://dox.doi.org/10.14084/1-1-2>; Panzavecchia & Pearce, 2014: 112; Coroxon & Maginnis, 2013:238; Botma et al, 2012: ; Hilli and Leena-Melender, 2014:1-4; Rose, 2008:106; Mothiba et al., 2012: 192-205).

5.3.1.2 Category 1.2 Increased time pressure

Time pressure was perceived as having negative impact on preceptorship since it does not give preceptors and students time to meet and discuss students' learning objectives nor do they have time to effectively monitor students' clinical performance. Similarly the findings indicate that nurses educators' lack time to attend to preceptorship issues. DeYoung (2003:241) pointed out that in the preceptorship model, some nurse educators perceive barriers such as fear that preceptors do not really have time to supervise students as worrisome and could lead to serious errors committed by unsupervised students. The following subcategories emerged; No time allocated for preceptors; Lack of time for nurse educators to follow up preceptors and students.

Sub-category 1.2.1 No time allocated to preceptors Participants verbalized that no time is allocated to allow preceptors to perform the preceptorship. Preceptors indicated busy areas of work and patient care taking priority over preceptorship role. The subcategory was supported by the narratives that follow.

Another preceptor (G2P3) said:

"The time you try to sit, there is something you have to do of which at the end you are exhausted. So even the objectives you can't see all the objectives of the students; maybe you are going to meet only two. Maybe you want to take some time to sit down with the students, review their work and try to help but you cannot; there is too much work. No one considers that you are a preceptor you have to be with students as well".

An expression by another preceptor (GIP6):

"There is no time set aside for you to be with students and if it so happens, you have to finish your work that you were assigned then find your own time with the students such that it will be more strenuous on your side, such that you say nyaa" (meaning no) there is nothing I' am benefiting from this preceptorship wena you are a student your lecturer will come and take over. When you find many people have dissociated themselves from preceptorship it's not that they don't want to do it, but because they have no time. They have to finish what they are assigned to do then attend to students during their own time".

A nurse educator expressed the challenge of time pressure and said:

“But if you go in the clinic you find somebody very busy and you want to take them through something that is so critical like a tool to assess students, this is not a core job for the person. The person just admits, because it is a ministry of health issue. If it was a personal matter I would say I can’t do this job but since it is for nurses thus why they feel gone gore (meaning they feel that) aa--ahh-- they can go on and supervise the students”.

The findings are congruent with Panzavecchia and Peace (2014:1121-112) wherein 83% of respondents indicated that time was a major barrier to effective preceptorship that time should be considered in planning the working time of the preceptor and preceptee against the workload of the preceptor. In another related study, Monareng et al. (2009:124)’s findings revealed time and work load as the most limiting factors to the success of preceptorship and highlighted the need for allocation of time for preceptorship activities.

Sub-category 1.2.2 Lack of time for nurse educators

Both nurse educators and preceptors FGDs agreed that there is inadequate or lack of time for nurse educators to follow up preceptors and students due multiple roles. The following was said by a nurse educator (G2NE2):

“We become busy with other things, there is no time. You find that one person will be teaching and following some other levels at the same time they are to follow the preceptor and the students she is with. So it happens that when you prioritize your activities you end up saying at least those ones are with the preceptors and you will prefer to go to the other levels (level one and level two) or class rather than going there. If I happens that you go and see her after two weeks when the students are left with only three (3) days to finish up even if I’m querying the marks I can’t tell her or say let’s re-do this because the time has already lapsed ga kere.” (Meaning is it not so?).

Another nurse educator (GN3NE1) affirmed that nurse educators lack time for preceptorship activities and said:

“And apparently the students’ clinical attachments will be running concurrently with other programmes; that is the theoretical aspects of other students. Interviewer asks: which other students?) G3NE1 responds; First and second years. Participant continues; so if I’m teaching other students maybe I will be teaching two levels, first years and second years and at the same time I have to follow up the level three, it becomes a bit of a challenge. Only when I am off class that is when I can make that follow up to go and give the support to the preceptors; ee- -maa (meaning yes madam) uu—hhhmm.”

The findings are contrary to literature (Yamardas & Ota, 2012:229; Hill et al., 2014:565) wherein it is emphasized that educators should be available to facilitate preceptorship activities. Yamardas and Ota

(2012:229), emphasize the importance of availability of faculty to guide preceptorship activities. Similarly, 15% of students in Hill et al., (2014:565) indicated that they would like increased visits by their lecturers during preceptorship. The need for regular meeting between preceptors and faculty was also highlighted in Madhavanpraphakaran et al (2013:32).

5.3.1.3 Category 1.3 Problems with preceptorship guidelines

Participants particularly preceptors verbalized lack of guidelines in different forms such as preceptorship objectives, expectations, protocols and model while nurse educators agreed to a lesser extent. Two sub-categories emerged which include, no clear guidelines for implementation of preceptorship and inconsistent implementation of guidelines.

Sub-category 1.3.1 No clear guidelines

Participants verbalized problems associated with either no guidelines given to preceptors or where guidelines are given, instructions for the implementation were inconsistent amongst health training institutions impacting negatively on the effectiveness of preceptorship. Participants' expressions were captured in the quotes that follow.

One preceptor (G3P3) emphasized the importance of guidelines by saying:

"I think it will be helpful if when they are coming to the clinical area, you give us a list of what they are coming to do. I have noticed that... they usually tell you that "we were never taught at school" So if they are coming; first years, second years or third years we have list of things that they were taught at school that we are supposed to reinforce and teach. It will be very helpful so that when they say this thing we never did at school and I'm not supposed to be doing it; you know that this one is lying and this one is telling the truth."

Another preceptor (G2P3) verbalized this:

"The other thing is those students I don't know if they don't know what is expected of them during their practice work. We are not always in the wards. What is happening is, everyone who is there takes over and assists the students of which it becomes a challenge if guidelines are not clear. The other thing sometime it's like we volunteer to become preceptors "there was no training but we use only that manual. That manual guides us there and there. It guides what to do but I think training is also important."

The following was an expression from a preceptor (G1P4) from another focus group:

"It is important for the IHS to give us the information or some guidelines to know what is necessary or we need from us to guide the students. These days people do advanced diplomas so maybe things have changed they are no longer like we used to do in the past. Even preceptors I think they should be aware of that."

These findings are not unique to this study. The findings accentuate the views and experience of preceptors in Liu, et al; (2010:806), wherein preceptors expressed confusion regarding expectations of their role and recommended that clear guidance for clinical preceptors should be developed. Similarly in related studies conducted in Botswana; preceptors shared the same sentiments that lack of clearly defined preceptorship guidelines and policies were major challenges faced by preceptors and students (Monareng, et al 2009:121; Madisa, 2012: 48-49). To reduce the lamentations of preceptors about this problem; a preceptorship model with clear guidelines on facilitation of preceptorship in clinical nursing education should be developed to guide preceptors and students to prevent confusion and frustrations.

Findings are however, akin to Hilli and Leena-Melender (2014:4)'s findings that revealed challenges encountered by preceptors in the evaluation of students because preceptors at times do not know what to expect from students as learning outcomes are not communicated earlier, and at times objectives are not made clear. Contrary to the findings of this study, literature purports that clear preceptorship guidelines are critical for preceptorship to be successful. Such guidelines should clearly delineate the roles of the nurse educator; preceptor and students should be clearly delineated (Panzavecchia & Peace, 2013:1122; De Young, 2003:24; Billings & Halstead, 2012: 486).

Sub-category 1.3.2 Inconsistence in implementation of guidelines

Some preceptors verbalized that where preceptorship guidelines are given; expectations are inconsistent or differ from one health training institution to the other which becomes a challenge for preceptors to know what to do with students from different institutions.

One preceptor (G1P4) narrated this:

“There is no uniformity on how these assessments should be conducted. I believe every time students come, they (nurse educators) are supposed to be with the students full time so that they do procedures, they can also show preceptors how assessments are done but from other training institutions at times they do not come. It is not well structured.”

Another preceptor (G2P4) said this:

A-a-a-a, the other thing, I think the national institute of health or NHI (former name for health training institutions), yaa IHS The school of nursing should formalize or make their preceptorship manual be uniform. We always receive people from different institutions, i.e. Molepolole, Serowe, Francistown but mostly the people (nurse educators) who engage us are from Francistown. But these one from Molepolole and Serowe we just find the students there. And we were not informed about their coming, we just find the students there. You now have a challenge to get accustomed to assessing the students whom the lecturers didn't tell you their expectations and maybe you use the guidelines from Francistown to assess them. I think they should meet and formalize and make them similar. Interviewer asks: Who are the “they” you

are referring to? Preceptor (G2P4)'s response: *Lecturers, nurses and midwives should meet and make the guide to be uniform.*"

Similarly, one preceptor said;

"IHS(s) (referring to Health Training Institutions) should standardize or formalize their expectations with preceptors because it not uniform. We are coming from different backgrounds and it affects the way we precept on our students."

Sadly, the findings are contrary to Billings and Halstead (2012:486), who affirm that sharing of objectives, expectations of students and clinical evaluation with preceptors / staff by nurse educators, promotes evaluation partnerships. Inconsistence in implementation of guidelines can result in confusion and conflicts between to both preceptors and students and compromise clinical learning.

The narratives are congruent with expression of preceptors in another study that cited insufficient guidance from nursing faculty; wherein one participant said; *sometime I feel I'm at sea.... it would be better if they could give us a guideline or hold a briefing before making changes* (Liu et al,2010:806). Based on the findings of this study; preceptors' experiences in relation to guidelines are similar to expressions of preceptors in the cited study. In another study Rose (2008:106), emphasized the need for preceptors and students orientation to basic areas like course objectives and logistics of the preceptorship experience in order to prevent stress and burnout that can hinder the preceptorship experiences.

5.3.2 Theme 2: Inadequate processes to facilitate effective preceptorship

Participants indicated that processes to facilitate effectiveness of preceptorship were lacking and highlighted the need for certain processes to be established in order to facilitate effective preceptorship in clinical nursing education. The categories that emerged includes lack of support for preceptors; unstructured preceptorship and ineffective communication

5.3.2.1 Category 2.1 Lack of support for preceptors

Participants indicated minimal or lack of support for preceptorship from clinical setting management and supervisors, preceptors' colleagues from nurse educators. On the contrary; nurse educators indicated that they provide support to preceptors and agreed that preceptors lacked support from the clinical setting management and preceptors' colleagues. The following are sub-categories that emerged from category 2.1' minimal support for preceptors from nurse educators; lack of managerial support and minimal support from the preceptors' colleagues.

Sub-category 2.1.1 Minimal support for preceptors from nurse educators

Participants indicated that preceptors receive minimal support and at times no support at all from the nurse educators. The responses attributed to lack of support were validated in the participants' quotes.

This was said by another preceptor (G3P3):

"I think we need to define support itself (acknowledging suggestion). When you say you are getting support; you mean what is it that you are getting from the nurse educators and from the school of nursing or from the whole system. Preceptor continues: Like I mentioned earlier, I think the issue of information dissemination handing out of pamphlets and stuff, I think that one is a bit behind. The last that we received from you (referring to the researcher's training institution) was that booklet when we came from the workshop that was it. So it's either your visits or we talk thus it. But we don't have resource materials; like a check list of the material that you can research on your own or material that is researched already, so that if the students come and ask questions this is the information that you can use to help them."

Another preceptor (G2P1) said:

"I think there isn't any support that is there at all besides interactions that we have with them when they visit their students. Most of the times we don't have access to journal articles and all these kind of things like educators. If they come with what they teach in the learning room and bring them to the clinical area and say these are current trends of managing these conditions, these are the current trends in nursing care. That kind of interaction would eventually help us. But unfortunately there isn't anything like that. All in all we don't have any help; we don't have any help (repeated). It's just what we know, what individuals can get to dig out on their own."

The experiences of preceptors in this study are contrary to literature findings that faculty needs to work cooperatively with clinical instructors to help them fulfill their role to provide continual support to preceptors and students for successful outcomes of the preceptorship experience (Rose, 2008:107; Yamardas & Ota, 2012:229). The affirmations from the findings is that preceptors struggle with students' learning activities with no or minimal support from nurse educators. This accentuates the need for development of preceptorship model that embrace preceptor support by nurse educators.

A nurse educator (G2NE2) alluded to the narratives of the preceptors and had this to say in relation to preceptor support:

"It is not adequate. At times we are just not available for them. They lack our support. We become too busy with other things that we do not realize they need us. We need to improve on that. You can imagine if the preceptor is there with the students and she is confused experiencing some challenges; who is she going to communicate those to, how is she going to manage those problems alone when we are not there? So nna (referring self), to me I would say to some extent we provide minimal support".

Another nurse educator (G2NE1) had a contrary view and said. *"To me to some extent the support that probably the nurses / the preceptors are looking for; really is lack of what, I would say leadership in their part because, if you know what you are expected to do as a mentor, as a supervisor then a student is not*

going to be able to cheat you and tell you we no longer do this, this is old method ee- - ee or whatever. It's like parenting kana nowadays as parents; we want the school or somebody else to take responsibility of our parenting. To me sometimes I feel that people don't want to be seen as supervisors. They want to transfer responsibility to somebody else. I don't see anything wrong with a nurse at a clinical area to discipline the students.

One nurse educator (G3NE2) affirmed the minimal support given to preceptors in the following utterance:

"The issue of support; gone (meaning in fact or at any rate) we do minimal support to some extent. Like what we do here; is that every clinical time or duration we conduct a meeting with the educators and clinic staff. We take them through our objectives, our competences, uum--mm our plans so that it becomes a bit with direction rather than leave them with students then they have to struggle gone gore (meaning such that) as to how do I assist the students? At least they have a light as to what they should do with the student in the hospital or clinic in these four weeks at least they know."

The findings are akin to sentiments of nurses supervising students in Hovland, (2011:3) who expressed the need for more support from teachers in students' supervision. Similarly, Gaberson & Oermann, (2007:225; and Rose, (2008:106) highlighted the importance of the role of the nurse educator in the selection, support, and providing guidance for selection of appropriate learning activities and serving as a resource to the preceptor. The roles of the nurse educator in relation to preceptorship are not evident in this study. This highlights the need for a contextual preceptorship model to address the gap.

Sub-category 2.1.2 Lack of managerial support

Lack of support from managers and supervisors was a major concern raised by both preceptors and nurse educators in this study.

The findings support Kristofferzon et al, (2013:446)'s findings that nurses have a more positive attitude of themselves as preceptors if they get support from the unit managers.

A preceptor (G2P8)'s comments:

"Then the other area is the support from the supervisor, is very- very minimal. It's like they don't value preceptorship that much; because when you are in the ward, you are expected to do your expected activities which are patient care and mostly these are demanding. You are not excused from those duties. Students are expected also to be mentored during the same period, so it's quite a challenge in support."

An expression from a preceptor (G3P6):

"I had a supervisor; I can't mention the name she sometimes used to harass me. She said you are not paid to be teaching the students. G3P2: interjects and says; that is common. G3P6 continues; she will say you are supposed to be working. So I will just smile and make my own way. I will say you were once a

student *Mma* (meaning madam) and some people had to teach you. I know there is shortage; I know I have a duty but I have to teach as well. Others will tell you that you spend more time with the students instead of your allocated work.”

Another preceptor’s comments (GIP3):

‘I wouldn’t say we do get support from matrons or our colleagues. The whole group responds at once: our colleagues--- our colleagues GIP6 continued; Even the supervisor; one time I asked another psychiatric nurse to assist when we had students. This time it was not the nursing students. It was a group of primary school children because the group was too large; 180 in number. I asked another nurse so that we could divide students into two groups. I thought the group was too overwhelming. My supervisor was not very supportive on that one. She thought it was something else we are dodging or kind of an excuse. We had to struggle a bit, but eventually we did.’

The study reveals a need to critically examine and devise measures to facilitate preceptor support to attract and retain preceptors and sustain preceptorship as a clinical teaching strategy. Horton et al, (2012:E2)’s study emphasized the importance of support of preceptors to enable them to effectively execute the preceptorship role as a cornerstone of clinical nursing education and students’ supervision. Findings are corresponding with Panzavecchia and Peace (2014:1123), wherein 94% of preceptors stated that they experienced lack of support from their managers on the wards. Likewise, Hallin and Danielson, (2009:161-162) emphasize that; success of preceptors in their preceptorship role depends to a greater extent on the support they get, their interest in the role, preceptors’ experiences in the role and the preceptorship model used. Based on the narratives of preceptors; the lack of support and guidance experienced by preceptors in Botswana could be disadvantageous to the quality of clinical learning experience students receive.

Subcategory 2.1.3 Minimal support from preceptors’ colleagues

Preceptors indicated that they do not always get support from their colleagues. Tan et al (2011:18), highlighted that without proper understating of the goal and purpose of preceptorship the risk of lack of managerial and staff support for preceptors resulting in burnout is inevitable. The following utterances corroborate the perceived lack of support.

An expression from a preceptor (G3P1):

“Students have a tendency to going to those nurses who a- a-a- are I didn’t want to use the word soft, but I don’t know which word we can put. G3P2 and G3P4 added at the same time their friends. G3P1 continued: They tend to sideline you and wait for those people to come on duty The next thing you will hear them saying don’t go to Mma Ma.....wait for so and so to do with her, that one will give you more marks. So I don’t know how that one can be rectified because our colleagues we talk to them. Someone

will say to you; you were once a student also why are you being cruel, and yet you are not being cruel. But they feel that you are being cruel and they will say no why you are being like that? Those who say that;, where if you go through their assessment properly, thus where you will see that the signature of that one nurse appears in most of the students' evaluation booklets, and you ask yourself why? Was she the only one who was on duty that day? Or was she the only one who was on duty the whole week with different dates but one signature?"

Sentiment of another preceptor (GIP8):

"Nna (myself) what they have said so far is what I have also experienced, that you will be allocated to do your normal duties. But when these students come; wena (you) are expected to give them time, do those assessments as well as do your normal duties of which it becomes difficult because at the end of the day what you are allocated your colleagues won't do it. They will say wena you decided to go with your students but definitely you knew gore (meaning that) you are allocated a certain duty which you did not do."

The findings from this study are in conformity with others studies in which both preceptors and nurse educators highlighted that preceptors lack support from their colleagues or peers, faculty and supervisors (Matua et al, 2014:531) and that the preceptorship role is not recognized (Panzecchvia & Peace, 2014: 1123; Martensson et al 2013:446; Hovland, 2011:33; Lwatula, 2011: no page number; Higgins et al, 2010:409–508). These studies construe that support is key to the success of preceptorship and affirm that the much needed support to perform the preceptorship role is often not provided. These assertions and supporting literature are conclusive evidence that lack of support for preceptorship from key stakeholders does not only demotivate preceptors but also compromises the quality of clinical nursing education for students.

5.3.2.3 Category 2.2 Unstructured Preceptorship

Participants verbalized that the use of preceptorship in Botswana's clinical nursing education is not well structured. Both nurse educators and preceptors showed mutual agreement as reflected in the quotes and narratives captured during FGDs. Two sub categories emerged which were; inadequate and lack of training and orientation of preceptors and no consideration in the clinical placement of preceptors.

Sub-category 2.2 1: Inadequate and lack of training and orientation

Most of the participants articulated comments similar to the following:

This was said by one nurse educator (G3NE1):

"We also had a situation where some preceptors would say they were not trained and as such they were not sure of how to go around assessing students or executing the preceptorship role. But in any case what we normally do as faculty here, before we send the students we make an effort to meet preceptors at the

various stations were students attached. We do discuss roles for both the preceptors as well as the students and encourage them to follow through and ask question where they are not clear.”

Another expression from a nurse educator (G3NE4): *“From our facilities we should make sure that ee- - ee (laughter); as training institutions we must make sure that preceptorship is taken seriously. We need to take them through the whole process. Often times we just assume that there are preceptors there, while indeed there are not trained preceptors. We must make sure that preceptors are trained.”*

The findings are consistent with other studies conducted in different parts of the world which indicate that preceptors are not trained or adequately prepared for the role and lack teaching experience (Callaghan et, al 2009:246; Tan et al 2011:18; Sharif & Masoumi, 2005 cited in Kaphagawani & Useh, 2013:183; Panzavecchia & Pearce, 2014:2021).

In like manner, preceptors also verbalized concerns about the inadequate training for the role as indicated in their narratives.

One preceptor (G1P1) had this to say:

“If we can start with that one of training; Interviewer responds and says, Uu-hhmm. Preceptor continues; it used to be there, where lecturers were organizing workshops for the preceptors those who were doing for the general and those for post basic. Majority were transferred out because there have been transfers in and out. Those who came in; it was not easy to identify that this one is already a preceptor from wherever he came from. Management in the IHS; they seem to have stopped on those workshops. Kanye has been doing good in terms of training of preceptors from here and southern region but these other institutions they seem to have calmed down but it is part of the incentives.”

In response another preceptor in the same focus group (G1P3) said this in astonishment:

No (Loud and confident). Actually I’m surprised to hear that they have been trained. I thought it was automatic as he said gore (meaning as he said that) after two (2) years in service you are told that now you can be a preceptor.” Maybe that is what happened to me. Even myself I was not trained.” I was told that; no-- now you can be a preceptor, now that you are two (2) years in service. Myself I have never recognized myself as preceptor. I was thinking gore (literary meaning I was thinking that) I’m an abused man. Other participants laughed but some of them nodded to concur with sentiments expressed. The participant continued to say; I usually assist the students but not knowing the direction.”

The findings from both preceptors and nurse educators support literature evidence that many preceptors are not adequately prepared for their role, particularly in the areas of teaching and evaluating students (Lambert & Glacken, 2005; cited in Kristofferzon et al., 2012:1253 ; Martensson, Engstrom, Mamhidir & Kristofferzon, 2013: 448; Hovland, 2011:3; Horton et al, 2102; E2; Hyrkas, et al, 2014:120, 131; Happel, 2009: 37; Panzavecchia & Pearce, 2014: 1120-1121). The insinuation from the participants’ responses

and supporting literature is that untrained preceptors are mostly likely to be ineffective in teaching, supervising and evaluating students' clinical learning activities with resultant adverse effects on students' learning outcome.

Sub-category 2.2.2 No consideration in the clinical placement

Participants highlighted that clinical placement of preceptors in the units and facilities is done indiscreetly without consideration of their role in relation to the students' clinical attachments time period and placement specific area within the clinical settings.

One nursed educator (GINE2) had this to share:

"The other one--- ya— a-a—is transferring of preceptors from the clinical area which they were trained and sending them way --way far where there are no students." At that times when you get to the clinical area there is no preceptor. The preceptor has resigned, gone somewhere else or has been transferred thus another challenge."

Another nurse educator said:

"The preceptors are rotated anyhow not looking at what they do and the contributions they make to students."

Another nurse educator (G3NE2) had this to say:

"Actually the—the—the--most important point is that one of transferring of preceptors. When transfers are made; even within the hospital or from one locality to another, they don't consider that this person is a preceptor and will receive the student every year in this unit. They just transfer. Like currently our main referral hospitals like bo (meaning such as) Nyangabgwe where we send students, you find you come to a unit the preceptor has been moved to another unit. There is no consideration that no we need to replace this person or leave this person here for the sake of assisting the students."

A narrative from another nurse educator (G2NE3) in a different FGD:

"The other thing is that the institutions that we are using; being the teaching hospitals that we are using; I would say the management of health facilities doesn't consider the issue of preceptorship, because it's not well aligned just from the word go; from ministry to health. They have the leeway-to rotate preceptors to any ward. Let me just give an example, probably I had a good preceptor out of interest not out of training in the ICU but next time I find that person working in female surgical ward for example. There; (referring to the unit) probably is not a very good area for her and even—because-- preceptors they base on knowledge the – -the - - fact that I have been working in that area, and most of them they are just doing it not that they are interested. Yes you find a few who are interest in teaching. But it's not everybody; some they feel that students are a burden to them because they have never been inducted into

that.”

Quote from a preceptor (G1P4): *“Maybe during the time the students are allocated here, there can be an arrangement to say preceptors should give the- - the-- straight shifts, 7:30-4:30; straight shifts: at least that whole week we should be able to be accessed by students.”*

This was articulated by one preceptor (G2P3):

“Hhhmmmm-- the other thing ke gore, (it’s because) this is a referral hospital we are not based in one ward; we keep on changing. You might find that sometimes you are precepting, what might happen is that you might find that maybe; you are familiar with say male medical ward and you know what is supposed to be there, then from there you are moved maybe to surgical ward. When you go to surgical ward you are being expected to assess students, then you are just blank. You don’t know what to do; so which means it becomes very difficult for you to assess the students. So to them (students) they will be wondering what kind of a preceptor is this one. They will know what to do. They are fresh from the class; they know that underwater seal drainage you do, 1, 2, 3 but I not I’m familiar with the skill so this becomes a problem.”

Findings reveal that preceptors’ clinical placement does not facilitate consistent supervision of students since preceptors can be rotated or transferred anytime. The finding further indicates the non-supportive structure of preceptorship to both students and preceptors wherein the probability of students being left in the unit or clinical setting without a preceptor is high. Contrary to the experiences of the preceptors in this study; O’Brien (2015:17), emphasized that supervised clinical experiences are provide the learner with opportunities to apply knowledge and theory to real world situations and gain necessary skills for entry into practice. Similarly, Harvey and Radomski, (2013:2) advocate that students can be rostered alongside the preceptors so that supervision remains regular.

5.3.2.3 Category 2.3 Ineffective communication

Ineffective communication between nurse educators and preceptors was another concern that was put across by preceptors and was support by a few nurse educators in this study. The sub-categories that emerged from ineffective communication include no regular meetings and no feedback on preceptorship.

Sub-category 2.3.1 No regular meetings

It was clear from the discussions that preceptors and nurse educators do not meet regularly to discuss issues pertaining to preceptorship.

One preceptor (G2P1) said:

“But there isn’t any formal meeting that we have with them to say ok this is what I expected you to do, how far are you with students, did they manage to accomplish the objectives that they set out to come and do when they came? So there isn’t anything like that. They just come to see the students and then just go

like that. My thinking is that for somebody to be a preceptor they should be a linkage between the education and clinical part; because we are in the clinical set up we should meet and discuss.”

Another preceptor (G2P8) had this to say: *“Sometimes students come for management and they don’t want to do other……and say I’m not supposed to put my hands on the patient. I am only doing supervisory work today. So I will not know the truth because the lecturer is not there, we have not met for me to know exactly what the students should do or not do. It becomes a big challenge. The other point is maybe to increase the frequencies we meet with the training schools to discuss issues; because once a semester seems to be too long.”*

“Yes’ not only challenges; it is also for us to identify the strengths that school is already having and identify the weakness while there is time to improve on them.”

Findings are in contrast with O’Brien (2015:17-20), who advocates open communication between the clinical coordinator and the program director to ensure the success of students’ placement in the clinical site. However, the results are similar to those by Matua, Seshan, Savita and Fronda (2014: 531), wherein challenges encountered by preceptors included lack of support and effective communication from the faculty members.

A quote from a nurse educator (G2NE1) in relation to communication with preceptors:

“We make an effort to meet preceptors at the various stations where students are attached. We do discuss roles of both the preceptors as well as the students and encourage them to follow through and ask questions where they are not clear. Sometimes they do follow up by telephone to ask certain aspects which they are not so sure about in relation to preceptorship.”

The declaration from the nurse educator reflects that efforts are made to keep a flow of communication with preceptors though not through meetings. In response to how often the nurse educators communicate with preceptors whether physical or by telephone on issues affecting preceptorship;

Another nurse educator (G1NE4) said:

“Hhmm-mm; personal I think it’s an over sight on our part. I have never thought of it that it that I can make a call just to check on them. It is important; we usually meet them when we go there on schedule visits only. We should improve on that one.”

The participants’ observations and comments show that lack of communication negatively impacts on the success of preceptorship. Lack of communication verbalized by participants in this study is incongruent with findings and recommendations from studies (Liu, et al, 2010:808; Madisa, 2012:49; De Young, 2003: 241; O’Brein, 2015:17, 20; Happel, 2009:374; (Iglesias- Parra, et al 2015:4; Mothiba, et al., 2012:202; Sedgwick & Harris, 2012:4-5) who emphasize the importance of establishing frequent

communication between clinical preceptors and faculty or educational institutions as a way to facilitate success for preceptorship.

Sub-category 2.3.2 No feedback on preceptors' performance

All participants voiced out lack of feedback on preceptors' performance on their role, and this is evident in the following narratives from the preceptors.

A comment by one preceptor (G2P1):

"The other thing is that at the end the attachment there is evaluation that is being done. So it was going to be better if at all at the end of the evaluation, they do evaluate the preceptors or the institution with the students, from there they give feedback so that we know our strengths and weaknesses. Last time there were some students from Norway, they said they will give us a feedback but now it's a couple of months, we have not yet received any feedback. We don't know whether they were comparing the settings or what. I think we need to be given a feedback by the institution; the one they get from the students. I think there is a situation whereby those students who are performing well are taken outside to other countries (exchange program attachment) so when they come back to us and say while we were there; we saw 1,2,3, so that we also know if we can able to implement that or do something so that we come to that standard."

A quote from another preceptor (G2P8):

"And also in giving feedback, if you do not give feedback to the school, the school does not even follow up. I understand when students finish their attachments in the clinical area, there should be communication between the preceptors and the school on how the group performed in general, is there any loophole where there they should improvement, where the school should pull up also or is there any where there is need for further improvement?. But at times we don't have such communication between the school and the clinical area."

The lack of feedback cited by participants in this study is a cause for concern as they indicate a contrary view from literature that highlights the importance to feedback to both preceptors and students. Literature indicates that nurses have a more positive view of themselves as preceptors if they receive more feedback related to their function as preceptors and that feedback builds preceptor (Rose, 2008:106-107; Martensson et al, 2013:446).

On the contrary, one preceptor (G2P4) expressed this:

"At least with Francistown they have met us. We had two meetings. We had one in January and March at least tutors they meet us; telling us when students were coming first year, second and third years and what they expect from us. They meet us together with our management. The first meeting was with senior nurses then the second they called us to the institution so that we could share freely."

Although the findings indicated that giving feedback was perceived to be lacking, feedback during preceptorship is considered to be a great way of evaluating a student on gaps and provides guidance and consistency to skills development and allows modification of the teaching process to meet the needs of the learner (Callaghan et al, 2009:249 and Tan et al, 2011:19).

5.3.3 Theme 3: Perceived outcomes of preceptorship

Participants highlighted that preceptorship has both positive and negative outcomes. Two sub categories emanating from the outcomes of preceptorship are: benefits and challenges.

5.3.3.1 Category 3.1: Benefits of preceptorship

Despite several challenges associated with preceptorship in Botswana, participants identified some benefits of preceptorship to both the students and preceptors. The following sub-categories emerged from this category: increased preceptor's personal and professional growth and contribution to students' training;

Sub-category 3.1.1 Increased preceptors' personal and professional growth

Personal and professional growth was preceptors' benefit as they also learn from the students they supervise as articulated in the following quotes:

This was one preceptor's (G3P1)'s view:

“On a positive note; it was a learning experience from them to us as well because some of the things we had forgotten them. Some of the things have been changed and have been upgraded and students have more current information on them.”

Another preceptor (G3P4) said:

“As a preceptor you take the charge of the teacher – the – the lecturer. When the teacher is not there you take over. You continue teaching rather than when the lecturer is not there, there is nothing that they do. Some nurses just leave the students to only do bed making and nothing else. As a preceptor you are there to take the position of the lecturer you supervise and guide students and learn from them as well. They also know a lot of new things and concepts we do not know or example the nursing care plan and others.”

Study findings are supported by literature which states that preceptorship benefits for the preceptors include; opportunities for lifelong learning, improved professional growth, motivates the preceptor to up-to-date and learn new technology from students, stimulate thinking, evaluate one's own practice and knowledge (Tan et a., 2011; 17; Connor, 2015:337; Fudger, 2015:13-14).

Subcategory 3.1.2 Contributing to students' training

Participants acknowledge that preceptors and preceptorship have a significant contribution to the training of students.

A nurse educator (G1NE1) said: *"The positive things about preceptorship are that; preceptors tend to be rich in terms of skills. Usually they understand the environment within which nursing care takes place. So you find that in that regard; they are very beneficial for our students. Most often, you find that aa- aah-- if we had trained preceptors, gakere now we are saying, saying preceptors (repeated for emphasis) meaning the nurses with the students there not necessarily that they have been trained to be preceptors. If we had trained preceptors I think our students would benefit, aah-aah---will benefit much from that."*

This expression reinforces the affirmation from Shepard (2014:73) that students perceive preceptorship experiences to be beneficial for enhancing clinical competence and professionalism.

An expression from one preceptor (G3P4):

"The students benefit hands on nursing and have time to see and ask. I mean those who are keen to learn. As a preceptor you are there to take the position of the lecturer and facilitate learning."

Another preceptor (G3P1)'s comment: *"It is actually a good experience because you will be helping someone and you see them actually mature and grow in your eyes. By the time they leave the ward you can actually see that I have done something with somebody. Those who can be changed or those that can learn you can actually enjoy now talking with them and communicating with them and doing everything with them because now they have knowledge at their fingertips. They would have changed, they would have matured."*

It is evident from the findings that despite challenges entailed in preceptorship, contributing to students' training is a great benefit for both the students and preceptors. Findings further support literature that preceptorship is beneficial for personal growth and development, provides opportunities for lifelong learning and reflection for both preceptors and preceptees. Furthermore, it helps students to attain clinical competency in the clinical skills and makes them feel confident as team members alongside their supportive preceptors who teach and influence practice in contributing to the training of students (Callaghan et al, 2009:246, 249; Myrick, et al, 2011: 134-139; Tan et al, 2011:17,20; Kaphagawani & Useh, 2013:183; Hilli et al., 2014:565)

5.3.3.2. Category 3.2: Challenges to effective preceptorship

The following sub categories emerged from this category; lack of incentives; increased workload for preceptors and nurse educators and a lack of commitment by some students.

Sub-category 3.2.1 Lack of incentives for preceptors

Participants particularly nurse educators identified lack of incentives for preceptors as one of the barriers to effective preceptorship.

The following was a quotation from a nurse educator (G3N5):

“The other thing is that, this preceptorship is seen as an extra work considering the factor that there are no incentives for preceptorship. Even those nurses who may have those qualities maybe demotivated by the fact that there is no recognition, something that shows that we recognize that you are doing this preceptorship work in addition to what you are doing as a nurse.”

This was an expression from a nurse educator (G1NE3):

“I think they are not motivated that is why they are not able to do their roles as preceptors. There is no incentive.”

Another nurse educator (G1NE5) said this: *“On the incentives aspect; I think it is getting better nowadays because if they assist the students they get CPD points. With that; they are coming forth to assist the students because it is some form of incentive, they will get some CPD points otherwise there were no incentive given to preceptors.”*

A quotation from another nurse educator (G2NE3): *“The other thing is that, if we are still taking preceptorship we should consider that; it’s a-a-a-a-a, it is an additional activity on their normal day-to-day work load; and to a certain extent there is no remuneration for that. Though sometimes we say professionally money is not a motivation, but if you are doing something that you know that ----yes, I have an extra benefit; they will make it to a point that they do it at least to the nearer level that we are expecting. Currently they are not getting any thing for it.”*

However, it is worth noting that lack of incentives for preceptorship is not unique to preceptorship in Botswana. Tan et al., (2011:18) stated that in these times of fiscal uncertainties there are issues of lack of financial resources as compensation or reward which can impact on the development and sustainability of preceptorship programmes.

Sub-category 3.2.2 Increased workload of preceptors

The increased demand for health human resource in Botswana which has been identified as top priority depicted in the Ministry of Finance Botswana, 2003 /04-2008/09:306-309 and Ministry of Finance Botswana, 2009-2016:66 and has resulted in an increase in the number of students enrolled in health training institutions. The increased number of students subsequently results in increased workload of preceptors who are to supervise the students in the clinical settings.

A nurse educator (G1NE3) was quoted saying:

"I don't think we are really meeting the objectives of preceptorship; especially because of the workload issue. That one is a big challenge. Our students they go there, they end up being used to check vital signs and things like that, because the preceptor is too busy to attend to them."

In addition another nurse educator (G1NE5) who shared the same sentiments said:

"E ee- e-e, to add on what our colleagues has just mentioned, yaa--- the workload is just too much."

One nurse educator (G3N4) started with laughter then said: *"Ke bue ka sekgowa"* (meaning should I speak in English?) He continued to say:

"I was saying in choosing preceptors; the management of the facilities or units should understand the importance of preceptorship. We know often times the nurses are faced with so many challenges as they have to do so many things so eee—eee preceptorship seems to be a burden also to their everyday undertakings. We must make sure we give them support or take off some duties and relieve the burden so that they can be able to attend to students."

Based on findings and supporting literature, it is comprehensible that preceptors' workload does not allow them time to attend to students' learning needs. This notation from the nurse educator is congruent with O'Brien (2015: 18), 's assertion that it is of paramount importance that "all parties should be clear that students are not a paid employee nor are they free labour and that their clinical experience is viewed as a crucial part of their education. The sentiments are further backed up by literature that highlight the need for development of strategies that address the needs of clinical preceptors to foster a sense of recognition and belonging of which incentives are part of. Recognition was viewed to be a significant predictor of preceptors' perceptions of their performance (Liu et al., 2010: 807; Martensson et.al, 2013:448; Panzavecchia & Pearce, 2014:1122).

Preceptors shared similar sentiments that increased workload impacts negatively on their role of preceptorship. This was a comment from a preceptor (G2P5):

"Hhmmmm.... I think eemm—mmm, mixing our routine duties with preceptorship is impacting negatively on the students and how we follow them up, because for us to know that they are doing the right thing we have to follow them up. But then, leaving them and doing the ward routine is impacting negatively."

This was said by another preceptor (G1P4):

"I was trained as a preceptor for 3 days in Kanye; last year in June. But ever since then I don't see myself useful to students because of work, sometimes they come here and I am on night duty and will be away the whole week."

Participants' narratives reflect that preceptors are not exempted from routine tasks to allow them time to focus on the supervision and evaluation of students' learning activities. The expressions from participants

confirm recommendations from a related study whereby students expressed concerns that workload issues compromised their learning opportunities (Kaphagawani & Useh, 2013:82). The findings are further supported by other authors (Liu et al 2010; Gaberson & Oermann, 2007:228; Martensson et al., 2013:448; Courtney-Pratt et al, (2012:1380) who underscore the importance of adjustment of the preceptors' workload as an important measure to be undertaken to facilitate the preceptors' role. Development of a preceptorship model that recognizes the role of the preceptors in students' clinical teaching is imperative to facilitate improved implementation of preceptorship.

Sub-category 3.2.4 Lack of commitment by students

Participants especially preceptors expressed concerns related to lack of commitment and unprofessional behaviours of some students.

A quote from another preceptor (G3P4): *"I would want maybe the people in charge of the student nurse; the nursing school is to address their professional adjustment and the ethics in the working place. They don't really behave like---maybe let me say some of them behave like they are not training to be professional nurses."* *"They just behave like they are in the village or anywhere else. We believe when you are doing nursing, there should be what we call professional adjustment I don't know if it is there in your curriculum or ethics? When they come as a group they just behave like they are still outside there not knowing they are in an environment where you are expected to behave in a certain manner. I don't want to mention names because I know some actually by name; who would come when doing night shift; like you do assessment, after that you don't even know where they are. The next thing-- the next time you see them it's in the morning at 5o'clock to come for assessment again. When you ask them where they were; they will tell you we went to sleep because there was nothing to do. Meanwhile patients are crying all over, you don't know where to get help from. So basically I'm saying they should adjust and know when to do what."*

Another preceptor (G3P1)'s comments:

"The behaviours are totally different if you look at it. On night duty you are not supposed to sleep. You are supposed to be working. When now we are talking about resting, where are you supposed to rest? Because there is no bed in the ward for a nurse; you are there to look after patients. The other problem is; these students are also not seen by us only. So it might be that one day they will be with Mma Ma.... Mma Ma..... (meaning Ms so and so) who doesn't allow a nonsense, doesn't allow them to misbehave and they are very fruitful but if they go to let's say to somebody", they see her sleeping, they see her take a blanket and say I'm going to rest, they will also do it too. The quotations is support by Koontz et al., (.2010:240-246)'s declaration that preceptors should role model positive professional behaviours to students. G3P1 continued: The way they behave tells you that this one tomorrow is going to be a

problem. The nurses that we are going to produce are going to be something else. They are the ones who are going to nurse us also when we get sick. This is what we experience while dealing with the students.”

A statement from one another preceptor (G2P1):

“I don’t know. Maybe I will ask for advice ee- ee- (clears throat) the....the lecturers that side if they can build trust and cooperation within them and the students. Sometimes it’s difficult to work with them. Interviewer asks, with whom? G2PI responded; with the students. They will be having some issues there. When they come this side it’s another issue, from what they were taught by the lecturers now we are trying to teach them the real field work it becomes a challenge Uu--hmm.”

Another preceptor (G2P3) verbalized this: *“The other thing; those students I don’t know if they don’t know what is expected of them during their practice work. Sometimes they do the procedures. When they do the procedure they just come with that assessment tool and give it to you and say may you please mark for me here. I did procedure 1, 2, 3, but there was no pre-arrangement with me that I have to assess. Some time we used to talk to them that when you are doing a procedure you have to consult me so that I know and I should be in a position to assess what you are doing. At times they don’t alert you but want to give you the assessment tool to sign that they did the procedure; which is not right.”*

One nurse educator (G1NE)’s expression:

“One other challenge is on the students’ side. The students when they are allocated to the clinical area usually they know what procedure they are going to do. So they will be more procedure orientated that they don’t want anything else outside that. You find them standing in the passage; they are waiting to do the procedure even if there is an emergency, ‘emergency aside; “I’m waiting to be assessed.” They become too much procedure oriented and sometimes the nurses also they leave them. They back-off from the students because the students are not willing to be taught or to learn.”

This comment was from another nurse educator (G2NE3):

“So students normally play around with what they should be doing. They twist everything and it appears to be. That is why at times preceptors end up over scoring them (referring to giving high or inflated marks) because students will say No thus no longer the expectation simply because preceptors have little knowledge the students will take advantage of that. Ee-ee, they will manipulate the system. Even when it comes to discipline, because training we are not only looking at the marks, but we are looking at shaping behavior of an aspiring professional; so that tomorrow they will be able to be people of discipline. But to what extent can that poor individual, that preceptor discipline the students? It will wait until students play it around and write letters and they get away with whatever; that uncalled for behavior.”

Findings indicate that most students are not taking an active role in their learning and lack self-motivation and self-directness. This observation is contrary to literature which highlights that during preceptorship

there is need for students to recognize learning objectives and outcomes and identify learning opportunities (Lwatula, 2011: ICN Poster, no page number).

5.3.4 Theme 4: Suggestions for the success of preceptorship

Participants suggested strategies that can be employed to make preceptorship successful. Two categories emerged from this theme namely: Empowerment and training of preceptors and collaboration with key stakeholders.

5.3.4.1 Category 4.1 Empowerment and training of preceptors

Participants suggested empowerment of preceptors as pivotal in their contribution to the clinical training of students and the success of preceptorship. Two sub-categories emerged namely; increased training of preceptors and incentives for preceptor.

Sub-category 4.1.1 Increased training of preceptors

Inadequate training and orientation of preceptors and few preceptors was identified as a sub-category under unstructured preceptorship and inadequate human resources respectively. It is in this context that participants suggested the need to increase training of preceptors.

A preceptor (G1P5's comment:

"I have a suggestion, we don't have a training school here but I believe we are a training hospital for psychiatric attachment. It could be ideal for all nurses to be trained as preceptors in my own opinion, so that whoever is around can assist the students."

Another preceptor (G1P3) supported the notion and said:

"As you see gore (translated to mean as you see that) if every nurse could be trained that will be a good thing because once there are more nurses trained; it will be easy. Preceptors are not there, as for Mr Nzi..., (name withheld for anonymity) at least you know he is a preceptor because you know he was trained. We need to be trained as preceptors. We just do it without direction so we don't know whether we are taking students to the right way or we are doing the wrong thing."

A nurse educator (G1NE4) verbalized this:

"We need to do more training of preceptors for preceptorship to be effective and beneficial."

The narratives of participants support literature findings and recommendations that preceptors require specialized skills and competence related to different learning of students in order to be competent and responsive as clinical teachers. Furthermore, training of the preceptor increases confidence and preparedness for the assessment role (Johnson & Mohide, 2009:346; Hiden, Jacobs & Marshall, 2014:179).

A comment from another nurse educator (G1NE6): *"Training of preceptors will help them perform their role and meet clinical learning objective for students."*

This was a narrative from another nurse educator (G3N2):

“I think this one, what they normally call commitment to training of nurses in the country; the ministry has to committee itself and sees to it that preceptors’ training is part and parcel of a-a-a of the training of nurses in the country. They have left them to training institutions but the institutions do not have the budget to train the preceptors. They have to take from their limited budget that they are given every April to put in for training of preceptors which is not possible.”

An expression from a nurse educator (G3NE5): *“We must make sure that preceptors are trained. We should train then funds should be available for us to train them. Ministry of health should provide funding.”*

It is evident from the homogenous responses of both preceptors and nurse educators that the need to prepare preceptors for the role through training and to increase training sessions cannot be over emphasized. The findings of this study are commensurate with literature that emphasizes the importance of adequate training and preparation of preceptors for the role (Happel, 2009: 37; Horton et al, 2102; E2; Lambert & Glacken, 2005; cited in Kristofferzon et al., 2012:1253; Martensson et al, 2013: 448; Hovland, 2011:3; Hyrkas, et al, 2014:120, 131; Panzavecchia & Pearce, 2014: 1120).

Sub-category 4.1.2 Incentives for preceptors

Giving incentives to preceptors was another suggestion the participants perceived would contribute to the success of preceptorship. Incentives as a form of recognition; confer reward power to the recipient thus motivating preceptors in performing their role.

A nurse educator (G1NE1) made this suggestion:

“Maybe another suggestion is for the current preceptors who are in the clinical are to have some incentives. During the time that the students are in the clinical they should always be available knowing that at the end when the students are gone the can be given an extra off or just some kind of incentive to help them to be motivated.”

An expression from another nurse educator (G2NE3):

“Probably that preceptor; she would love to go into the school to teach, and we should be saying probably after this experience of preceptorship now we take them to the higher level that if they qualify they can be further trained just as a developmental plan for somebody to progress to the formal teaching at the institution. Let preceptorship have some incentives. Let there be something that we will say because you are a preceptor have this, we recognize you with this.”

Another one (G2NE5) had this to add: *“Certificate maybe. Yes something. It can be a certificate or something monetary or something in the demarcation of work to say that if students are in, you are a*

preceptor so you will be focusing on students and not be given general duties like any other nurse ee—ee, that can also be assisting.”

The quotations concur with Liu, et al. (2010:807), who suggested that provision of ongoing professional development activities may be a valuable strategy to replace the monetary awards.

Preceptors made similar suggestions to those of nurse educators as indicated in their narratives.

Another preceptor (G1P3)’s expression:

“These days people do advanced diplomas so maybe things have changed, they are no longer like we used to do in the past. Even preceptors I think they should be aware of that. They (preceptors) should be given some education, if not a certificate maybe a diploma course (big laughter by all participants but all in agreement). Some of us are not interested; so you are the ones (referring to the training institutions) to make us have interest because we are not recognized. If you are recognized; maybe that is when you can contribute. But if you are not recognized for what you are contributing in the daily teaching of the students and the development of the hospital somehow ..., ke tsa gore (meaning I take it that) preceptors should be recognized.”

One preceptor (G1P1) from the same focus group made this addition: *“For preceptors to feel appreciated; it’s an incentive. Also a small token to show that; this one is a preceptor even if it’s P200 above one’s salary. It is not easy I know. This was followed by a big laughter from other participants who at the same time were in agreement.”*

It was interesting to note that participants did not only consider incentives in monetary form, but suggested a wide menu of affordable incentives. Suggestions of participants in this study are supported by other studies which emphasized that recognition and support from faculty, management and staff is essential to the success of preceptorship. The authors highlighted that recognition can be offered as a luncheon, certificates, invitations to recognition events, or even a letter as a token of appreciation for the job well done (Rose, 2008:107; Tan et al., 2011:18 De Young, 2003: 242). Findings also corroborate with Liu, et al (2010), who posited that provision of ongoing professional development activities may be a valuable strategy to replace the monetary awards.

5.3.4.2 Category 4.2 Collaboration with key stakeholders.

Collaboration between HTIs and their stakeholders was suggested as one of the strategies that could enhance success of preceptorship. Two sub-categories that emerged were: Partnership of health training institutions and clinical settings; and partnership with accreditation bodies.

Sub-category 4.2.1 Partnerships between Health training institutions and clinical settings

Two preceptors (G1P1& G1P2) from one focus group said:

Health Training Institutions; and continued to say: It is what they want from of the students and they bring it to us; and tell us this is what we want these student to come out like. (G1P3) added to say: But we cannot also leave out the health facility because this student is being taught there and we have hands on, we know what we want from a nurse. We want to take this student Re morote tiro (we teach her work) (ummmmm... hmmm group agreement then laughter from group) G1P4 contributed by saying: We need each other; even the preceptor is an important person. (Laughter from group members) G1P6 concurred with other participants by saying: Yes, it's an egg and hen issue we need each other."

Another preceptor (G3P1) said:

"Those from the clinical area; please ask those who are hands on; they are the ones who know what is really happening or what will be going on in the ward. If you ask somebody who is in the office they will tell you that there is 1, 2, 3, and yet in the ward maybe the kids come, that thing is not there and you at the school are expecting that the thing is going to be available when in actual fact there is nothing in the ward. I think both the school and clinical area they should work together, because in the clinical area you know what you want and what you need and what you are working with. At the school they know what they are teaching so they can work together."

Another preceptor (G3P5)'s comment: *"Eee—ee; the supervisors' should be included for support also. Because like she was saying that she was told she was not being paid for this; it means the supervisor did not understand why she had to spend such a long time with the students. So we also need the supervisor and the one who is hands on, they are all needed."*

A nurse educator also expressed the same sentiments and said:

"I think also the staff (supervisors) in the clinical area should be oriented to the roles of a preceptor so that they know what is expected. Probably if they know what is expected they can relieve them of some of their duties. Maybe they are not relieving then because they are not sure of what they are supposed to be doing."

A preceptor (G2P2) said this:

"We can also include our customers, because they are the major beneficiaries of our services. They need to know that this is what happens in a nursing programme. Students are taken for preceptorship. They need also to look through the components and say ok is this what we expect as the users of facilities or as beneficiaries if this service that this individual when they exit their studies they are going to bring to us things. I think they should also be taken on board when IHS (s) have open days or pitso (pitso refers to

stakeholder consultative workshops). *They can add on and say; this is what we expect can be done as communities or customers.*”

A suggestion from another preceptor (G2P8):

“I think the nurses; since they are the cadre who are supposed to be precepting student nurses. They should be actively involved in the planning phase because not all nurses are interested in precepting. All nurses should be taken on board.”

Similar to the findings in this study, Hallin and Danielson (2009:163), accentuate that a preceptor model with a unique partnership for facilitating learning environments that accommodate all kinds of nursing students, nurse preceptors and teachers is vital. The authors identified supporters with a strong interest in collaboration and preceptoring as elements for success of preceptorship. According to Jeggles et al. (2013:6), a preceptorship model developed from the partnership formed between universities / training institutions and provinces that provided the clinical learning environment for students during preceptorship would enhance the clinical training of students and delivery of services to the recipients of health care services.

Sub-category 4.2.1 Partnership with accreditation bodies

Different accreditation bodies that were suggested to form partnerships with health training institutions include Ministry of Health and Wellness; Botswana Qualification Authority (BQA); Human Resource Development Council (HRDC) Nursing and Midwifery Council of Botswana (NMCB).

A preceptor (G2P2) shared these sentiments:

“I feel with the current certification standards we should involve HRDC or BQA because it matters most on what the students have at the end of the day. Them being people who are certifying or accrediting courses being offered, they should also look at preceptorship how it is being done. Is it up to scratch or there are areas we need to work on because nursing is more practically than academic. At the end of the day you are going to have students who are not practically oriented outside there. It’s going to be a challenge. So they also should take part in looking at the preceptorship. When they evaluate the courses they should look at the preceptorship component. How is it being done? Is it something that is up to scratch or they need to overhaul some few things? I also feel there should be a kind of a champion that eee--hhh- mmm, lead and guides on preceptorship. A kind of national structure whether inclusive of the University Of Botswana, Institutions of Health Sciences so that they can be able to say ok; this is what we expect in a preceptorship program for a diploma level, degree level or master’s degree level so that eventually the output being the students are of a higher quality.”

Another nurse educator (G3NE2) made the following comments:

“Yaa it can be ee-ee a cadre among the- the--- normal ones in the ministry of health. E ee-ee it needs to be a cadre on its own. Like we have got auxiliary, we know we have a porter, nurse and orderly. This also must be officiated. It must be an official responsibility within the health cadres ee—ee. Preceptorship should be catered for at the level of the ministry. In the training of preceptors I think they should also have a hand, I mean the ministry of health. They are a very important body.”

Findings are coherent with Morgan et al. (2012:35), who state that without the support of stakeholders and professional bodies, the effort and enthusiasm of practitioners who serve as preceptors may be destroyed due to lack of recognition. Similarly, other researchers indicate that a model of supervision in which different facilitators have clear roles and developed through cooperative discussion can be a successful model with the preceptor being an important bridge between education and the practice setting (Hilli and Leena- Melender, 2014:8; Tan, et al., 2011:170). The allusions call for all stakeholders and accreditation bodies’ partnership in preceptorship planning; support for the role in order to facilitate the success of preceptorship. Registration of preceptors by accreditation bodies and keeping a database for all preceptors at clinical settings could enhance the success of preceptorship. Participants narrated their perceptions as stated:

A quote from a nurse educator (G2NE1):

“Yaa I was going to propose that; probably even the Nursing and Midwifery Council could also come into play as a stakeholder because after all, they are the prescribers of nursing practice. So; Nursing and Midwifery Council (NMCB) should also have a say towards the – the prescription of preceptorship training just like they own the general nurses’ training.”

Another a nurse educator (G2N3) had this to say:

“Like nurses; preceptors also need to be registered as preceptors, gore if you are a preceptor then it has to show that you are a nurse practitioner also a preceptor in your certificate; in practice the license or something.” (Other participants also agree by saying yes)

A narrative from another preceptor (G1P3):

“Also maybe to have a register of nurses, to know gore (that) which nurses have been sent somewhere with this qualification so that wherever he or she is; even the matron will know gore this one is a preceptor, so that we don’t miss them. Some people ga kere (means is it not so?) when they get lost they say; “no I’ am longer a “psych” nurse I’m a general nurse. They will be hiding somewhere so that they will only do the other work to reduce the workload.”

The findings further, support Rose (2008:105), who opines that maintaining record should be a key component faculty must include in the implementation of preceptorship. The author affirms that record

keeping is an essential component of preceptorship experience for nursing program, and accreditation bodies. The information in the records should include; active licensure status, qualification, years of experience, facility contact information, preceptor contact information, contractual information between the facility and the nursing program, contractual information between the preceptor and individual nursing program.

5.4 SUMMARY

In this chapter the results of the qualitative approach (focus group discussions) were presented. Analysis revealed strongly positive and negative perceptions from both preceptors and nurse educators regarding preceptorship practices. Themes, categories and subcategories that emerged were discussed in line with supporting literature. The data also revealed challenges, benefits and suggested strategies to improve the effectiveness of preceptorship. Suggestions for improvement were made. Chapter 6 presents merged results of the quantitative and qualitative designs

CHAPTER 6

INTERPRETATION OF MERGED FINDINGS

6.1 INTRODUCTION

This chapter merges the quantitative and qualitative data described in chapters 4 and 5 and reports the findings from preceptors and nurse educators' responses regarding preceptorship as a teaching strategy in clinical nursing education in Botswana. The chapter compares and interprets significant results from the quantitative and qualitative designs supported with relevant literature sources and conclusions drawn from the merged results. Quantitative and qualitative responses of participants to their perceptions on the structure, process and outcome of preceptorship experiences and practices merged and similarities and differences highlighted. In this converged Mixed Method Design (MMD), results were compiled from nurse educators' and preceptors' (n=157) responses from the quantitative descriptive survey component using self-administered questionnaires whilst qualitative result emerged from FGDs comprising a total of (n=39) participants using semi-structure interview guide. The quantitative and qualitative data were collected concurrently giving the two designs equal weighting.

6.2 FINDINGS

Table 6.1 illustrates the distribution of participants from the quantitative and qualitative designs of the study in terms of their numbers.

Table 6. 6 Number of participants and respondents in the MMD

Quantitative Results	Qualitative results	Merged findings
Preceptors n=107	FGDs n=22	Preceptor :N=129 (quantitative 107 + qualitative 22)
Nurse Educators n=50	FGDs n=17	Nurse Educators: N =67 (quantitative 50 + qualitative 17)
Total =157 (107+ 50)	Total = 39 (22+17)	Total Participants: N=196 (129 preceptors + 67 nurse educators)

A total of 110 questionnaires were distributed to the preceptors and (n=107; 97.3%) were completed and returned. Questionnaires distributed to nurse educators were 52 and (n=50; 96%) were completed and returned. Three (3) FGDs were conducted for preceptors with a total of 22 participants. Similarly three (3) FGDs were conducted for nurse educators wherein a total of 17 participated. Findings from preceptors and nurse educators will be discussed concurrently for comparison.

6.2.1 Demographic characteristics of participants

Table 6.2 presents the demographic characteristics of as preceptor or nurse educator following students and preceptors during preceptorship.

Table 6. 7 Demographic profile of participants and respondents

Variable	Quantitative	Qualitative	Merged Results
Age	range 25-64years mean age 49.8years	range 29-56years mean age 41.3years	range 25-64 years mean age 45.5years
Gender	Female: n=108;68.8% Male: n=49; 31.2%	Female: n=24; 61.5% Male: n=15; 38.5%	Female: n=132; 67.3% Male: n=64; 33.7%
Designation/ position	Preceptors=107; 68.2% Nurse Educators =50; 31.8% Total: n=157	Preceptors =22; 56.4% Nurse Educators=17; 43.6% Total: n= 39	Preceptors=129; 65.8% Nurse Educators=67; 34.2% Total: n=196
Years of experience in current position	Maximum years of experience was 23 yrs. whilst minimum was 1year	Maximum experience was 34 yrs. whilst the minimum experience was 2 yrs.	The differences in the experiences of respondents might have been due to the convenience and purposive samples used. However, the majority (n=28; 71.8%) of participants in the qualitative and (n=126; 80.3%) from the quantitative and have been in their current positions for 10 years and below
Highest qualification	Master's Degree =15 Bachelor of Nursing Science= 46 Bachelor of Education (Nursing)= 6 Post Basic / Advanced Diploma=25 Diploma in General Nursing= 58 Others (not specified)=5	Master's Degree= 3 Bachelors of Nursing Science =18 Bachelor of Education (Nursing)=1 Post Basic diploma / Advanced= 8 Diploma in general nursing =9 Others (not specified)=0	Master's Degree =18 Bachelor of Nursing Science=65 Bachelor of Education (Nursing) =7 Post Basic/ Advanced Diploma=33 Diploma in general nursing=67 Others (not specified)=5

Age: There was a difference between the minimum and maximum ages of participants in the quantitative and qualitative components as the analysis revealed minimum and maximum age differences of 4 and 6 years respectively. Age difference could have been attributed to the purposive and convenience sampling

techniques used to recruit participants. The ages of participants might also have an influence on their experience and perception about preceptorship since older nurses have more experience in the professional role than younger ones (Hyrkas, Linscott & Rhudy, 2014:120,131; Canadian Nurses Association, 2004:1).

Gender: Females comprise the majority compared to their male counterparts in both designs. This could be attributed to the fact that nursing is still a predominantly female dominated profession.

Designation / Position: The majority of the participants were preceptors in both study designs. Participants in the study were nurse educators from the six (6) health training institutions who are involved in preceptorship practices. On the other hand, preceptors who participated in the study were nurses from clinical settings who supervised preceptorship clinical learning activities of level three (3) students from the health training institutions during clinical attachment. Position or designation in terms of rank or seniority was not a selection criterion for recruitment of participants. Both senior and junior nurses and nurse educators participated in the study by virtue of their roles or involvement in preceptorship practices.

Years of experience in current position (as a preceptor or nurse educator following students and preceptors during preceptorship)

Years of experience as a preceptor or nurse educator following up preceptors and students ranged between one (1) year to 23 years for the quantitative component and two (2) to 34 years for the qualitative component respectively. There was no significant difference between the minimum years of experience for participants in both components of the study since the years of experience are almost similar one (1yr) for quantitative and two (2yrs) for qualitative. A significant difference was observed between maximum years of experience in the two designs; 23yrs for the quantitative component and 34yrs for qualitative component of the study.

The differences in years could be a result of two possible causes namely; the non-categorical ranking of age on the survey tool wherein participants were writing their actual ages. Secondly, use of the non-probability sampling techniques in both study designs. It is worth noting that, (n=154; 81.0%) of participants who responded to the item had been involved in preceptorship activities for 10 and less years. These findings could be indicative that participants lacked experiencing in their role as preceptors or in following up and giving guidance and pedagogical support to preceptors and students as nurse educators.

Highest qualification of participants

The highest qualification was a Master's degree for nurse educators and bachelor's degree for preceptors from both the quantitative and qualitative components. However, five (n=5; 2.6%) of participants from the quantitative component did not indicate their highest qualifications. Slightly over 50% (n=101;

52.9%) of participants (preceptors) had a highest qualification of a diploma; either diploma in general nursing or post basic / advanced diploma in one of the nursing fields as shown in chapter 4; Tables 4. 1 and 4.17. The merged findings indicate that the majority of participants (preceptors) might not be very skilled and competent nurses to perform the preceptorship role as they do not possess a teaching qualification. The majority (n=184; 96.3%); did not possess an education or teaching qualification. Only (n=7; 3.7%) had a Bachelor of Education-Nursing degree; i.e. six (6) nurse educators from the quantitative and one (1) from the qualitative design respectively. None of the preceptors had an education or teaching qualification. Their qualifications might also influence their ability to socialize students and evaluate learning outcomes. The findings are consistent with preceptorship literature globally that preceptors are appointed or selected to the preceptorship role with no or inadequate preparation for the role (Hilli and Leena-Melender, 2014:4; Kristofferzon et al., 2012:1253). In this study only one of the 17 nurse educators who participated in the focus group discussions possessed an education or teaching qualification. Some of the nurse educators have only undergone a one week workshop on effective teachings skills through trainings done by the MoHW in partnership with Jhpiego developmental partners, while others have not received any formal orientation to teaching.

This observation is contrary to with Hill et al (2014:573) that the most effective preceptors are senior nurses and should be well prepared for the role. Results reveal that participants are not well prepared academically to effectively facilitate clinical teaching and learning. Similarly, Kalomo et al., (2015:1096) affirms that educational qualifications need to be considered when choosing preceptors. However, it is worth noting that the findings in this study might have been influenced by the convenience of preceptors.

6.3 PERCEPTIONS REGARDING STRUCTURE OF PRECEPTORSHIP

In the quantitative design, questionnaires were used to obtain information from respondents' about the structure of preceptorship; while FGDs were conducted to obtain information for the qualitative component. Table 6.3 depicts the perceptions of participants from both designs regarding the structure of preceptorship.

Table 6. 8 Preceptors' and nurse educators' perceptions on the structure of preceptorship

	Quantitative findings	Qualitative findings	Interpretation
Inadequate Human Resource	74.7% of respondents disagreed that preceptors are always available to students	Unavailability of preceptors and nurse educators during preceptorship	Quantitative findings are supported by participants' quotations in subcategory 6.3.1.3; wherein participants verbalized shortage of preceptors to effectively resource supervise students and nurse educators to follow up and provide guidance to preceptors and students.
	80.3% agreed that the selection criteria for preceptors need to be revisited	Unclear selection criteria for preceptors	Both the quantitative and qualitative findings are in agreement that the criteria used for selection of preceptors needs revisiting. The selection of preceptors is done without consideration of interest and preparation. Findings are supported by (Hyrkas, Linscott & Rhudy, 2014:120,131; Hilli and Leena-Melender, 2014:4) that selection of preceptors is done without consideration of interest and preparation. The conclusion is that the criteria for selection of preceptors is not appreciated by participants and needs to be re-considered to get the right nurses to perform the role.
Time pressure:	Over seventy four percent (n=80; 74.8%) of preceptors and (n=44; 88%) nurse educators disagreed that preceptors have sufficient or adequate time to discuss learning objectives on daily basis with each individual student.	No time allocated for preceptors	Findings from both study designs concur that there is no time allocated for preceptorship activities. Time pressure might be attributed to increased workload. Lack of time by preceptors compromises the effectiveness of preceptorship
	68.3% of preceptors indicated that they have insufficient time to perform their nursing roles while functioning as a preceptor		
	64.0% of nurse educators agreed that due to time constraint they only follow	Minimum time for muse educators	Findings from both designs corroborate in that nurse educators experience time pressure in

	preceptors and students for assessments and seminars		facilitating preceptorship activities for preceptors and students. Lack of time by preceptors was a factor impacting on their learning at times preceptors were hard to find. Similar to the findings of this study, lack of designated time for preceptorship was identified in other studies (Croxon & Maginnis, 2009:240 Martensson et al., and 2013:448).
Problems with preceptorship guidelines	65.5% of the respondents agreed that guidelines for preceptorship are available and clear	No clear guidelines for preceptors	Conflicting results evolved from the quantitative and qualitative study components in relation to availability and clarity of preceptorship guidelines. Over two thirds (65.5%) of participants in the quantitative design indicated that clear preceptorship guidelines were available to preceptors. On the contrary, a great majority of participants in the qualitative design verbalized that preceptorship guidelines were either not available or were not clear and not implemented the uniformly by different training institutions. The conclusion from the findings is that lack of guidelines poses a risk of objectives of preceptorship not being met. While recommendation of preceptors indicates unstructured preceptorship, Tiwaken, et al., (2015: 68, 72) confirmed that expectations of students are not met as staff are sometimes not aware of students learning objectives and lack guidelines thereof.
		Lack of uniformity in the implementation of guidelines	
	91.0% of respondents agreed that they recommend development of preceptorship model specific to the Botswana context	Not indicated in the qualitative but supports problems of unavailability and no uniformity in implementing guidelines	
	86.0% disagreed that the model of preceptorship used in Botswana was well known and understood by all nurses, students and preceptors	Not clearly reflected in qualitative results but was inferred to be part of problems with guidelines	Although participants in the qualitative design did not clearly verbalize lack of a preceptorship model, lack of such a model was inferred in the participants' quotations and narratives such as lack of formalization of preceptorship activities by training institutions, lack of and inconstant implementation of preceptorship guidelines. If there was a clear model such gaps would not exist. Most respondents in the quantitative design indicated that
	80.9% agreed that preceptorship needs a lot of restructuring to meet its objectives	Not indicated in the qualitative design. However, it is supported by	

participants' expressions such lack of preceptorship guidelines and lack of support

they recommend development of a preceptorship model for Botswana and asserted the need for restructuring of preceptorship. The quantitative results are supported by themes and subcategories from the qualitative design and quotations from participants indicated in subcategories: 6.3.1.1; 6.3.1.2. From the merged results it can therefore be concluded that there is no preceptorship model if present, it is unknown to stakeholders. The need to develop the model to guide preceptorship is imperative.

6.3.1 Inadequate Resources for Preceptorship

Findings from the study indicate that resources for preceptorship are in inadequate and that preceptorship needs restructuring. The highlighted inadequate sources were; lack of preceptorship guidelines and inconsistencies in the implementation of guidelines for preceptorship, inadequate human resource and increased time pressure / lack of time for preceptorship activities by both preceptors and nurses' educators.

- **Lack of clear preceptorship guidelines**

Mostly the responses on the structure of preceptorship from the two designs of the study are analogous. Only few differences were observed. In the quantitative design, the majority of respondents (91.0%) agreed that they would recommend a model of preceptorship to facilitate clinical nursing education in Botswana. Furthermore, (84.0%) agreed that preceptorship needs a lot of restructuring for it to meet its intended objective. In the qualitative phase participants verbalised concerns about lack of guidelines and indicated that where guidelines were availed there was lack of uniformity in their implementation by different training institutions which supports the need for restructuring of preceptorship and development of a preceptorship model to facilitate implementation of preceptorship.

- **Lack of uniformity in implementing guidelines.**

In spite of 65.5% of the respondents in the quantitative design who agreed that guidelines for preceptorship are available and clear, participants in the qualitative component, particularly preceptors disagreed. Findings concur with Hill and Leena-Melender, (2014:4) who affirmed that learning outcomes are communicated to preceptors earlier and objectives are not made clear. Preparing content to serve as quick reference during preceptorship leads to better preceptor preparation and increases confidence of the preceptor to provide meaningful guidance to nursing students Staykova et al., (2013: e35).

Conclusion: The differences in the perceptions of participants indicate ambiguity in the way participants understand preceptorship guidelines and their importance to effective preceptorship. Furthermore, the lack of uniformity in the implementation of guidelines subjects students to variations in learning and achievement of preceptorship objectives. Lack of clear guidelines and lack of uniformity in the way guidelines are implemented might cause confusion to preceptors especially those preceptoring students from all health training institutions. This therefore requires health training institutions to standardize preceptorship guidelines to ensure consistency.

- **Unclear criteria for selection of preceptors**

In the quantitative design participants (n=126;80.3%) agreed that the selection criteria for preceptors should be revisited. In the qualitative component this was expressed with sentiments like; preceptors should volunteers for the role as opposed to being selected by supervisors. Some participants suggested that colleagues of preceptors should be consulted when a decision is to be made about who should be a preceptors. The findings support (Botha et al., (2012 [http:// dox.doi.org/10.14804/1-1-25](http://dox.doi.org/10.14804/1-1-25)) that to match the preceptor to the role requires a structured process and should include specific selection criteria and screening interviews. Furthermore, Young et al.,(2014:1-6) indicate that excellent preceptors are those who are interested in teaching, accessible to students, provided feedback, served as role models, were organized and spent more time with students.

Conclusion: It is evident from the empirical findings that the criteria used to for selection of preceptors does not consider the preceptor's interest in the role and other qualities of a preceptor described in preceptorship literature. It is therefore imperative that the selection criteria currently used be aligned with literature recommendations in order to get the right nurses to perform the role and ultimately assist students to accomplish their clinical learning objectives during preceptorship.

- **Category: Inadequate Human Resource**

Unavailability of preceptors and nurse educators during preceptorship

Findings from both study components are in agreement that preceptors and nurse educators are not always available to facilitate teaching and learning activities during preceptorship. Quantitatively, the majority of nurse educators (n=44; 88%) disagreed that getting nurses to serve as preceptors was not a challenge. Similarly, preceptors (n=80; 75.5%) disagreed that; they are always with students in the clinical setting to facilitate learning attribute indicating that there are not enough preceptors to facilitate effective clinical teaching and learning. Quantitative findings were supported by participants' verbalizing that both nurse educators and preceptors are not always available to implement and support preceptorship activities. The importance of availability of nurse educators and preceptors in enhancing students' clinical learning during preceptorship cannot be overemphasized. Findings are congruent with preceptorship literature that preceptors are not always available to students (Fudger & Belcourt, 2015:15)

Conclusion: From the findings and literature support there is conclusive evidence that key players like preceptors and nurse educators are not available to guide preceptorship. From the results it is suggestive that clinical settings and health training institutions should work collaboratively to develop logistics of availing adequate human resource, agree on selection criteria for preceptors to facilitate effective implementation of preceptorship to overcome the current challenges emanating from this study.

- **Category: Increased time pressure**

Both participants from the qualitative and quantitative designs agreed that nurse educators and preceptors do not have sufficient time to effectively execute the preceptorship activities as reflected in the results on Table 6.3. Some participants verbalized that the reason why some nurses are not willing to take up the preceptors' role is because there is no time allocated for it hence they dissociate themselves. Lack of time for preceptorship has been documented in literature as a problem and potential risk for medication and other errors that can be caused by unsupervised students (DeYoung, 2003:241; Jeggles et, al., 2014: 27; Matau et al., 2014:e533).

Conclusion: Time pressure also expressed as increased workload has been indicated in this study as one of the reasons nurses are not willing to take up the role of the preceptor. Findings support the need to develop a preceptorship model which takes into account time as a valuable resource for both nurse educators and preceptors if preceptorship is to be successful and beneficial to the intended recipients (students, preceptors and profession).

6.4 PERCEPTIONS REGARDING THE PROCESS OF PRECEPTORSHIP

This section addresses perceptions of the participants in relation to perceived outcomes of preceptorship. Themes, categories and subcategories that emerged from this section of the study are shown in Table 6.4, compared with quantitative findings and conclusions were drawn.

Table 6. 9 Preceptors' and nurse educators' perceptions on the process of preceptorship

	Quantitative findings	Qualitative findings subcategory	Interpretation
Support for preceptorship	80% of nurses educators show that preceptors' co-workers and supervisors are not supportive of the goals of preceptorship while only 41.1% (n=44) of preceptors disagreed with the statement (Table 4.3).	Lack of managerial support	Quantitatively the preceptors and nurse educator had differing perceptions on the preceptors' supervisors and co-workers support for preceptorship goals. In the qualitative design both preceptors and nurse educators agreed that preceptors either lack support or get minimal support as reflected by direct quotes under category 6.4.1. Although the direct quotations from preceptors indicate a contradiction from their quantitative responses, there is convincing evidence that preceptors are not getting adequate support from their unit managers and supervisors. Consistent with the findings of this study, Martensson et al., (2013:448-449) purport that recognition of preceptors role by unit managers and assisting preceptors to have access to resources needed during preceptorship were essential conditions facilitating positive performance of preceptors in their role.
	90.0% of participants disagreed that clinical setting management provide preceptors with resources need for clinical teaching and learning	Minimal support from preceptors' colleagues	
	57.0 % of preceptors disagreed that nurse educators are always available for the preceptor to share information on experiences during preceptorship 86% of nurse educators and 56.0% of preceptors indicated that visits by nurse educators are not adequate to accord preceptors the support they need	Minimal support for preceptors from nurse educators	Findings from both study designs are evidence that preceptors receive minimal support from nurse educators. Support visits by nurse educators need to be more frequent to enhance preceptor support and avoid compromising attainment of preceptorship. Luhanga et al., (2015:85) support the findings of this study and indicated the importance of faulty guidance and support particularly when critical decisions regarding students' competence are to be made.
Ineffective communication:	Preceptors 50.5% (n=54) agreed that there is always clear and easy communication between preceptors and nurse	No regular meetings	In the quantitative study design a total of 56.6% (n=87) respondents disagreed that there is clear easy communication between nurse educators and preceptors. Quotations

	educations while 49.5% (53) disagreed. Table 4.16 depicts that 68.0% (n=34) nurse educators indicate that communication between preceptors and nurse educators is inadequate to facilitate effective teaching and learning.		from the qualitative components support the nurse educators' quantitative results. The implication from the study studies is that communication between preceptors and nurse educators is ineffective and unclear. Consistent with these findings, Rose, (2008:107) affirmed the need for faculty to maintain contact with preceptors and students either through face to face meetings, telephone, email or a combination of methods.
	Feedback to preceptors was not included in the questionnaire	No feedback on preceptor's performance	Although there was no statement addressing feedback on preceptor performance in the quantitative questionnaire, FGDs findings revealed that preceptors are not given feedback on their performance. Lack of feedback could imply feeling unappreciated for the work done and result in failure to address existing gaps and weaknesses that might impact negatively on the outcome of preceptorship. Tan et al, (2011:19) assert that feedback provides guidance for preceptors and allows modification of the teaching process to meet the needs of learners.
Unstructured Preceptorship	63.6% of preceptors indicated that they feel adequately prepared for the preceptorship role, while 90.0% of nursed educators disagreed that preceptors are able to plan learning activities for students 72.0% of nurse educators disagreed that all preceptors are trained for the preceptorship role 90.0% of nurse educators perceived that preceptor training is not coordinated across all health training institutions, similarly, preceptors 90.0 % of nurse educators indicated that orientation	Inadequate and lack of training and orientation	Quantitative findings indicate a variation in the perceptions of preceptors and nurse educators regarding training and orientation of preceptors wherein preceptors perceived that they adequately trained for role. This was an unexpected and interesting observation that preceptors in the qualitative component indicated that they were not trained for the role contrary to responses from the quantitative component. To support that they were prepared for the role; preceptors further indicated they were confident with assessing and evaluating students learning activities; a notion disagreed by the majority of nurse educators. Nurse educators affirmed their perception that preceptors were not adequately prepared; as such were not confident with assessing students with quotations from participants hence awarding students very high marks during clinical assessments. Findings of this study are commensurate with other

and training of preceptors is not adequate to equip preceptors with teaching and students assessment skills		researchers in that many preceptors were not adequately prepared for their role. and need to be trained for the preceptorship role (Hyrkas, Linscott and Rhudy, (2014:120, 131 Panzavecchia & Pearce, (2014:1120;)Tan et al, (2011:19) Lack of preceptor training and orientation revealed in this study is an impediment for preceptorship to become effective and compromises the quality of clinical learning for nursing students.
83% (n=88.0) of preceptors agreed that they are confident with assessments and evaluation of clinical learning activities this was contrary to 78% (n=38) of nurse educator who disagreed	Allocating high marks to students	Participants reflected differences in perceptions of preceptors' skills and confidence in assessing and evaluating students' learning activities. Based on the qualitative findings it is apparent that preceptors are not adequately trained or oriented to the role, lack pedagogical skills and confidence in evaluating students' learning activities. (Botha et al., (2012: http://doi.org/10.14804/1-1-25) concurs with findings of this study that nurses serving as preceptors are not often prepared to facilitate students learning.
Consideration for preceptorship role during transfer and clinical placement of preceptor was not included the questionnaire but the following related response support lack of consideration: 88 % (n=44) of nurse educators, while 57.5% (n=61) of preceptors who responded disagreed that preceptors' supervisors and clinical setting managers are committed to the success of preceptorship	Lack of consideration during transfers and clinical placement of preceptors	Although there was no direct statement indicating lack of consideration for the preceptorship role during placement and transfer of preceptors in the questionnaire; quantitative findings support the qualitative results in that respondents indicate that supervisors of preceptors and clinical setting managers are not committed to the success of preceptors. Findings are supported literature, Tan et al., (2011:119) indicated lack of management commitment in the support and clinical placement of preceptors is a potential cause for pressure and preceptor burnout.

6.4.1 Minimal or lack of support

The subcategories that emerged from this category: include lack of managerial support, minimal support from nurse educators and minimal support from preceptors' colleagues.

- **Lack of Managerial Support**

The study revealed that preceptors either get minimal support or lack support from their supervisors and managers. However, an interesting and unexpected finding from the quantitative component was that while 80.0% of nurse educators indicated that preceptors lack support from supervisors and managers, only a few (41.1%) of preceptors agreed that they get minimal support. Preceptors' responses from the quantitative component were contrary to their narratives from the qualitative component whereby they indicated that at times they are reminded by their supervisors that they are not employed for students, they have work to do. Tiwaken et al, (2015:73), purport that nurse managers should ensure that there is sufficient equipment and personnel within the clinical facilities to facilitate clinical teaching and learning.

Conclusion: From the findings it is inevitable that preceptors need a lot of support from their supervisors if preceptorship is to achieve its intended objectives.

- **Minimal of support from nurse educator**

Findings from both components of the study reveal that preceptors get minimal support from nurse educators. Over two thirds (65.5%) of participants indicated that visits by nurse educators to support and discuss preceptorship experiences are not adequate. More preceptors alluded to this notion than the nurse educators. However, qualitatively; nurse educators alluded to preceptors' narratives by verbalizing that due to time pressure and workload they do not visit preceptors and students adequately to give them the support they need. Preceptorship support by nurse educators needs to be strengthening as an empowerment strategy to equip preceptors with the knowledge and skills needed to effectively facilitate clinical teaching.

- **Minimal support from preceptors' colleagues**

Participants from both components of the study unanimously agreed that preceptors lack or receive minimal support from their colleagues. However, from the quantitative responses a variation in the level of agreement between nurse educators and preceptors was evident at 80.0% and 41.1 % respectively. Qualitatively participants verbalized that preceptors' colleagues do not consider that being a preceptor is part of the nurse's role as such; they feel preceptors avoid routine nursing duties by being with students. Lack of support might be attributed to lack of understanding of the preceptor role.

Conclusion: Preceptor and preceptorship support has been recognized to be generally lacking from the findings of this study. Support for preceptors and preceptorship by all stakeholders (peers, nurse managers and nurse educators) is paramount to facilitate clinical teaching as well as achievement of students' clinical learning objectives. The insinuation from the study findings is that there is minimum preceptorship support in Botswana. The development of a preceptorship model to ensure that stakeholders are conversant with preceptorship and their roles in supporting its implementation is recommended.

6.4.2 Ineffective communication

The quantitative findings revealed mixed feelings in the responses of preceptors and nurse educators to the statement whether there was clear and effective communication between educators and preceptors (Table 6.4). Ineffective communication was verbalized by many participants (both preceptors and nurse educators) In like manner; in the qualitative design ineffective communication was verbalized as no regular meetings and no feedback on the performance of preceptors. The need for faculty to maintain effective communication with preceptors and students through different communication modes such as meetings, telephone, email or a combination of methods is desirable.

- **No regular meetings**

One important finding was that 68.0% of preceptors and only 49.5% of nurses' educators disagreed that nurse educators and preceptors meet regularly to discuss issues pertaining to preceptorship. From the qualitative component, participants alluded to lack of meetings which they cited as a challenge to effective preceptorship. Lack of regular meetings might compromise the quality of clinical nursing education since preceptors and students need guidance from nurse educators. The role of the faculty in facilitating open communication with preceptors and students through regular meetings or physical availability when needed to discuss preceptorship issues is critical to the success of preceptorship. The importance of regular meetings between students, lecturers and preceptors during clinical periods to clarify objectives and learning outcomes and discuss students' progress was heightened in (Lofmark et al, 2012: 165).

- **No feedback on performance of preceptors**

Results indicated that formal feedback from nurse educators and students on the performance of preceptors was lacking. Lack of feedback was described as discouraging as preceptors are not sure if they are performing the role effectively. Giving preceptors feedback should be considered an important part of preceptorship.

Conclusion: While the importance of feedback is emphasized in preceptorship literature, the results of this study show that feedback to preceptors from faculty and students is often not given the importance it deserves. Strategies for giving preceptors constructive and timely feedback to preceptors on their performance cannot be overemphasized and should be ongoing throughout the preceptorship period. Regular and open communication between nurse educators, preceptors and students facilitates dialogue that provides a platform for assessing preceptorship effectiveness and giving feedback that will empower and support preceptors to come up with corrective measures to effect change where need arises.

6.4.3 Unstructured Preceptorship

Findings indicated overwhelming evidence on the unstructured preceptorship activities. Subcategories that emerged from this category include; Inadequate and lack of training and orientation and lack of consideration during transfers and clinical placement of preceptors.

- **Inadequate training and lack of orientation**

An unexpected and interesting finding from the quantitative findings was that 64.1% of preceptors perceived they were adequately prepared for the role of a preceptor; and 82.3 % agreed that they were confident with students' assessment and evaluation. However, a large number of nurse educators (72.0%) did not agree with the preceptors. Nurse educators indicated that not all preceptors are trained or oriented for the role while (78.0 %) disagreed that preceptors were confident to evaluate students' clinical activities objectively. Contrary to the preceptors' quantitative results, participants in the qualitative design (both preceptors and nurse educators) verbalized inadequate training and lack of orientation of preceptors as a major setback of preceptorship in clinical nursing education requiring structuring of preceptorship. However, inadequate training of preceptors is not a unique finding for this study, Lack of preceptor training has been recorded in Ghana as an impediment for preceptorship to become an effective clinical component of nursing education (Kristorffezon et al., 2015: 1253; Linscott and Rhudy, 2014:120, 131; Horton et al, 2012:E2; Atakro & Gross, 2016 <http://dx.doi.org/10.1155/2016/191924>).

Conclusion: It is envisaged that if preceptors are not trained, they neither can assist students in achieving clinical learning objectives nor can they effectively evaluate students' clinical assessments. The results necessitate development of a preceptorship model to facilitate clinical nursing education that will allow for robust preceptor training to equip preceptors with the knowledge and skills needed for students' assessment and effective execution of the preceptorship role in all its dimensions.

- **Transfers and lack of consideration in clinical placements of preceptors**

Although this subcategory was not reflected in the quantitative questionnaire, it was apparent from related quantitative findings and narratives from qualitative participants that during placement of preceptors in the units / wards being a preceptor was not a criterion taken into consideration by the supervisors and managers of clinical settings. This was supported by (88%) of the participants who disagreed that preceptors' co-workers and clinical setting managers / management are conversant with objectives and expectations of preceptorship. Preceptors confirmed that supervisors and management are not committed to the success of preceptorship and are not available to help the preceptors developed in the role as preceptors. Lack of consideration for preceptorship role was expressed through statements like preceptors are just transferred to any facility like any other nurse even to clinical settings where there are no students leaving students they have been preceptoring unattended.

Conclusion: Most preceptors in study are either not trained or are inadequately trained or oriented to the preceptor role. Furthermore, lack of consideration in the clinical placement of preceptors as reflected in this study might compromise the quality of clinical nursing education. The findings highlight that improving preceptor preparation for the role and appropriate placement of preceptors to facilitate clinical teaching and learning during preceptorship is imperative if preceptorship is to meet its intended objectives.

6.5 PERCEPTIONS REGARDING THE OUTCOME ON PRECEPTORSHIP

This section addresses the perceptions of the participants in relation to perceived outcomes of preceptorship. Table 6.5 shows both the qualitative and quantitative findings and their interpretation.

Table 6. 10 Preceptors' and nurse educators' perceptions on outcome of preceptorship

Benefits of preceptorship	Quantitative findings	Qualitative findings	Interpretation
	87.8% of respondents revealed that being a preceptors keeps the preceptor up-to-date and stimulated in the professional role	Increased Preceptors' personal and professional growth	A finding from the two study designs are complementary and support that preceptorship has benefits to both students and preceptors. Benefits for preceptors include; personal and professional development, providing opportunity for leaning and reflection, it encouraging preceptors to remain in the profession and helps them acquire and improve teaching and leadership skills.
	83.1% of preceptors indicated they gain satisfaction from the preceptorship role		
	87.9% preceptors showed that their analytic and critical thinking skills greatly improved by being preceptors. 85.1 % of preceptors and indicated that being a preceptor improved their teaching skills		
	88.8% of preceptors agreed that socializing students to the profession was fulfilling and improved the preceptors' leadership skills	Contribution to students training	Preceptors from both study designs indicated that preceptorship makes them contribute meaningfully to the profession through their role in contribution in the training of students which they viewed as a benefit facilitating lifelong learning.

Benefits to students	93.3% of respondents to this statement agreed that students gain competence and proficiency in clinical skills and decision making during preceptorship 78.0% of disagreed that preceptorship had no benefits; an affirmation preceptorship has benefits.	Competence in clinical skills and having role models for professional behaviors	Development of competence in clinical skills through professional socialization by knowledgeable and experienced nurses was unanimously revealed as a core benefit to students by participants. The findings of this study are congruent with benefits of preceptorship highlighted in literatures that include; personal and professional development, providing opportunity for leaning and reflection, encouraging preceptors to remain in the profession, helps preceptors acquire and improve teaching skills of preceptors giving students an opportunity to develop competence in clinical skills, development of critical thinking and decision making skills (Tiwaken et al, 2015: 73; Kaphagawani & Useh, 2013: 183; Callaghan et al 2009:246, 249).
Challenges of preceptorship	96.0% of respondents agreed that preceptorship has challenges Availability or lack of incentives was not included in the questionnaire as an entity 58.9% of preceptors disagreed that their the workload appropriate to allow them to function as preceptors 96.0% nurse educators of the nurse educators similarly disagreed that the preceptors' workload is reduced to allow them to carry out the preceptorship role Commitment to preceptorship was not included in the questionnaire	Lack of incentives for preceptors Increased workload of preceptors Lack of commitment by some students and preceptors	Although not mentioned in the questionnaire, lack of incentives for preceptors strongly came up in all the six FDGs as impacting on the effective preceptorship. Similar findings were revealed in Lofmark et al., (2012:168) that challenges of preceptorship include lack of rewards. Lack of incentives could attribute to nurses not being interested in taking up the preceptorship role Study results show that the workload of preceptors is not reduced to allow them to perform preceptorship and verbalized as major challenge faced by preceptors in the qualitative designs. The heavy workload of the preceptors and shortage of nurses raises concerns about the effectiveness of preceptorship and appropriateness of the clinical environment in achieving students' learning outcomes. In literature; increased workload has been reported as major a challenge of preceptorship (Panzavecchia & Pearce, 2014:1120; Martensson et al., 2013:448 Participants' indicated that some students and preceptors lack commitment resulting in difficulties fulfilling preceptorship objectives. Lacking of commitment included some students disappear from the wards to go and sleep leaving the nurses alone

			with patients or not willing to participate in patient care e Some preceptors were not willing to take responsibility in the supervision and discipline of students. Similar results were recorded in Madhavanpraphakaran et al, (2013: 32) where preceptors indicated lack of motivation, commitment and direct patient care by students and that students often prefer to get patient information from the computer rather than from the patients.
Suggestions for the success of preceptorship:	Themes that emerged from the open ended question on the questionnaire were: Increasing training of precepts was indicated as a suggestion	Increasing training of preceptors	Findings from study designs corroborate showed the need for more nurses to be trained for the preceptorship role to curb the current problems associated with shortage and unavailability of preceptors to teach and guide and evaluate student. Finding are akin to preceptorship literature on the importance of preceptor training (Atakro & Gross, 2016 no page number).
	Not included in the questionnaire	Incentives for preceptors	Both findings indicate that giving incentives to preceptors can be a way of encouraging more nurses to take up the preceptorship role and feel recognized for their contribution.
Collaboration with key stakeholders:	Not reflected included in the questionnaire	Partnerships between Health training institutions and clinical settings Partnership with accreditation bodies and regulatory bodies	Collaboration and partnership has been verbalized as a valuable strategy to facilitate the effectiveness of preceptors. Suggestions brought forward in this study have implications for nurse education and practice to put in place strategies and measures to improve the implementation of preceptorship. Findings are corroborate with other studies (James, 2015: 8; Atakro & Gross, 2016 ; Kalomo et al., 2015: 1096).

6.5.1 Benefits of preceptorship

The majority of participants (93.3%) recognized that despite several challenges, preceptorship has many benefits to both preceptors and students. In view of the perceived preceptorship benefits, 89.7% of preceptors indicated that deciding to be preceptors was not a mistake on their part. Sub-categories that emerged were benefits to preceptors and benefits to students. Benefits to the preceptor included; Personal and professional growth and contributing to the training of students.

- **Personal and professional growth**

The majority of participants from the quantitative design indicated that preceptorship keeps preceptors up-to-date 87.8%; improves their leadership skills 88.8%, and teaching and analytic skills 87.9%. Quantitative results were complemented by expressions whereby preceptors indicated that they learn new knowledge and technology from students as well.

- **Contribution to students' training**

Participants' indicated that contributing to the training of students was one of the benefits associated with preceptorship. The benefit of preceptorship emanating from contributing to students' learning was expressed as a good thing to help and observe some grow and mature in the profession as a way of giving back to the profession. Participants' responses agree with literature that preceptors protect students from health care errors committing errors that could be detrimental to themselves and others (Omer et al., (2015:4).

- **Benefits to students**

Participants agreed that students benefit from preceptorship by gaining competence and proficiency in clinical skills, critical thinking and decision making skills. Results indicated that preceptors protect students from committing health care errors that can be detrimental to themselves and patients. Fudger and Belcourt, (2015:13) affirmed preceptorship is giving back to the profession and shaping the future of nursing. Preceptors experience joy of teaching and influencing the development of future professionals. Precepting was describes as exciting and making preceptors feel good by giving back to the profession Concor, (2015:337).

Conclusion: Despite several challenges expressed in preceptorship literature and by participants in this study (chapters 4 and 5), findings of this study indicate conclusive evidence that benefits of preceptorship outweigh the challenges. Implementation of recommendations from participants in this study and development of a preceptorship model to facilitate effective clinical nursing education in Botswana can further improve the benefits of preceptorship and clinical education for all stakeholders.

6. 5.2 Challenges to effective preceptorship

Both study components revealed several challenges associated with preceptorship as a clinical teaching strategy used in the higher diploma in general nursing programme.

- **Lack of incentives**

Lack of incentives for preceptors was also referred to no rewards as verbalized by some participants in this study. Participants indicated that not giving incentives to preceptors makes preceptors feel unrecognized and hence lose interest in taking up the preceptorship role. Findings are akin to Hallin and Danielson, (2008: 171) that lack of incentives is one of the challenges of preceptorship.

Conclusion: It is clear from the research findings that incentives play a major role in motivating preceptors to execute their role.

- **Increased workload for preceptors**

Increased workload was voiced by many participants 58.9% and 96.0% of preceptors and nurses educators respectively. 86.0% indicated that preceptorship is an added responsibility, a notion that supports that it increases the workload. From the qualitative most participants articulated increased workload for preceptors as characterized by preceptors not being relieved from some routine duties: when students are in clinical area, preceptors should not be assigned to work the same shifts with the students which they referred to as 7.30 to 4.30 duty shift. Workload associated with the role of a preceptor is a deterrent to most nurses in taking up the preceptor role.

Conclusion: Despite preceptorship having been used as a clinical teaching strategy in nursing education in Botswana for over 20 years, to this end preceptors do not have their workload reduced to allow them to perform preceptorship activities without developing stress and burnout. The workload of preceptors does not allow them time to facilitate students' clinical learning. The current situation requires the health training institutions and clinical settings' managements to collaboratively address it if preceptorship is to be sustained and at the same time benefit students and preceptors.

- **Lack of commitment by some students and preceptors**

Participants have indicated that some students lack commitment to their learning responsibilities and are not self-directed learners. On the other hand, some preceptors have also been seen to lack commitment in teaching, supervising, guiding students and instituting disciplinary measures to students' exhibiting non-professional conduct. The lack of commitment from either the students or preceptors impacts on the clinical teaching and learning process negatively. Lack of commitment by both preceptors and students has been documented in preceptorship literature, (Both et al, 2012: 2-3; Tiwaken, et al., 2015: 70) Lack of supervision of students by preceptors may result in students learning incorrect procedures, becoming incompetent practitioners, frustration and lack of interest in the profession Kaphagawani and Useh, (2013:182).

Conclusion: Lack of commitment by students and preceptors exhibited in this study provides insight into the need to restructure preceptorship through development of supportive structures to facilitate implementation of preceptorship and achievement of positive outcomes.

6.6 SUGGESTIONS FOR IMPROVEMENT OF PRECEPTORSHIP

Suggestions to improve preceptors: partnership and collaboration with key stakeholders, increasing training of preceptors; giving incentives to preceptors; partnerships of health training institutions and clinical settings and partnership with accreditation bodies.

- **Increasing trainings**

Participants verbalized that increasing the frequency of training preceptors and the number of nurses to be trained as preceptors can be one of the important strategies to improve the success of preceptorship. From the open-ended questions in the questionnaire, respondents suggested that nurses' educators should also be trained in preceptorship to enable them to efficiently and effectively facilitate in preceptorship activities. The need for all nurse educators to undergo training and acquire an education qualification was also highlighted as crucial to effective preceptorship. Findings concur with James, (2015:7) that preceptor preparation is important factors for the success of preceptorship. Similarly, Kalomo, et al., (2017: 1096) assert that preceptor preparation may build confidence and knowledge in precepting. Akin to other studies, Al- Zayyat and Al- Gamal, (2014: 334) emphasized that preparing in all professionals involved in training nursing students adequately is imperative and might help students deal with clinical stressors.

Conclusion

The success of preceptorship requires robust training orientation and re-orientation of preceptors and nurse educators. It would seem illogical to expect preceptors and nurse educators to be effective and efficient in execution of their roles without adequate training or preparation for the role.

6.6.1 Collaboration with key stakeholders

Two suggestions were verbalized under this category namely: partnership of HTIs and clinical settings and Partnership with accreditation and regulatory bodies

Partnership between health training institutions and clinical settings

Suggestions and recommendations from the two designs support each other in that partnership between health training institutions clinical settings and ministry of health should be strengthened to support preceptorship activities. According to the results of this study, there is conclusive evidence that current problems faced by preceptors and preceptorship such as inadequate resources and lack of support for preceptors emanate from weak or lack of collaboration between clinical settings and health training institutions and to a great extent the ministry of health. Participants suggested that clinical setting and health training institution management, preceptors' supervisors and nurse educators collaboratively plan preceptorship activities jointly to foster ownership and encourage support for preceptorship.

The MoHW has been described in this study as the "custodian" of health training institutions and clinical settings and therefore should take the lead in coordinating clinical practice and nursing education through providing funds for training of preceptors. Participants further suggested that the MoHW as the employer for nurses in clinical settings and nurse educators should provide adequate human resource and, take into consideration the role of preceptors when transfers for nurses are affected.

6.6.2 Partnership with accreditation bodies

Another suggestion was partnerships and collaboration of health training institutions with accreditation and professional and regulatory bodies such as HRDC, BQA, UB, BONU and NMCB. The accreditation bodies (BQA, HRDC) were suggested because of their quality assurance role in higher education and training in the country. The suggestion from participants was that the accreditation bodies will accredit courses included in the training of a preceptor and prescribe minimum qualifications for a nurse to be a preceptor and for nurse educators. Health training institutions are affiliated with the University of Botswana which provides certificates for students graduating from such institutions, while NMCB is a professional regulatory body for Nursing and Midwifery that ensures high quality standards of nursing education and practice are upheld to protect the public from unsafe practices by incompetent nurses and midwives and preserve the image of the profession. Findings support Kalomo, et al., (2015: 1096) that academic and service collaboration has a positive impact on preceptorship.

Conclusion: Collaborative relationship partnerships amongst health training institutions, clinical settings, regulatory and professional bodies and MoHW as stated by participants could improve the quality of clinical nursing education for students as well as enhance professional growth for preceptors. Lack of collaboration and partnership amongst stakeholders compromises the quality of clinical education and the objectives of preceptorship.

6.7 SUMMARY

In this chapter the findings from merged quantitative and qualitative designs were reported. The study designs complemented each other in many aspects with regard to perceptions of preceptors and nurse educators. Themes, categories and subcategories from the qualitative designs complemented quantitative results. Congruencies in responses were identified in the following:

Inadequate resources for preceptorship implementation particularly: unavailability of preceptors and nurse educators, lack of a preceptorship guidelines and model, unclear selection criteria for preceptors, unstructured preceptorship, ineffective communication, time pressures including, no time allocated for preceptors to perform the role of preceptorship and lack of time for nurse educators to follow up and guide preceptors and students, lack of support for preceptors and preceptorship specifically from managers, supervisors and to a lesser extent from nurse educators and benefits and challenges of preceptorship.

The differences mostly resulted from the nature of each design. In the quantitative, participants simply responded by measuring while in the qualitative results rich descriptions were given to explain responses. The merged findings emphasize the need for development of a preceptorship model to facilitate clinical nursing education. Chapter 7 describes the development of a Preceptorship Model and proposed guideline for implementation.

CHAPTER 7

DEVELOPMENT OF A PRECEPTORSHIP MODEL TO FACILITATE CLINICAL NURSING EDUCATION

7.1 INTRODUCTION

Chapter 6 outlined the merged findings and their interpretation. This chapter gives the conceptual framework for the development of the model. The conceptual framework was developed based on the empirical data and literature review. Effective preceptorship is pivotal in producing competent nurses to meet the healthcare needs of the nation.

7.2 OBJECTIVES

This chapter seeks to achieve the following objectives:

1. To construct a conceptual framework for the model development according to Dickoff, James & Wiedenbach (1968) model.
2. Model development using Chinn and Kramer (2012)'s concepts of theory development
3. Formulation of guidelines for the operationalization of the preceptorship model.

7.3 CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT

Conceptual framework is the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs the research, thus is a key part of the design (Miles, & Huberman, 1994: 18). The authors further describe the conceptual framework as a visual or written product, which explains, graphically or in narrative form, the main things studied, namely; the key factors, concepts, or variables and the relationships among them. This conceptual framework is constructed using findings from merged empirical phase of the study and literature reviewed. The conceptual framework is essential to bring focus within the content and also acts as a link between literature, methodology and results. The main concepts from the convergence study results are identified and classified according to Dickoff et al.'s (1968: 422-423), six survey list of activities or elements of practice theory namely: the agent, recipient, context, procedure, terminus and dynamics and their related question. The survey list was used as a mind map to assist in the operationalization of the concepts. Table 7.1 depicts the survey list and the related questions.

Table 7. 1 Dickoff et al. (1968: 422-423)'s survey list of activities and clarifying questions

Survey activity / component of theory	Corresponding question (s) (Dickoff et al (1968:422)
1. Agency /Agent	Who or what performs the activity?
2. Patiency / recipient	Who or what is the recipient of the activity?
3. Context/ Framework	In what context is the activity performed?
4. Terminus	What is the end point of the activity?
5. Procedure	What is the guiding procedure, technique, or protocol of the activity?
6. Dynamics	What is the energy source for the activity whether, material, chemical, physical, biological, mechanical or psychological?

7.3.1 Definition of concepts used in developing the conceptual framework to guide model development

Context: the environment or setting where clinical nursing education and preceptorship activities occur. The context includes the HTIs and clinical settings.

Agents: Individuals who oversee the implementation of preceptorship and provide necessary resources. In this model, nurse educators, clinical setting management and HTI management constitute the agents in the model.

Recipient: Recipients are preceptors who supervise, coach and evaluate students' learning activities during proctorship. Students are recipients' learners during preceptorship, while health care users are beneficiaries of health services offered by students and preceptors.

Procedure: In the context of the preceptorship model to facilitate clinical nursing education, procedure refers to all activities involved in preceptorship during clinical nursing education. The procedure / process include planning, selection, and training, placement of preceptors and monitoring and evaluation of preceptorship activities in clinical nursing education.

Dynamics: In the model dynamics are factors or forces that influence the effectiveness of preceptorship in clinical nursing education. Dynamics include: collaboration, communication, commitment, support and recognition.

Terminus: It is the outcome or end point of clinical nursing education reflecting the effectiveness of preceptorship in clinical nursing education. Figure 7.1 shows the conceptual framework for a preceptorship model to facilitate clinical nursing education.

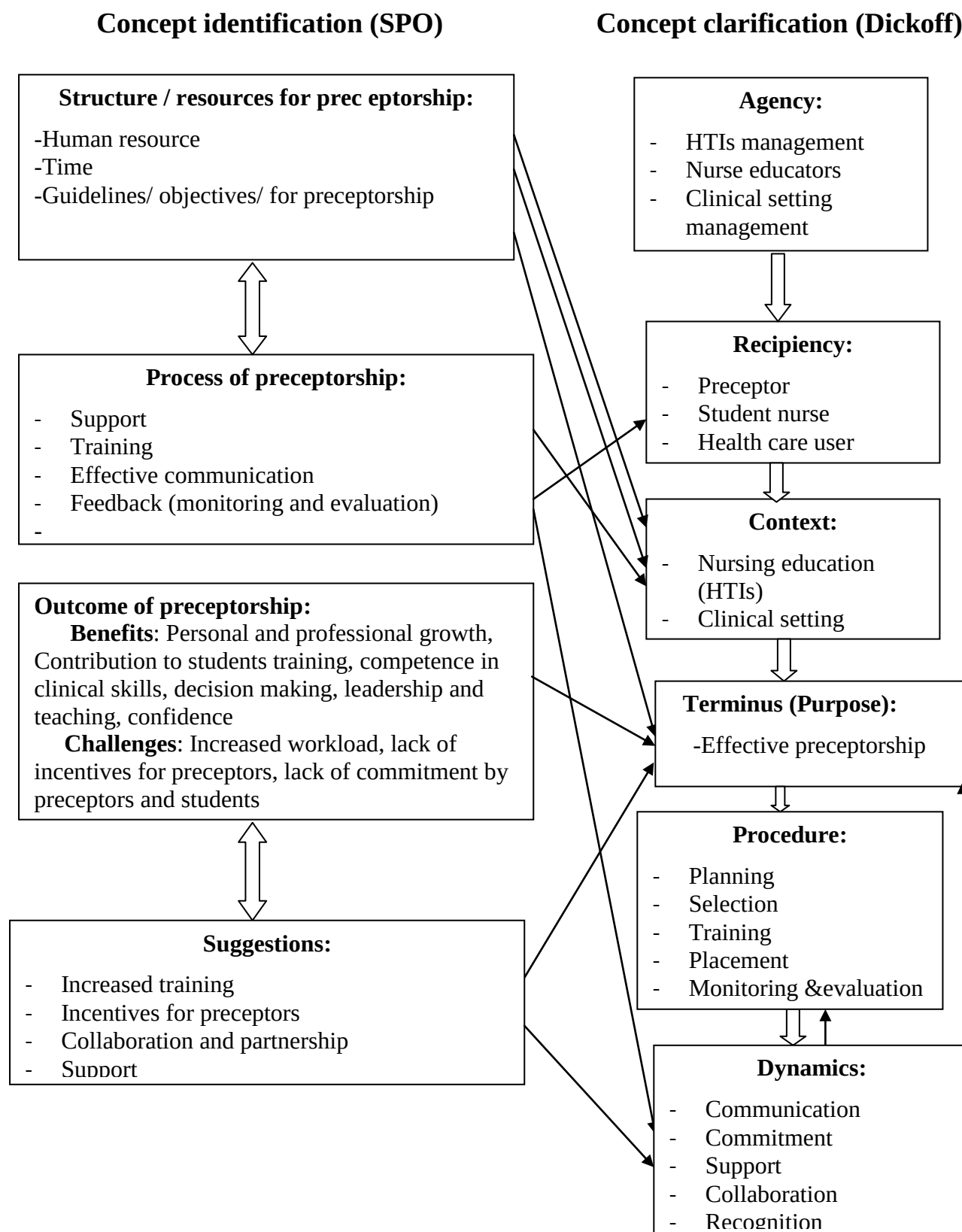


Figure 7. 1 Conceptual framework for the Preceptorship model development

7.4 DESCRIPTION OF THE CONCEPTS AND THEIR APPLICATION TO MODEL DEVELOPMENT

The following section describes the concepts in details and their application in model development

7.4 1 Context: Nursing education and clinical setting

The term context or framework refers to the environment, setting or situation. Context refers to the setting where preceptorship takes place. According to Dickoff et al. (198:422), the context of an activity is also termed the framework. In the model, the context includes nursing education (HTIs) and the clinical settings where the preceptors and students interact for clinical teaching and learning during preceptorship.

Preceptorship activities occur in two contexts namely: HTIs where students are enrolled for training as nurses and the clinical settings where preceptors work and supervise students during preceptorship. The outer box of figure 7.2 represents nursing education setting in the HTIs, while the inner box represents the clinical settings context. The perforated line between the HTI and clinical context indicates the close and collegial relationship between two contexts. Nursing Education is regulated by legal and professional statutes such as Botswana Qualification Authority Act, Tertiary Education Act, and The Nurses and Midwives Act among others. Such documents should be accessible to, and adhered to by both preceptors' and students during preceptorship.

Due to new trends in nursing and nursing practice, both the HTIs and clinical setting environments are continuously evolving making them more complex and challenging. According to Gaberson, Oermann and Shellbarger, (2015:ix), students have to be prepared for the new roles to address the changes and complexity of the nursing education environment. The theoretical aspect or knowledge acquired by students in nursing education is translated to skills and practiced in the clinical setting hence the notion "application of theory to practice. Preceptorship facilitates the application of nursing knowledge into nursing practice. The relationship between nursing education and nursing practice during preceptorship is the impetus for the establishment of the context of a preceptorship model to facilitate clinical nursing education. The context takes into consideration the uniqueness and collaborative realities of each of the two environments. Figure 7.2 depicts the context as it relates to the model. Nursing education is regulated by statutory instruments namely: the Nurses and Midwives Act (1995), the Tertiary Education Act, (1999) and the Botswana Qualification Authority Act no 24 (2013). Figure 7.2 shows the contexts or environments in which preceptorship occurs and the statutory instruments that regulate nursing education within the context.



Figure 7. 2 Context of preceptorship

- **The Tertiary Education Act. (Chapter 57.04 of 1999)**

This is an Act to provide for the establishment of the education council to provide for its powers, duties, functions and matters incidental thereto. The Act commenced on the 30th of April 1999. The Tertiary Education Act (1999) brought about the establishment of the Tertiary Education councils that has been empowered and mandated to perform the following functions amongst others

- Promotion and coordination of tertiary education and determine maintenance of standards of teaching, examination and research in tertiary institutions Tertiary Education Act, 1999 Section 5).
- Ensure every opened institution has prepared to the satisfaction of the council the academic, physical and other resources necessary for establishment of a viable tertiary institution (Section 5 Part III)
- Ensure quality measures are in place in all tertiary institutions
- Approve programmes of study in tertiary institutions
- Suspend, revoke registration of an institution that fails to comply with set standards

The HTIs like other tertiary institutions have an obligation to comply with the requirement of the TEC Act: Chapter 57.05, (1999 retrieved online no page number) in ensuring that nursing education is facilitated by availing all resources needed to enhance teaching and learning during preceptorship such as time, human resource and guidelines needed by preceptors to effectively facilitate clinical education.

- **Botswana Qualification Authority Act No 24, (2013)**

The Act was established in 2013 to provide and maintain a National Qualification Framework (NQF) and coordinate the Education Training and Skills Developments system in Botswana (Qualification Authority Act, 2013: A 362 Part II, 4 (1). Health training institutions are ETPS and are responsible to have quality assurance measures to facilitate development of professional nursing skills and competences and therefore are regulated as such in accordance with Botswana Qualification Authority Act No 24, (2013). Importance of a preceptorship model to facilitate clinical nursing education in this regard cannot be underestimated. Furthermore, the Botswana Qualification Authority Act, (2013: A362: 2 (e); (k); (l); (m); (n); (o) mandates the authority to accredit and keep a national data base for assessors and moderators, design qualifications for tertiary education, accredit learning programmes, and review quality standards to ensure compliance through monitoring and evaluation design procedures and rules to protect enrolled learners. Preceptors are assessors of students' learning activities during preceptorship and shall be expected to comply. This function of BQA is supported by empirical findings from phase I of this study whereby participants recommended that HTIs should facilitate accreditation of preceptors as assessors to ensure compliance with the BQA and HRDC requirements.

- **Nurses and Midwives Act, (1995)**

NMCB is the professional regulatory body for Nurses and Midwives. The Nurses and Midwives Act: Chapter 61.03, (1995) is the legal instrument or document that regulates the education and practice of nursing and midwifery in Botswana. NMCB keeps registers of registered nurses, enrolled midwives, psychiatric nurses, nurse specialists and students studying in any field of nursing in the HTIs including the higher diploma in general nursing and those studying nursing in UB. HTIs get a pool of preceptors from all these different cadres of nurses and collaborate with NMCB and clinical settings to ensure those nurses who serve as preceptors have valid practice certificates. Nurse educators' should discuss education regulations with preceptors and students to ensure adherence during preceptorship. Education regulations and the Nurses and Midwives Act: Chapter 61.03, (1995) should form part of the package of guidelines for preceptorship. The Act prescribes the minimum duration of training for nurses and midwives in terms of theory and practice hours. Qualifications of nurse educators who facilitate in different diploma programs are also stated in the education regulations within the Nurses and Midwives Act: Chapter 61.03 (1995). However, it is worth noting that the Nurses and Midwives Act, (ibid) is in the process of amendment (Unpublished reports and researcher's knowledge as former member of the council who participated in the activity). The HTIs are expected to enforce the education standards (diploma or degree) for both theory and practice.

- **Heath Training Institutions (HTIs) Context**

HTIs are the first points of entry for students in nursing education. Higher diploma in general nursing students are enrolled learners in the health training institutions. The students initially acquire nursing education theory in the class or lecture rooms and practice in clinical nursing skills laboratory to gain competence prior to attachment in the clinical setting during preceptorship, it is therefore mandatory that HTIs enforce compliance and monitor to such legal instruments to facilitate nursing education in all its dimensions as prescribed by the laws of the country. It was saddening to know from the findings of this study that preceptors are not adequately trained for the role, this is contrary to the requirements of all statutes regulating education and training in the country. Section 7.2 describes the legal instruments that regulate nursing education how they apply can be applied during preceptorship. Similar to the findings of this study, Cosme and Valente (2013:601), affirm that although the preceptor plays a key role in the socialization of the student in clinical nursing education, preceptors receive no or inadequate training or preparation.

- **Clinical Setting Context**

This is the second context according to this preceptorship model to facilitate clinical nursing education. Preceptorship occurs in the clinical setting environment with all its complexities. The practice of nursing is regulated by the Nurses and Midwives Act Chapter 61.03, (1995) legal professional instrument that also regulates nursing education. Nursing education and practice are inseparable as the student is equipped with theory in order to practice nursing and gain competence in the clinical setting. DeYoung (2003: 241), asserts that preceptorship increases clinical experience for students and exposes them to more of the realities of the work world. Preceptorship allows students to learn from practitioners with a high skill level while still being guided by faculty who have a wealth of knowledge. Similar to DeYoung (2003:241), participants in this study revealed that preceptorship has benefits for both students and preceptors. Based on the cited evidence provided from the study's findings and literature reviewed, provision of a clinical setting environment that facilitates effective preceptorship cannot be over emphasized.

The clinical learning environment should be supportive and enabling to facilitate teaching and learning. The findings from this study revealed that preceptors have overwhelming workload that does not allow them time to address students' learning needs during preceptorship. Furthermore, they are getting limited or no support from their supervisors and colleagues which resulted in many nurses losing interest in taking up the role. From the study's findings, participants suggest that preceptors should be recognized for their role and be eligible for registration to practice as preceptors by the NMCB. Clinical setting management should provide supportive learning environment to students and preceptors by providing resources needed to facilitate clinical teaching and learning.

7.4.2 Agents and Recipients

Agents

These are the driving forces that are needed in the planning, initiation and sustainability of preceptorship. According to Dickoff, et al (1968: 425), an agent can be internal or external. Agents determine who is to perform the activity. Furthermore, the authors indicate that it is misleading to assume that there is one agent for an activity. In this preceptorship model, the agents shall refer to nurse educators, management of clinical settings and management of HTIs. This triad has a responsibility to collaboratively and independently mobility resources plan and support preceptorship activities.

Nurse educators

Nurse educators' should discuss education regulations with preceptors and students to ensure adherence during preceptorship. The nurse educator acts as a resource person for students and preceptors and a link between HTI and clinical setting management .The nurse educators should discuss all procedures, policies, statutory instruments or documents such as: Tertiary Education Act, (1999); BQA Act no24 (2013), tools for evaluation of students learning activities', teaching and learning and other policies, disciplinary, grievance, academic and non-academic regulations that govern nursing education with both preceptors and student. All policy documents including proctorship guidelines should form part of the orientation or training package for preceptors.

The documents to be given to the preceptors and should include the Curriculum for Higher Diploma in General Nursing (2008), Academic regulations for Affiliated Health Training Institutions, Teaching and Learning Policy (2006), Assessments Standards for HTTs (2004), clinical evaluation / procedure tools and clinical expectation among others. Preceptors are clinical teachers and should be familiar with all documents used in teaching so that students are provided with such documents. The nurse educator is responsible in collaboration with other agents like HTIs and clinical setting management. The nurse educator should drive or spearhead the process procedure of preceptors according to the preceptorship model developed for this study. The process involves planning for resources and other logistics, selection and training of preceptors, advocating appropriate clinical placement or deployment of preceptors in consideration of their role, monitoring and evaluating the effectiveness of preceptorship and outcomes of clinical nursing education.

Management of clinical setting

Tan et al (2011:18), highlighted that without proper understanding of the goal and purpose of preceptorship, the risk of lack of managerial and staff support for preceptors is resulting in burnout is inevitable. It was evident from the results of this study that preceptors lacked support from their supervisors. In the model, clinical management will offer support to preceptors, through provision of

resources needed by students and preceptors. Together with management of HTIs, clinical setting management should negotiate for rewarding of preceptors for their role. Support in the context of the model includes allowing preceptors time to attend to students during preceptorship, provision of equipment and material resources, reducing the workload of the preceptor. Tan et al, (2011:18) highlighted that without proper understanding of the goal and purpose of preceptorship the risk of lack of managerial and staff support for preceptors resulting in burnout is inevitable. It was evident from the results of this study that preceptors lacked support from their supervisors. Furthermore, clinical setting management as custodians of patient in the clinical setting, should ensure nursing education and practice is done in accordance with the standards of nursing education and practice as stated in the Nurses and Midwives Act: Chapter 61.03 (1995): 8:(a) (b) (c) (d) (e) (f) to protect the patients and the reputation of clinical setting from malpractice from uncommitted nurses and students.

Management of HTIs

Management of HTIs as senior management in institutions entrusted with the responsibility of developing organizational structural processes need to recognize valuable contribution of preceptorship and preceptors to nursing education Health training institutions are ETPS and are responsible to have quality assurance measures to facilitate development of students' professional nursing skills and competences and therefore to regulate as such in accordance with Botswana the statutes and policies regulating the education and training of a nurse. HTI management is the key in driving nursing education activities. It is therefore their obligation to provide or negotiate for provision of all resources needed to effectively implement preceptorship. The management develops a budget for training workshops for preceptors and nurse educators and procurement of all resources needed to facilitate effective outcome based nursing education.

In this study, preceptors indicated lack of teaching and learning resources such as journals for reference when teaching students in the clinical area. Other participants suggested that due to lack of or inadequate equipment in the clinical settings, the HTI should buy equipment for students to take to the clinic settings during proctorship so that what the students are taught in the skills laboratory or classroom does not differ with what is practiced in the clinical setting. Such equipment would be brought back to the skills laboratory at the end of each day to prevent loss. In collaboration with stakeholders like MoHW and clinical settings, the HTI management can negotiate for incentives for preceptors. The clinical setting and HTI management together with NMCB should collaborate and negotiation for recognizing preceptors as another cadre of nurses and decide on opening a register for preceptors; such a move maybe be an incentive for nurses to take the preceptors role.

Recipients

According to Dickoff et al (1968:426), the recipients of an activity are those persons or things that receive actions from the agent. They describe the recipient as an interactor with the agent towards an activity of a desired kind and regarded as possessing a repertoire of capabilities and limitations just like the agent. In the implementation of this preceptorship model to facilitate clinical nursing education recipients are students and preceptors and indirect recipients are health care users. Students and preceptors are primary recipients of preceptorship practices. Although the model was developed in the context of clinical education, the researcher included healthcare users as recipients because preceptorship takes place in the clinical setting where the student is a practicing nurse on health care users. Figure 7. 3 depict the agent and recipient.

Preceptors

Preceptors are a key human resource in the preceptorship process. The preceptor has a responsibility towards the student, the healthcare user, the clinical setting and the HTI. The preceptor receives the students from the nurse educator from the HTI. The preceptor orientates the student to the clinical setting context, an environment that is completely different from the HTI context. The preceptor supervises students, acts as a role model of professional behavior and facilitates and evaluates students' clinical learning activities.

According to Martensson et al (2013:448), being able to plan and prepare clinical education for students is an important role of preceptors. The preceptor should be knowledgeable about policies that regulate teaching and learning in HTIs such as the Curriculum for Higher Diploma in General Nursing (2008), Academic regulations for Affiliated Health Training Institutions, Teaching and Learning Policy, (2006) and Assessments Standards HTTs,(2004), procedure tools and clinical expectations. Knowledge of such policies facilitates the smooth process of preceptorship, prevents legal suits and conflicts between students and preceptors.

As a nurse, the preceptors should work within the confines of the Nurses and Midwives Act: Chapter 61.03 (1995) to prevent issues of malpractice and misconduct which can lead to discipline, suspicion or revoking of the practice license. For effective preceptorship in the clinical setting, the preceptor needs support from all agents namely: the nurse, educator, and clinical setting and HTI management. The preceptor carries a full load of patient care in addition to the role of precepting student. The management of HTI clinical setting as senior management in the development of organizational structures should provide full support to preceptors and students to facilitate the preceptorship process. The preceptors should be allocated time for preceptors to plan and discuss with students objectives and other learning needs of students. During preceptorship the preceptor has a role to protect the student, a novice being socialized to the profession and the healthcare user as a recipient of health services from the student. The

preceptor should create learning opportunities for students and show interest in teaching. Phuma- Ngaiye and Bvumbwe (2017:167), state that a preceptor is a link person between the clinical area and the nursing college.

Students

The structure of preceptorship should be such that the relationship between the learning context, HTIs and clinical setting management, nurse educator and the preceptor should facilitate learning opportunities for the student during preceptorship. According to Kaphagawani and Useh (2012:182), learning in the clinical practice takes place if students know that what they are doing is right or wrong which requires students to be given feedback. Although students are expected to be self-directed and visionary learners, good interpersonal relationship, effective communication and support between student and preceptor facilitate effective clinical nursing education. The preceptor should provide adequate orientation to students on clinical setting policies that regulate the practice of nursing. To enable them to implement such policies during preceptorship, the student should implement and comply with all academic and professional policies and regulations that govern their clinical nursing education practice.

The student should develop learning objectives, discuss with the preceptors and jointly plan on strategies to be used to achieve the clinical learning objectives. The student should exhibit competence in performing nursing activities that they have been taught to prevent legal suits resulting from incompetency in the provision of health services such as medication errors and causing harm to health care users.

Healthcare users

Health care users have the right to quality health services provided by competent preceptors and students. It is in the responsibility of the student and preceptor to provide health services while the agents provide recourses to facilitate provision of such services. Figure 7.3 depicts the relationship between the agent and recipient during preceptorship.

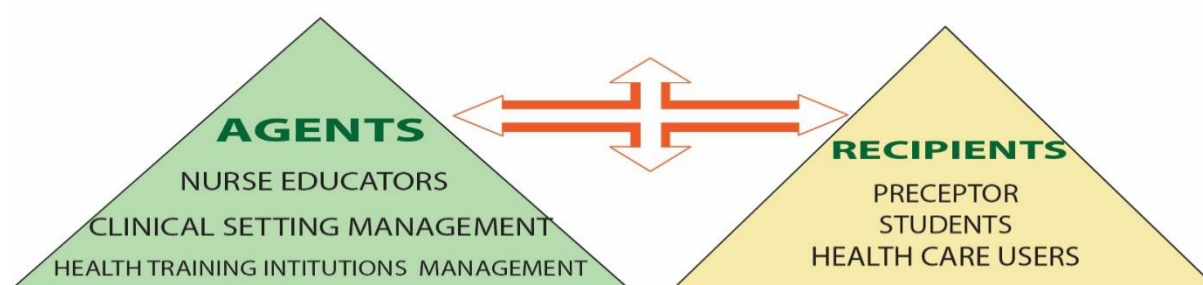


Figure 7. 3 *Agents and recipients of preceptorship*

7.4.3 Procedure

The procedure or process stipulates that all activities or actions are to be carried out in order, to achieve the terminus or purpose. Dickoff et al (1968:426), define a procedure as the path, steps and pattern whereby all activities are performed. In this model, procedure refers to the preceptorship processes and all activities to be performed to reach the terminus or purpose of the preceptorship model which is to facilitate clinical nursing education. In the context of this model, the procedure for preceptorship includes activities such as planning, selection of preceptors, training; placement of preceptors and monitoring and evaluation. Madhavanpraphakaran et al, (2013:32) emphasized the need to identify factors that facilitate and those that hinder students learning during preceptorship and develop process to promote and mitigate them as might be.

- **Planning**

Planning is the first step in any activity or process. Planning of preceptorship should be a collaborative effort between preceptors, nurse educators and management of both the HTIs and clinical settings. Planning helps in identification of resources needed for preceptorship which include; human, material, and time, finance, space and equipment. Study findings point to inadequate resources for preceptorship in all dimensions.

- **Selection**

A clear selection criterion for preceptors should be in place. The characteristics of a good preceptor as cited in the literature and this study should be used to guide the process of selecting preceptors. According to Young, Vos, Cantrell and Shaw (2014:1), effective preceptors should demonstrate

professional expertise, actively engage students, foster a positive environment for learning, demonstrate collegiality, discuss career-related topics and concerns with students, are open to questions and give constructive feedback. Empirical evidence has revealed that in Botswana preceptors are often chosen by their supervisors based a minimum of 2 years nursing experiences; without considering interest in teaching. This therefore requires re-visiting of the selection criteria for preceptors.

- **Training**

Preceptors need to be trained for the role. Training equips preceptors with teaching and assessment skills and fosters confidence in role performance. Empirical evidence has revealed that most nurses serving as preceptors are neither trained as preceptors nor adequately oriented to the role of a preceptor. Findings of this study were supported by literature that most preceptors are not trained for the role (Kaphagawani & Useh, 2013:183; Hyrkas, et al, 2014:120, 131). The impetus toward prioritizing training of preceptors is therefore imperative.

- **Placement**

Following training, preceptors should be strategically placed in the clinical setting so that they can be accessible to students. Clinical setting management in collaboration with MoHW should consider the nurses' role as preceptors when transfer of nurses is done. Study findings revealed that being a preceptor was not consider as such, preceptors like all other nurses, often find themselves placed in units or clinical settings where there are no students allocated.

- **Monitoring and evaluation**

Monitoring and evaluation is critical aspect of preceptorship. To determine the effectiveness of preceptorship, nurse educators, preceptors and students should evaluate the activities entailed and give a feedback. Students should evaluate the preceptors' and nurse educators' performance. Nurse educators should monitor the process throughout and give feedback to preceptors, students, HTIs and clinical setting management. Feedback provides information on strength and weakens of the process which is necessary for improvement or re-engineering of the preceptorship process. Empirical evidence revealed that feedback to preceptors by student .and nurse education was not common practice, and yet very crucial to determine the effectiveness of preceptorship. The process is cyclic. The initial phase is planning of preceptorship activities it involves mobilization all resources including finance, equipment and relevant clinical settings for students during preceptorship. Selection and training of preceptors follow the planning phase. After training preceptors are placed in clinical settings to facilitate preceptorship in clinical nursing education. Monitoring and evaluation of preceptorship is ongoing to determine the outcome of preceptorship in clinical nursing education the ultimate purpose of the model. Figure 7.4 depicts the preceptorship process.

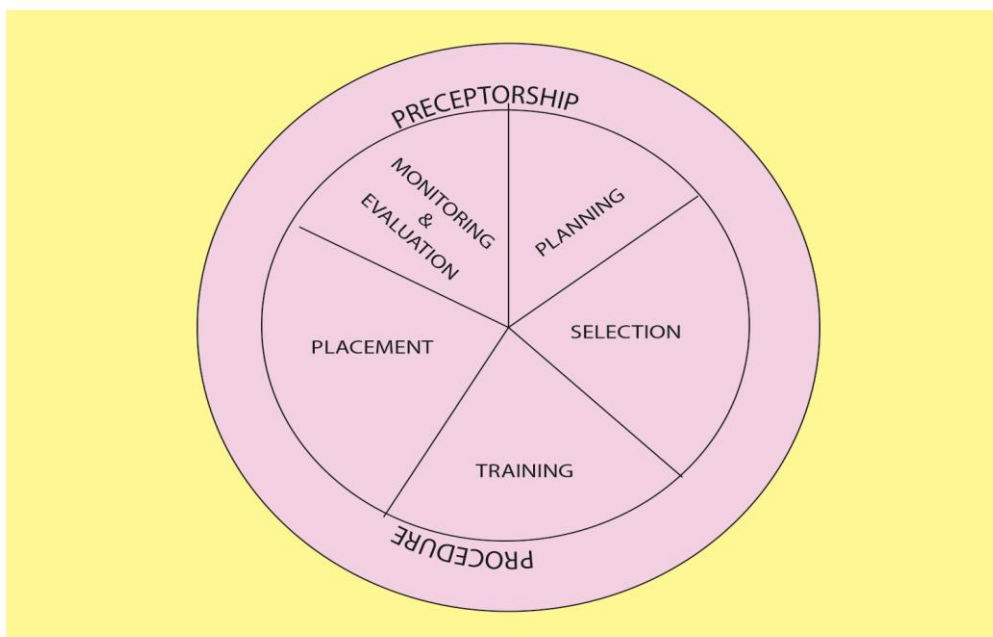


Figure 7. 4 *Preceptorship Procedure*

7.4.4 Dynamics:

According to Dickoff et al (1968:422) dynamics are energy sources or factors that influence preceptorship practice either positively or negatively: Dynamics of preceptorship in the model include: communication, support collaboration, commitment and recognition. All these dynamics that exist during preceptorship within the context of HTI s or clinical setting influence effectiveness of preceptorship and influence the agents and recipients either positively or negatively. The arrows from the dynamics to different components or concepts of the model indicate the influence of dynamics on all aspects of preceptorship namely: the context, procedure, agent, recipient and the terminus which exists within the context of clinical settings and HTIs. The following dynamics were suggestions to improve preceptorship from the empirical phase of the study.

- **Communication**

Effective communication between nurse educators and preceptors has been highlighted from the study findings as having a positive influence on the effectiveness of clinical nursing education. Participants in this study indicated that communication during preceptorship was not effective. Regular meetings between nurse educators and preceptors to discuss issues of concern and nurse educators' support visits to students and preceptors were cited as important factors to the effectiveness of preceptorship. Good communication between students and preceptors was suggested as a factor that facilitates preceptorship (Madhavanpraphakaran et al, (2013:32).

- **Commitment**

Commitments by all stakeholders can result in effective preceptorship for clinical nursing education. Findings and literature indicate that some students and preceptors' commitment is lacking (Tiwaken et al. 2015: 70). Lack of commitment negatively influences attainment of effective proctorship. Individual commitment by different agents and recipients activates the desire to participate in the implementation of preceptorship activities. According to Luhanga, Koren, Younge and Myrick, (2014:123), the importance of the faculty's role as an integral part of preceptorship in so far as facilitating students' and preceptorship success particularly for unsafe precepted students cannot be underestimated. Lack of commitment by nurse educators, students and preceptors could culminate into unsafe practice by students that can result in health care errors compromising health care users 'health and safely.

- **Support**

Gaberson & Oermann (2007:225) and Rose (2008:106), highlighted the importance of the role of the nurse educator in the selection, support, and providing guidance for selection of appropriate learning. The findings from this study suggested that preceptors need more support from clinical management, supervisors, preceptors' colleagues and nurse educators. Support entails reduced workload, allocating time for preceptors to attend to students, visits by nurse educators and provision of resources to facilitate effective teaching and learning during preceptorship.

- **Collaboration**

HTIs and clinical settings are to collaborate with regulatory and professional bodies (HDRC, BQA, UB, and NMCB) respectively for the purpose of accreditation which authorizes the institution to offer education and training services. Collaboration with MoHW can assist the institution and clinical setting to get support in terms of human and financial resources needed to support and sustain preceptorship and improve its effectiveness.

- **Recognition**

Preceptors should be appreciated for their contribution to the training of students over and above their core responsibilities. The findings indicated that preceptors are not recognized for their role which has resulted in nurses not willing to take up the role of being a preceptor for students. Recognition includes preceptors being given incentives which could be monetary, certificate of recognition, time off, time to be with students, reduction of workload, or invitations to special events. Figure 7.5 illustrates the dynamics for preceptorship within the context of the model.



Figure 7. 5 *Dynamics that influence effectiveness of preceptorship*

7.4.5 Terminus

According to Dickoff et al (1968:422), terminus or end point of an activity can also be referred to as the purpose of the activity. The model will lead to effective preceptorship in clinical nursing education. The terminus is achieved as the end results of the interaction between all concepts forming the structure re of the model. Figure 7.6 shows terminus or end point of preceptorship in clinical nursing education. It is envisaged that the model will effectively facilitate preceptorship to achieve the intended purpose of clinical nursing education.



Figure 7. 6 *Terminus of preceptorship*

7.5 MODEL DEVELOPMENT

Based on the conceptual framework classified according to Dickoff et al (1968), the preceptorship model to facilitate clinical nursing education is classified according to (Chinn and Kramer, (2012:184-196). Chinn and Kramer (ibid), identified the following components: 1) overview of the model, 2) structure of the model, 3) assumptions, 4) relationship statements and 5) the nature of the structure. The description of the model process is followed by the model evaluation.

7.5.1 Overview of the Model

A model is a schematic representation of how preceptorship will enhance clinical teaching. This model is based on the premise that preceptorship is necessary for effective clinical teaching and learning. The empirical data from the nurse educators and preceptors in the convergent mixed method indicate the need for a preceptorship model. In addition to this is the fact that there is great pressure on the HITs by

government and regulatory authorities to produce clinically competent nurses who are able to contribute positively to healthcare outcomes. Clinical setting environment promotes attainment of clinical competence. This preceptorship model to facilitate effective clinical nursing education will guide stakeholders in preceptorship towards attainment of students' clinical learning objectives.

7.5.2 Purpose of the clinical model

According to Chinn and Kramer, (2012:185) the best way of describing the purpose of the model is to consider who will implement it and under which conditions or circumstance. It is envisaged that the preceptorship model will be used as a framework of reference to facilitate clinical teaching and guide HTIs and clinical settings on the guidelines for operationalization of the proposed model.

7.5.3 Structure of the model

According to Chinn and Kramer, 2012:191), the structure of the model depicts the overall form of conceptual relationship. The structure assists in understanding the relationships between concepts order of occurrence and how they relate to each other. This model is based on the following elements: assumptions, concept definition, relationship statement, and nature of structure (Chinn & Kramer, 2012:196).

7.5.4 Assumptions of the model

Assumptions are acceptable truths on which the model is based (Chinn & Kramer, 2012: 185). Assumptions are related to relationship statement and reflect the values underlying the model. The following are the assumptions upon which the model is based:

- The effectiveness of the preceptorship process requires collaboration of different stakeholders.
- The dynamics that exist within nursing education, clinical settings, agents and recipients influence the effectiveness of preceptorship in clinical nursing education.
- The clinical setting is the core context where preceptorship activities occur and should provide the best evidence-based learning opportunities for students.
- The preceptor and students are key persons in the preceptorship process and should be supported by nurse educators, management (s) of these and clinical settings to achieve the objectives of preceptorship

7.5.5 Concepts Definition

The concepts of this model were identified through the empirical study literature review and are clarified through Dickoff et al (1968),’s six survey activities or elements, these include:1) Context, 2) Agents, 3) Recipient, 4), Procedure, 5) Dynamics, 6) Terminus.

7.5.6 Relationship statements

Relationships are defined by Chinn and Kramer (2012: 190) as linkages among and between concepts and show how the concepts “hang” together (Walker and Avant, 1995: 18) the following are the relationship statements formulated for this model.

- Successful or effective preceptorship is influenced by the context wherein it existed or occurred, namely; HTI's and clinical setting.
- HTI's and clinical setting managers as well as the nurse educators are key role players to initiate and sustain successful preceptorship
- Preceptors, nursing students and healthcare users are at the core of preceptorship as they are the ultimate recipients of the process of preceptorship.
- The dynamics that drive the process of preceptorship include communication, commitment, collaboration, support and recognition,
- Preceptorship as a process or procedure influences the achievement of the terminus; namely; effective preceptorship. The process entails planning, selection, training, placement of preceptors as well as monitoring and evaluation.
- Successful preceptorship is dependent on the interactions of the key role players, namely, the agents HTI's managers and nurse educators as well as clinical setting manager) and the recipients (preceptors, nursing students and health care users)
- Communication, support, collaboration, commitment between the agents and recipients are intended to influence effective preceptorship to facilitate clinical teaching (terminus).

7.5.7 The nature of the preceptorship model

The preceptorship model is multidimensional and consists of the six elements as displayed

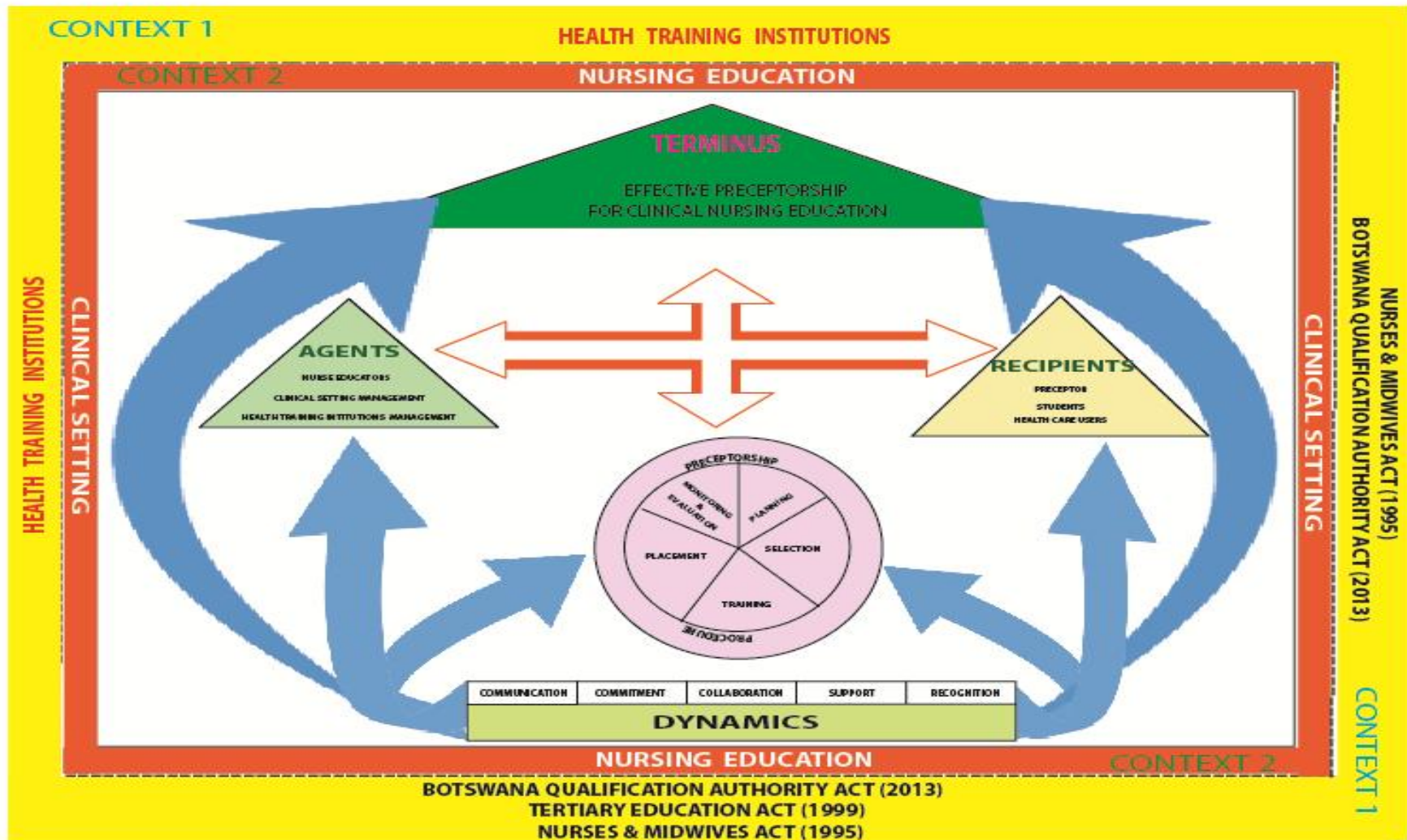


Figure 7. 7 A Preceptorship Model to facilitate Clinical Nursing Education

The symbolic meanings of the diagram or figure 7.7 are as follows:

- The outer frame around the model represents the context wherein preceptorship will occur, namely, Health training institutions and inner frame represents nursing education in the clinical settings where preceptorship activities are offered.
- The arrows symbolize the relationships or influence on each element.
- The circular structure represents the preceptorship process or procedure which is a continuous process.
- The smaller triangles represent the key role players in the preceptorship
- The bigger triangle represents the terminus or goal of the model.
- The four directional arrows between the terminus, recipient, agents and process indicate the relationships amongst the stated elements.
- The multiple arrows from the dynamics to various elements of the model indicate the underlying powers that influence the elements (agents, recipients, process and terminus)

7. 6 EVALUTION OF THE MODEL

The model was not evaluated by experts as it has not yet been implemented. Model evaluation and validation will be done post-doctoral. Although the model was not evaluated in the context in which it is intended to be used, critical reflection of the done model was done using Chinn and Kramer (2012:196-204)'critical reflection questions. The following five (5) critical reflection questions were used:

- How clear in the model?
- How simple is the model?
- How accessible is the model?
- How general is the model?
- How important is the model?

7.6.1 How clear in the model?

Clarity of the model was achieved through concept identification and classification in the conceptual framework (Figure 7.1) which informed the development of the model. According to Chinn and Kramer (2012:205), the clarity of the model is determined by both semantics and structural aspects of the model. In this study, semantic clarity of the model was achieved through the use of only core concepts of preceptorship, no new concepts were introduced. Structural clarity has been achieved by the use of Dickoff et al (1968)'s survey list of activities as the basis for describing the structure of the model.

7.6.2 How simple is the model?

Chinn and Kramer, (2012:205), state that; the simplicity of the model is concerned with the complexity of structural components and the relationships between categories. This model is relatively simple and not too complicated to understand as the structural components and their relationships are clearly indicated and explained. The procedure or process of how the model will facilitate preceptorship including the dynamic forces that exist within the contexts of nursing education and clinical settings and their influence on the effectiveness of preceptorship in clinical nursing education are clearly stated in simple terms.

7.6.3 How general is the model?

Generality of the model refers to its breath of scope, purpose, its applicability, and broad array of situations (Chinn and Kramer, 2012:202). Although the purpose of the preceptorship model is to facilitate clinical nursing education, it can also be used in other nursing contexts such as practice and administration particularly in the implementation of new initiatives and programmes. The model can be used in any learning and teaching situations that requires students to be supervised by qualified staff in the real work situation.

7.6.4 How accessible is the theory?

Accessibility addresses the extent to which the indicators for concepts can be identified and to what extent the purpose can be attained (Chin & Kramer, 2012:203). The model will be presented to the management of HITs and clinical settings in workshops, and seminars for them to appreciate the model and its purpose. Furthermore, it will be published in nursing journals, presented at conferences and made available to all clinical settings and IHTs where data for the study was collected.

7.6.5 How important is the model?

According to Chinn and Kramer (2012:202), the importance of the model is linked to its significance or practical value. The importance of this model is its value and applicability to preceptorship in clinical nursing education. The model is purposed to improve the effectiveness of preceptorship by addressing identified challenges in the education and clinical contexts such as inadequate resources, lack of expertise in role performance, lack of support, lack of commitment and ineffective communication.

7.7 GUIDELINES FOR OPERATIONALIZATION OF THE MODEL

The last part of model development is the application of the model. The application entails the description of guidelines on how the model is to be operationalized. The guidelines are applied and explained according to the six elements: guidelines pertaining to context, agents, recipients, procedure, dynamics, terminus or outcome.

7.7.1 Guidelines for the Context

HTIs: HTIs are coordinated by the Curriculum unit in the HPDM & E of the MoHW. Nursing education is regulated by statutory instruments on education and training. It is therefore envisaged that HTIs fulfill requirements needed for the training of a nurse namely:

- Provision of resources (human, equipment, material, and financial) for implementation of preceptorship activities
- The HTIs and clinical settings should provide teaching and learning opportunities in line with educational and professional regulations and standards. HTIs and clinical settings are regulated by legal and professional statutes such as Qualification Authority Act, (no 24 of 2013), Tertiary Education Act: Chapter 57.05 (1999), and Nurses and Midwives Act: Chapter 61.03 (1995), which should be accessible to, and adhered to by both preceptors' and students during preceptorship. Such statutes documents be provided as part of the preceptorship package
- HTIs should collaborate with accreditation and professional bodies such BQA, HRDC and NMCB to determine the qualifications and criteria for selection of preceptors and nurse educators as assessors.
- HTI s should have resource centered strategies to support nursing education initiatives. Resourced centers can be provided as learners support services like mobile libraries at the clinical settings and counseling services for preceptors and students.
- Development and signing of MOA(s) and or contracts for teaching and learning purposes. Contracts could include students' placement in clinical settings during preceptorship and contracts between the preceptor and HTI stating period of engagement of the preceptors in the preceptorship role.
- Commitment to the success of preceptorship through collaborative partnership with clinical settings and other key stakeholders such as MoHW, DPSM and DTF, IHS coordination.

Clinical setting: Provision of resources needed for clinical nursing education and training such as equipment, human and material is crucial to creating an enabling learning environment.

- The practice of nursing is regulated by the Nurses and Midwives Act; Chapter 61.03 (1995). The Act should be accessible in the clinical setting and adhered to by both preceptors and students during preceptorship.
- The clinical setting should provide learning space and opportunities for effective preceptorship. The renting of space by the HTIs at the health facilities could be an option in dealing with the challenge of inadequate space.
- Provide best practice evidence based learning environment whereby students work alongside preceptors during all shifts to observe and perform nursing skills under direct supervision of a professional nurse.

7.7.2 Guidelines for the agents

Management of HTIs: Spearhead the development and implementation of standards and policies to facilitate clinical teaching and learning during preceptorship.

It is mandatory for HTIs to ensure implementation of all statutory instruments and standard operational procedures that regulate nursing education and practice such as Acts, policies, standards guidelines, protocols and monitor compliance thereof. The HTIs should also embark on the following:

- Planning for all activities and mobilizing resources needed for teaching and learning by preceptors and students.
- Develop staff development plan and execute it. The purpose being to support nurse educators in preparing for and engaging in the preceptorship experiences (Luhanga et al 2014:123).
- Collaboration and partnership with identified partners as indicated in the study findings.

Clinical setting management: Tan et al (2011:18) highlighted that without proper understanding of the goal and purpose of preceptorship the risk of lack of managerial and staff support for preceptors resulting in burnout is inevitable. In accordance with the preceptorship model to facilitate, clinical nursing education the setting management shall:

- Mobilize resources to facilitate effective teaching and learning during clinical education and provide support to preceptors and students. Preceptors to be given time to attend to students learning needs
- Reduce workload of preceptors to allow facilitation of effective supervision.
- MOA should be signed with relevant stakeholders such as HTIs as binding agreements to collaboratively participate in the teaching of nursing students.
- Ensuring nursing education and practice standards are enforced as prescribed in the Nurses and Midwives Act: Chapter 61.03, (1995) and students' academic and professional regulations (2006).
- Provision of adequate preceptors for student supervisor.
- Ensure the rights of the students and patients are respected and protected by enforcing adherence to appropriate policy.

Nurse Educators': The role of the nurse educator in facilitating effective preceptorship cannot be over emphasized. Hovland (2011:3) expressed the need for more support of preceptors and students from teachers in students' supervision during preceptorship. The liaison person between clinical preceptors, clinical setting and HTIs management is the nurse educator. The nurse educator will contribute in the implementation of the model as stated:

- Identify appropriate clinical settings for students' placement during preceptorship.

- Solicit for preceptors from clinical setting management.
- Availing of preceptorship guidelines, expectations and objectives to preceptors and students before commencement of preceptorship activities.
- Plan for and organize trainings for preceptors.
- Orientate preceptors on their role; Monitor and evaluate the preceptorship process and give feedback to HTI and clinical setting management and the preceptors.
- Provide emotional and pedagogical support to students and preceptors through provision of reference material as recommended by preceptors in the findings from the qualitative component of the empirical phase of the study. .
- Facilitate for open and effective communication with preceptors and students by regular site visits.
- Create a conducive collegial and trusting work relationship with preceptors and clinical setting management.

7.7.3 Guidelines for the Recipients

Preceptors: Kristofferzon et al (2012:1253), affirm that preceptors are a crucial human resource in the success of preceptorship in clinical nursing education. In the implementation of this preceptorship model the preceptors shall:

- Mobilize learning resources for preceptorship in collaboration with the nurse educator from the HTIs, and supervisor from the clinical setting context these include equipment for procedures and reference materials.
- Establish and maintain clear and open communication with the nurse educator, colleagues and clinical setting management and students.
- Creative a positive teaching and learning environment through establishing a trusting and supportive relationship with the students
- Role model professional behavior in dealing with students, colleagues and healthcare users.
- Demonstrate competence in nursing knowledge skills in nursing by role modeling best practice in the performance of nursing skills.
- Demonstrate competence in the teaching and assessment of learning activities for students. Guide and supervise students' learning activities in the clinical setting.

Student

Students as learners and aspiring professionals have responsibilities towards attainment of their learning objectives.

- The student as a recipient of preceptorship practices should be a self-directed learner by identifying own learning needs, develops learning objectives and communicates them to the preceptor and jointly plan learning activities. Respect the patients' right to privacy and confidentiality.
- Be conversant with standard operating procedures (SOPs) and other policies that regulate the practice of nursing available in the clinical setting.
- Has the right to learn and to be taught nursing in non-threatening environment with adequate resources to facilitate effective preceptorship.

Healthcare user

- Preceptorship activities occur in a clinical setting and are often performed on healthcare users.
- As recipients of healthcare services from the student and preceptor the healthcare user has the right to be respected by healthcare provider, in this context preceptors and students.
- Should be given quality nursing at all times.
- Has the right to refuse to be cared for by a student, without fear of prejudice.
- Healthcare users have the right to information about the health status from the student and preceptor to allow informed decision making.

7.7.4 Guidelines for the Procedure

The preceptorship process should be well planned, structured and formalized based on evidence- based best practices from both empirical and literature sources.

- Resources' needed for implementation of preceptorship should be solicited and mobilize prior to commencement of preceptorship (human, material, clinical space, equipment, and financial).
- Measures for the support and sustenance of preceptorship should be implementing (availability of preceptors, clear selection criteria for preceptors, guidelines and objectives for preceptorship, training of preceptors, and appropriate placement of preceptors in the clinical settings).
- Monitoring and evaluation of the preceptorship process should be conducted to identify gaps in the effectiveness of preceptorship and develop measures for improvement.
- Recognition of preceptors through training and offering incentives to motivate nurse to take up the preceptorship role is a crucial procedure for the support sustainability of preceptorship

7.7.5 Guidelines for dynamics of preceptorship

The influences of dynamic forces in clinical nursing education can either “make or break” the effectiveness of preceptorship.

- Communication should be open to foster dialogue between stakeholders involved in preceptorship and nursing education.
- Collaboration should be encouraged as it fosters teamwork and can serve as a means to strengthen support and sustenance of effective preceptorship. The collaboration and partnerships amongst the HTIs, clinical settings, MoF and MoHW is crucial in ensuring the effectiveness of preceptorship particularly with reference to resources needed.
- Recognition of preceptors for their role in contributing to students' training in the clinical context of nursing education should not be underestimated. Empirical evidence and literature have revealed that giving incentives to preceptors for their role serves as one of the factors that motivate nurses to take the role.
- All stakeholders should exhibit commitment to the training of competent and globally competitive nurse through diligent execution of their mandate as an education or clinical context, agent, recipient or collaboration partner.
- Support structures and strategies for effective preceptorship and clinical nursing education should be designed, clearly defined and implemented by all stake holders.

7.7.6 Guidelines for the terminus

The terminus or end point according to this preceptorship model is effectiveness of preceptorship in clinical nursing education.

- Formative and summative monitoring of preceptorship implementation should be done. Evaluation of attainment of preceptorship and clinical nursing education objectives will ascertain the degree of the effectiveness of preceptorship in clinical nursing education.
- Recommendations from monitoring and evaluation of the preceptorship processes should be implemented to achieve the desired outcome of preceptorship.

7.8 SUMMARY

The chapter described the development of a preceptorship model to facilitate clinical nursing education. Objectives of the chapter and literature reviewed were highlighted. The overview of the model was given. The description of the model followed the format as indicated. The structure or nature of the model was described. The structure of the model was described based on the 3) assumptions, 4) relationship statements, and 5) nature of the structure. Proposed guidelines to operationalize the model were developed. Chapter 8 discusses justification, limitations, recommendations and conclusion of the study.

CHAPTER 8

JUSTIFICATION, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

8.1 INTRODUCTION

In the previous chapter a preceptorship model to facilitate clinical nursing education in Botswana was developed. This chapter gives an overview of the study and presents the justification, limitations, recommendations and the conclusion of the study.

8.2 JUSTIFICATION OF THE STUDY CONTRIBUTION

The original contribution of the study to the body of knowledge in nursing education and practice will be done through an overview of purpose and objectives of the study, the research design, limitations of the study and recommendations to nursing education nursing practice and nursing research and policy making. The development of a preceptorship model is a contribution to the body of knowledge in nursing education, nursing practice, research and policy making to improve the effectiveness of preceptorship in clinical nursing education.

8.2.1 Rationale of the study

Preceptorship has been used as a clinical teaching strategy for students in the diploma in general nursing programme in nursing education for over two (2) decades in Botswana. According to non-empirical evidence the standard of clinical nursing education has dropped. Very little research has been conducted to determine the effectiveness of preceptorship in relation to resource availability and support structures to sustain preceptorship and ensure it that it meets its intended objective or terminus.

The rationale for this study was to provide a true reflection of the preceptorship in Botswana from the perspective of nurse educators and preceptors with the aim of developing a contextual preceptorship model.

8.2.2. Purpose of the study

The overall purpose of the study was to develop a preceptorship model to facilitate clinical nursing education in Botswana.

8.2.3 Objectives of the study

The study objectives were categories according to the phases of the study namely; the Empirical and Model development phases. The following objectives were applied to achieve the purpose of the study:

Empirical phase

- To measure preceptors' and nurse educators' perceptions of preceptorship in nursing education of Botswana using an adapted Dilbert and Goldenberg's (1995) 4-part questionnaire comprising: Preceptors' Perception of Benefits and Rewards Scale, Perception of Support Scale, Commitment to the Preceptor Role Scale and Demographic Characteristics Scale. The adapted questionnaire was structured and contextualized to the SPO model that guides the study.
- To explore and describe the level of preceptorship support needed for the success of preceptorship in clinical nursing education in Botswana. The objective achieved through conducting Focus Group Discussion (FGDs). Semi structured interview guide was used to direct the discussion.

Model development phase

- To construct a conceptual framework for model development using Dickoff et al.,(1968)'s survey list of activities. The concepts that informed the development of the conceptual framework or model development were identified from findings of the empirical phase of the study.
- To develop a preceptorship model to facilitate clinical nursing education in Botswana using Chinn and Kramer's approach. Critical reflection of the model has been described as operationalization guidelines of the model were developed. The model was not evaluated since it has not yet been implemented. Model evaluation will be done post-doctoral after it has been implemented.

8.2.4 Research methodology:

The study was done in two phases

Phase I Empirical phase

This phase adopted a mixed method approach (Creswell, 2014:219-220). A **convergent** parallel design that combined the quantitative and qualitative research designs was conducted.

Phase II Model development phase

A conceptual framework was constructed using identified concepts from the mixed methods approach findings in phase I and literature review. The conceptual framework formed the basis for development of the preceptorship model to facilitate preceptorship in clinical nursing education as depicted in Figure 7.7.

Although the study used non-probability sampling techniques (Convenience and Purpose), the strength of study was derived from the use of the mixed method approach wherein the quantitative and qualitative designs complemented each other hence reducing the limitations of each method and increasing the credibility of the findings. The strength of the study was also contributed by the inclusion of all nurse educators (census) who met the eligibility criteria for the study. Nurse educators and preceptors represented

all HTIs in the country and clinical settings where higher diploma in general nursing students' are placed for clinical nursing education during preceptorship.

8.3 LIMITATIONS OF THE STUDY

The study limitations are as follows:

- The non-probability sampling technique (convenience) employed for the quantitative component limits the generalizability of findings.
- The unavailability of an accurate database for preceptors in HTIs, ministry of health and clinical settings resulted in the researcher changing the sampling methods and MM approach from Stratified Random Sampling to Convenience and Snowball sampling and from using the descriptive explanatory sequential MMD to Convergent Parallel MMD for the quantitative component of the study.
- The data collection period coincided with massive transfers of nurses to different clinical settings and health districts which resulted in problems locating of some preceptors.
- The study had financial and time limit implications for the researcher. The nature of the study in relation to characteristics of participants required the study to cover a large geographical area during data collection.

8.4 RECOMMENDATIONS

Recommendations are made from the study findings and are presented as implications to nursing education, nursing practice, nursing research and policy making.

8.4.1. Nursing Education

Preceptorship is the core clinical teaching strategy used for senior students (level three) in the Higher Diploma in General Nursing Programme. The following are recommendations made from the study:

- The preceptorship model developed in this study should be shared with nurse educators, IHS coordination unit and management of different HTIs and other stakeholders through presentations at workshops and conferences to facilitate increased awareness and appreciation of the model.
- The preceptorship model to facilitate clinical nursing education should be published in accredited Nursing and Health Sciences journals. This will increase accessibility to educators who might be interested in preceptorship. Educators may adopt, adapt, refine or make recommendation for the improvement of the model.

- Restructuring of preceptorship to embrace the learning needs of students and teaching needs of preceptors should be guided by this preceptorship model developed based on the experiences and recommendations from nurse educators and preceptors as key role players in preceptorship.
- In the light that most nurses serving as preceptors are not trained or adequately orientated to the preceptorship role, it is recommended that HTIs in collaboration with MoHW-(IHS Coordination unit) ensure that resources for training of preceptors are available and that regular and ongoing trainings are conducted to empower all preceptors if not all nurses with teaching and students assessment skills.
- Nurse educators should be available and willing to provide the much needed pedagogical and emotional support to preceptors and students to facilitate quality clinical nursing education during preceptorship.
- Regular meetings and effective communication between nurse educators and preceptors to discuss preceptorship and students issues including given feedback to preceptors on their performance is recommended as a way of motivation and helping them improve on identified weaknesses.
- Guidelines and objectives of preceptorship to be availed to preceptors well on time before students are sent for placement to the clinical settings. The guidelines should be explained to the preceptors and implemented consistently by all HTIs.
- HTIs to form and strengthen collaboration partnerships with clinical settings, MoHW, Regulatory and Accreditation Bodies, and Professional Bodies as key stakeholders in nursing and higher education regulation to improve the quality of nursing education through adherence to set standards. Collaboration is a positive dynamic force that could enhance effectiveness of preceptorship.
- Formal and clear guidelines for selection of preceptors should be developed in line with the desired characteristics of a preceptor, Nursing Education standards as prescribed by NMCB and BQA requirement for assessors in the ETP s should be implemented.
- Advocate incentives for preceptors through consultation with relevant stakeholders
- Establish a database for preceptors both at HTIs and Ministerial level (IHS Coordination level).

8.4.2 Nursing Practice

The quality of nursing care is gradually declining globally Botswana being no exception. The clinical setting is the environment in which nursing education takes place during preceptorship. The clinical environment should provide enabling and supportive procedures for the recipients order for effective preceptorship to occur. The dynamics in the clinical setting context can either positively or negatively affect preceptorship.

The following are recommendations made from this study:

- The preceptorship model to facilitate preceptorship in clinical nursing education should be disseminated to nurses and nurse managers through in-service education seminars, workshops and other consultative stakeholder meetings (Pitso) for awareness, buy-in and support.
- Clinical setting management, supervisors and colleagues of preceptors should work together to provide preceptors with the necessary processes and procedures needed for effective preceptorship as the terminus in the context of this model.
- Clinical settings management to partner with nurse educators and HITs management in the selection of preceptors based on the guidelines.
- Clinical placement of preceptors within units in the same clinical setting or from one clinical setting or district to another should be done taking cognizance of the preceptors' role in students' supervision. This can be achieved through open communication and collaboration between preceptors, supervisors and management and nurse educators' from HTIs.
- The workload of the preceptors should be reduced to allow adequate supervisions of students and prevent healthcare errors that can adversely affect the students and patients. This might require an increase in the number of preceptors.

8.4.3 Nursing Research

Recommendations for research include:

- Implementation and evaluation of the preceptorship model to facilitate clinical nursing education be done for relevance and effectiveness.
- Developing an evaluation tool to test the model within the Botswana's clinical nursing education context.
- Conducting a follow-up study on effectiveness of preceptorship in clinical nursing education in Botswana.

8.4.4 Policy making

- The policy makers in the health sector are the custodian of nursing education and practice and have an obligation to ensure best practices and quality of nursing education and practice in the country. Recommendations to this effect are that:
- The model could be incorporated into/as part of a national clinical nursing training framework. The preceptorship model should be presented to PDSM, Clinical Services, Chief Nursing Officer, and other government departments and ministries that have a direct contribution to nursing education like MoF for awareness and appreciation of the value of preceptorship and the role of supportive policies in the

sustenance of preceptorship. To achieve this; a special consultative meeting can be organized through IHS Coordination as a link unit between HTIs and government.

- Incentives should be included as a package for preceptors as a token of appreciation to motivate preceptors. These could be in form of appreciation certificates, extra day off, invitation to students' graduation ceremonies among others.
- There is need for a national and up to date database for preceptors.
- A policy should be developed on transfer of preceptors. The policy should take into account the preceptor role when nurses are transferred from one clinical setting to another.
- Development of job descriptions for preceptors for role clarity. A job description addresses issues of role ambiguity that preceptors often face when the preceptor role conflicts with and other nursing responsibilities.
- NMCB education and nursing practice standards to be enforced and implementation monitored during preceptorship to uphold quality of clinical nursing education and patient care. This can be achieved through development of quality assurance standards for nursing education and practice.

8.5 CONCLUSION

The chapter gives an overall summary of the study. The purpose of the study which was the development of a preceptorship model to facilitate clinical nursing education in Botswana was realized through the achievement of the study objectives. The study identified benefits, challenges, deficiencies as well as inconsistencies associated with preceptorship which were revealed in the quantitative component and supported by FGDs. The need for restructuring of preceptorship becomes evident from the findings of this study. Although preceptorship has been used for over 20 years in Botswana, it was surprising and interesting to note that the model guiding preceptorship in clinical nursing education is not known to both nurse educators and preceptor. Furthermore, there is literature dearth to the existence of such a model in Botswana. There is no database for preceptors; this makes follow up of preceptors to be challenging. A conclusion could be reached that the preceptorship model developed in this study will greatly contribute in facilitating clinical nursing education and effectiveness of preceptorship. Training and support for preceptors and nurse educators should be promoted for effective preceptorship. Giving preceptors' incentives may motivate more nurses to develop interest in taking up the preceptorship and alleviate the current problem of unavailability of preceptors. The rigor and intensity of the study was challenging, but the results are gratifying in their unique contribution to the body of knowledge specifically to nursing education, nursing practice, policy making and the nursing profession as a whole.

REFERENCES

- Al-Zayyat, A & Al-Gamal, E. 2014. Perceived stress and coping strategies among Jordanian nursing students during clinical practice in psychiatric/mental health courses. *International Journal of Mental Health Nursing*, (23): 326–335.
- Billay, D. & Myrick, F. 2008. An integrative review of the literature. *Nurse Education*, (8):258-266.
- Billings, D.M. & Halstead, J. A. 2012. Teaching in Nursing: A guide for Faculty. 4th.ed. St Louis: Saunders an imprint of Elsevier Inc.
- Billings, D.M. & Halstead, J.A. 2009. Teaching Nursing: A Guide for Faculty. 3rd. ed. Sunders: Elsevier.
- Borch, E., Ethlin, E., Hov, R., & Dupplis, G. S. 2013. Group's supervision to strengthen nurses in their preceptorship role in bachelor nursing education: Perceptions before and after participation. *Nurse Education in Practice*, 101-105.
- Botma, Y. 2016. Suggested competencies for a preceptor training programme. Trends in Nursing, 3 (1) <http://fundisa.Journal.ac.za> <http://dx.doi.org/10.14804/3-1-16>.
- Botma, Y., Jeggles, J., & Uys, L.N. 2012. Preparation of Clinical Preceptors. *Trends in Nursing*, 1(1) <http://fundisa.journals.ac.za> <http://dox.doi.org/10.14804/1-1-25>
- Bott, G., Mohide, A. & Lawlor, Y. 2011. A clinical teaching technique for nurse preceptors: the five Minute preceptor. *Journal of Professional Nursing*, 27 (1): 35- 42.
- Botswana Government Printers. 1995. Curriculum for Basic Diploma in General Nursing Gaborone: Botswana.
- Botswana Qualification Authority, Act No 24 of, (2013). Gaborone: Botswana.
- Bourgeois, S., Drayton, N., & Brown, A.M., 2011. An innovative model of supportive clinical teaching and learning for undergraduate nursing students: a cluster model. *Nurse Education in Practice*, 11 (2): 114–118.
- Boyer, SA. (2008). Nurses in Staff Development. *Journal of Staff Development*, 24(2): E1-E6).
- Brink, H., Walt, C, & Rensburg, G. 2014. Fundamentals of Research Methodology for Healthcare Professionals. 3rd Ed. Cape Town: Juta & Company.
- Brink, H.I. L. 1989. The term Preceptor: It's Interpretation in South African nursing colleges and International nursing literature. *Curationis*, 12 (3 & 4): 62-66.

- Burns, N. & Grove, S.K. 2005. *The practice of Nursing Research: Conduct, Critique and Utilization*. 5th Edition. Texas: Elsevier Saunders.
- Callaghan, D., Watts, W.E., McCullough, DL. Moreau, J.T., Little, M.A., Gamroth, L.M., & Durnford, KL. 2009. The experience of two practice education models: Collaborative learning units and preceptorship. *Nurse Education*, (9):244-252.
- Canadian Nurses Association, 2004. 'Achieving excellence in professional practice,' A guide to preceptorship and mentorship. <http://www.cna.aai.ca/>).
- Chinn, P.L., & Kramer, M.K. (2012). *Integrated Theory & Knowledge Development in Nursing*. 9th Edition. St Louis: Elsevier-Mosby.
- Connor, S. L. 2015. Preceptors enrich Practice, Profession: Practice Application. *Journal of the Academy of Nutrition and Dietetics*, 337. [http:// dx.doi.org/ 10.1016/j.j and 2014.12.023](http://dx.doi.org/10.1016/j.jand.2014.12.023).
- Cosme, F.S.M.N. & Valente, G.S.C. 2013. The development of competencies for nursing preceptorship in the primary health care environment: a descriptive-exploratory study. Online braz journal of nursing [Internet]. 2013 Oct [cited year month day]; 12 Suppl: 602-04. Available from: <http://www.objnursing.uff.br/index.php/nursing/article/view/4541>.
- Courtney, Pratt, H., Fitzgerald, M., Ford, K., Marsden, K. & Marlow, A. 2012. *Journal of Advanced Nursing*, 68 (6):1380–1390. doi: 10.1111/j.1365-2648.2011.05851.x
- Creswell, J.W. 2014. *Research Design. Qualitative: Quantitative & Mixed Methods Approaches*. International Student Edition (4th ed). Los Angeles: Sage.
- Creswell, J.W. & Clark, V.L.P. 2007. *Designing and Conducting Mixed Research Methods Research*. Thousand Oaks: Sage Publications.
- Croxon, L. & Maginnis, C. 2009. Evaluation of Clinical Teaching Models for Nursing Practice. *Nurse Education in Practice*, (9):236-243.
- Danielsson, A., Sundin-Andersson, C., Hov, R., Athlin, E. 2009. Norwegian and Swedish preceptors' views of their role before and after taking part in a group supervision program. *Nursing & Health Sciences*, 11 (2):107–113.
- Devore, J. & Peck, R. 2001. *Statistics: The Exploration and Analysis of Data*. (4th ed). Duxbury: Thomson Learning.

- DeVos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2013. Research at Grass Roots for the social sciences and human service profession. 4th ed. Van Schaail Publishers.
- DeYoung, S. 2003. Teaching Strategies for Nurse Educators. New Jersey: Prentice Hall. Upper Saddle River, NJ 074558.
- Dickoff, J., James, P., & Wiedenbach, E. 1968. Theory in practice discipline part 1. *Nursing Research*, 17 (5): 415-435.
- Dilbert, C. & Goldenberg, D. 1995. Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *J Adv Nurs*; 21(6): 1144-1151. [http:// dx.doi.org/10.1046/j.1365-2648.1995.21061144x](http://dx.doi.org/10.1046/j.1365-2648.1995.21061144x).
- Dobrowolskear, B., Mogonagle, L., Jackson, C., Kane, R., Cabrera, E., Cooney-Minerd, D., DiCara, V., Pajnkihar, M., Sigurdardottir, A. K., Kekus, D., Wells, J. & Palese, A. 2015. Clinical practice models in nursing education: Implications for students' mobility. *International Nursing Review*, (62): 36-46. *International Council of Nurses*.
- Donabedian, A. 2005. Evaluating the quality of medical care. 1966. *The Milbank Quarterly*, 83 (4): 691-729.
- Dube, A. and Jooste, K. 2006. The leadership Characteristics of the Preceptor in selected clinical practice settings in Botswana. *Curationis*, 29 (3): 24-40.
- Flo, S. & Kyngas, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62 (1) : 107-115.
- Fudger, N. & Belcourt, T. 2015. Preceptorship: A foundation for the future of RN practice. *Saskatchewan Nursing Students Association (SNSA) News Bulletin* Spring, 13-14.
- Gaberson, K.B., Oermann, M.H, & Shellenbarger, T. 2015. Clinical teaching strategies in nursing (4th ed). New York; Springer.
- Gaberson, & Oermann, 2007. Clinical Teaching Strategies in Nursing. 2nd ed. New York: Springer Publishing Company.
- Gidman, J., McIntosh, A., Melling, K., & Smith, D. 2011. Students' perceptions of support in practice. *Nurse Education in Practice*, 11 (6): 351-358.
- Government of Botswana 1999. Tertiary Education Act, 57:04. Gaborone: Government Printers
- Guba, E.J. 1981. Criteria for assessing trustworthiness of naturalistic inquiries, *Educational and Communication Technology Journal*, 29 (2): 75-91.
- Hallin, K. & Danielson, E. (2010). Preceptoring nursing students: Registered nurses' perceptions

- of nursing students' preparation and study approaches in clinical education. *Nurse Education Today*, 30(4): 296-302.
- Hallin, K. & Danielson, A. 2009. 'Being a personal preceptor for nursing students: Registered Nurses' experience before and after introduction of a preceptor model. *Journal of Advanced Nursing*, 65(1):161-174. <http://dx.doi.org/10.1111/j.1363-2648.2008.04855.x>, PMID:19032507.
- Happell, B. 2009. 'A model of preceptorship in nursing: Reflecting the complex functions of the role,' *Nursing Education Perspective*, 30 (6):372-376.
- Harvey, P. & Radomski, N. 2013. Clinical Supervision Models in Health Profession Education: Effective Clinical Teaching. *Teaching Resource for Rural Clinical Educators*, 22: 3-4.
- Hawkins, J.M. The Oxford Secondary Dictionary. 1991. The College Press.
- Hidden, H., Jacobs, S., & Marshall, B.C. 2014. New Zealand Nurses Views on Preceptoring International Students. *International Nursing Review*, 61, 179-185.
- Higgins, G., Spencer, R.L. & Kane, R. 2010. A Systematic review of the experiences and perceptions of newly qualified nurse in the United Kingdom. *Nurse Education Today*, 30 (6):499-508.
- Hilli, Y. & Leena-Melender, H. 2014. Developing preceptorship through action research Part. *Scandinavian Journal of caring Science*.
- Hilli, Y. Salmu, M. & Jonsen, E. 2014. Perspectives on good preceptorship: A matter of Ethics. *Nursing Ethics*, 21 (5) 265-275.
- Horton, C.D., DePaoli, S., Hertach, M. & Bower, M. 2012. Enhancing the Effectiveness of Nurse Preceptors. *Journal for Nurses in Staff Development*, 28 (4):E1-E7.
- Hovland, O.J, 2011. Together in Supervision: Nurse Students' Experiences. A Pilot Study. *International Journal of Human Caring*, (15) 4: 33-40.
- Hyrkas, E.K., Linscott, D.A. & Rhudy, J.P. 2014. Evaluating preceptors' and preceptees' satisfaction concerning preceptorship and the preceptor-preceptee relationship. *Journal of Nursing Education and Practice*, <http://dx.doi.org/10.5430/jnep>. 4 (4), 120-133.
- Iglesias-Parra, M.R., García-Mayor, S., Kaknani- Uttumchandani, S., León-Campos, A., García-Guerrero, A. and Morales-Asencio, J.M. (2015). Nursing Students' and Tutors' Satisfaction With a New Clinical Competency System Based on the Nursing Interventions Classification. *International Journal of Nursing Knowledge*, Volume, No.2015 1-8. *The official Journal of NANDA 2015 Inc.*

- Jeggles, J.D., Traut, A. & Africa, A.S. 2013 'A report on the development and implementation or preceptorship training programme for registered nurse'. *Curationis* 36 (1) Art.#106, 6 pages. [Http://dx.doi.org/10.4122/curationis.v36/1.106](http://dx.doi.org/10.4122/curationis.v36/1.106).
- Johnson, C. & Mohide, E.A. 2009. Addressing diversity in clinical nursing education: Support for clinical preceptors. *Nurse Education in Practice*, (9) 340–347.
- Jooste, K., 2010, The principles and practice of Nursing and Health Care. Van Schaik: Pretoria.
- Kalomo, E., Vernon, R. & Toffoli, L. A critical Review of Preceptor Development for Nurses working with undergraduate Nursing Students. *International Journal of Caring Sciences*, 10 (2) 1089-1100.
- Kaphagawani, N.C, & Useh, U. 2013. Analysis of Nursing Students' Learning Experiences in Clinical Practice: *Literature Review*. *Ethno Med*, 7 (3):181-185.
- Koontz, A.M., Mallory, J.L., Burns, J.A & Chapman, S. 2010. Staff Nurses and Students: The Good. The Bad, The Ugly. *Med SURG Nursing* – July/ August, 19 (4):240-246.
- Kristofferson, M.L., Martensson, G., Mamhidir, A.G., & Lofmark, A. 2013. Nursing students' perceptions of clinical supervision: The contributions of preceptors, head preceptors and clinical lecturers. *Nurse Education Today*, 33:1252-1257.
- Keller, G. & Warrack, B. 2000. *Statistic for Management and Economics*. (5th ed). Pacific Groove. Duxbury: Thomson Learning.
- Lekhuleni, E.M., van der Wal, D.M. & Ehlers, V. 2004. Perceptions regarding the clinical accompaniment of students in the Limpopo Province. *Health SA GEONDHEID*, 9 (3):15-27.
- Liu, M., Lei, Y., Mingxia, Z. & Haobin, Y. 2010. Lived experiences of clinical preceptors: A phenomenological study. *Nurse Education Today*, 30: 804–808.
- Lofmark, A., Thorkildsen, K., Råholm, M.B. & Natvig, G.K. 2012. Nursing students' satisfaction with supervision from preceptors and teachers during clinical practice. *Nurse Education in Practice*, 12:164-169. doi:10.1016/j.nepr.2011.12.005.
- Luahanga, FL., Koren, I., Yonge, O. & Myrick, F. 2015. The role of faculty supervisor in preceptorship. From a faculty point of view. *Journal of Nursing Education and Practice*, 5 (1)85-94.
- Luhanga, FL., Koren, I., Yonge, O. & Myrick, F. 2014. Strategies for managing unsafe precepted nursing students: A nursing faculty perspective. *Journal of Nursing Education and Practice*, 4(5): 116-124.

- Lwatula, L.T. 2011. Experience with Preceptor Development in Botswana, Lesotho, Liberia and Zambia: Poster form UNFP; State of words Midwifery Report.
- Madhavanpraphakaran, G.K., Shukri, R.K., & Baachandran, S. 2013. Preceptors' Perceptions of Clinical Nursing Education. *Journal of Continuing Education in Nursing*, 45(1): 28-34.
- Madisa, M. 2012. Preceptors' and Faculty's Opinions about the Implementation of Preceptorship in the Diploma Nursing Curriculum in Botswana: Thesis submitted in partial fulfillment of the requirements for the degree of Master of Philosophy in Health Sciences Education. Stellenbosch University: South Africa.
- Maginns, S. & Croxon, I., 2007. Clinical teaching model for nursing practice. *Australian Journal Rural Health*. 15 218-219. <http://dx.doi.org/10.1111/i.1440-1584.2007.00888.x>, PMid:17542797
- Mårtensson, G., Engström, M., Mamhidir, A.G., Kristofferson, M.L, 2013. What are the structural conditions of importance to preceptors' performance? *Nurse Education Today*, 33: 444–449.
- Matua, GA., Seshan.V., Akintola, AA. & Thanka, AN. 2014. Providing effective feedback during preceptorship; Perspectives from an Omani hospital. *Journal of Nursing Education and Practice*, 4 (10): 24-31.
- Matua, GA., Seshan, V., Savithri, R., Fronda, D C. 2014. Challenges and strategies for building and maintaining effective preceptor-preceptee relationships among nurses. *Clinical and basic Research*. 14 (4) e530-536.
- Miles, M. B., & Huberman, M. A. (1994): “Qualitative Data Analysis: An Expanded Sourcebook” (2nd edition). Beverley Hills, Sage.
- Ministry of Finance and Development, 2009. National Development Plan 10, 2009-2016. Gaborone: Botswana Government Printing and Publishing.
- Ministry of Finance and Development, 2003. National Development Plan 9, 2003 /04-2008/09. Gaborone: Botswana Government Printing and Publishing.
- Ministry of Health, 2008. Higher Diploma in General Nursing Curriculum. Gaborone: Botswana Government Printers.
- Monareng, LV, Jooste, K. & Dube, A. 2009. Preceptors' and Preceptees views on students' nurses clinical accompaniment in Botswana. *African Journal of Nursing and Midwifery*, 11 (2): 113-119.
- Morgan, A., Mattison, J., Stephens, M. & Medows, S. 2012. Implementing structured preceptorship in an acute hospital. *Nursing Standard / RCN Publishing*, 26 (28): 35-39.

Mothiba, T.M., Lekhuleni, M.E., Muputle, M.S. & Nemathaga, L.H. 2012. University of Limpopo students' nurses' clinical learning experiences in public hospitals at the Capricon district, Limpopo Province, South Africa. *African Journal of Physical, Health Education, Recreation and Dance, Supplement 2*:195-204.

Mosby Dictionary, 2009. 9th edition. Elsevier.

Mosby's Dictionary of Medicine, Nursing and Health Profession. 2006. Online.

Mounton, E.B.J. 2012. The practice of Social Research: South African edition. Oxford University Press: Sothorn Africa.

Munhall, P.L. 2012. Nursing Research. A qualitative perspective. 5th Edition. Sudbury: Jones and Barlett Publishers.

Myrick, F., Yonge, O., Billay, D.B., & Luanga, F.L. 2011. Preceptorship: Shaping the Art of Nursing through Practical Wisdom. *Journal of Nursing Education*, 50 (3):134-139.

Nesbit, H 2008. A model for preceptorship- The rationale for a formal structured programme development for newly qualified radiographers. *The international Journal of Diagnostic Imaging and Radiation Therapy*, 14 (1): 52-56.

Newton, J.M., Jolly, B.C., Ockerby C.M. & Cross W.M. 2012. Student centeredness in clinical learning: the influence of the clinical teacher. *Journal of Advanced Nursing*, 68 (10), 2331–2340. doi: 10.1111/j.1365-2648.2012.05946.x

Nurses and Midwives Act; Chapter 61.03 1995: Gaborone: Government Printers.

O'Brien, M. 2015. Development of Clinical Sites. *AANA Journal*, 83 (1):17-20.
www.aana.com/aanajournalonline.

Omer, T. Y., Suliman, W. A., Thomas, L., & Joseph, J. (2013). Perception of nursing students to two models of preceptorship in clinical training. *Nurse Education in Practice*, 13(3): 155–160.
doi:10.1016/j.nepr.2013.02.

Panzavecchia, L. & Pearce, R. 2014. Are preceptors adequately prepared for their role in supporting newly qualified staff? *Nurse Education Today*, (34) 1119–1124.

Phuma- Ngaiyaye, E. Bvumbwe, T, & Chipeta, M.C. 2017. Using preceptors to improve nursing students' clinical learning outcomes: A Malawi students' perspective. *International Journal of Nursing Science*, (4) 164-168.

- Polit, D.F. & Beck, C.T. 2014. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*. (8th ed). Philadelphia: Wolter Kluwer: Lippincott William & Wilkins.
- Rakhudu, MA. 2011. *A Model of Collaboration in the implementation of Problem Based Learning in Nursing Education*. A thesis submitted in fulfillment of the requirement for the degree: Doctor of Philosophy (PhD) Nursing. North West University, Mafikeng: South Africa.
- Rodgers, B.L & Knafl, K.A. 2000. *Concept Development in Nursing, Foundations, Techniques, and Applications*. (2nd ed). Saunders: An Imprint of Elsevier. United States of America.
- Rose, S.R. 2008. The Utilization and Role of the preceptor in undergraduate nursing programs. *Teaching and Learning in Nursing*, (3): 105-107.
- Russell, K., A., & Watts, R. The Team Leader, Model: An Alternative to preceptorship. *Australian Journal of Advanced Nursing*, Vol. 28 (3):6-7).
- Sedgwick, M. & Harris, S. 2012. A Critique of Undergraduate Nursing Preceptorship Model. *Nursing Research and Practice*, Volume 2012, Article, ID 248-356.
- Segen's Medical Dictionary, 2012. Farlex. Inc.
- Sharples, K. & Elcock, K. 2011. *Preceptorship for Newly Registered Nurses*. Learning Matters Limited.
- Sen Gupta, T.K., Murray, R.B, McDonnell, A, Murphy, B. & Underhill, A.D. 2008. Rural internships for final year students: Clinical experience, education and workforce. *The International Electronic Journal of Rural and Remote Health, Research, Education Practice and Policy*. *Rural and Remote Health*, 8: 827. (Online), Available from: <http://www.rrh.org.au>
- Shamian, J. & Inhaber, R.1985. The concept and practice of preceptorship in contemporary nursing: A review of pertinent literature. *Journal of Nursing Studies*, 22 (2):79-88.
- Shepard, L.H. 2014. Student perception of preceptorship learning outcomes in BSN programs. *Journal of Nursing education and Practice*, 4 (5):73-84. <http://dx.doi.org/10.5430/jnep.v4n5p73>
- Smit, E.M. & Tremethick, M.J. 2014. Preceptorship in an International Setting: Honduran Nurses and American Nursing Working together. *Nurse Educator*, 39 (2):91-95.
- Summers, J.A. 2017. Developing Competencies in Novice Nurse Educators: An Integrative Review. *Teaching and learning in Nursing*, 12 (2017): 263-276).

- Spur, S., Bally, J. & Ferguson, L. 2010. A framework for clinical teaching: A passion- centered philosophy. *Nurse education in Practice*, 10:349-354.
- Stanhope, M. & Lancaster, J. 2004. *Community and Public Health Nursing* (6th ed). St Louis: Mosby.
- Statistics Botswana, 2011. Population and Housing Census. Population of towns' villages and associated localities. Gaborone: Department of Government Printing Services.
- Streubert- Speliazze, H.J. & Carpenter, D.R. 2007. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. Philadelphia: Lippincott Williams & Wilkins.
- Staykova M.P, Huson, C., & Pennington, D. 2013. Empowering nursing preceptors to Mentoring undergraduate senior Students in acute care settings. *Journal of Professional Nursing*, 29 (5): e32–e36.
- Tan, K., Feuz, C., Bolderston, A., & Palmer, C. 2011. A Literature Review of Preceptorship: A Model for the Medical Radiation Science. *Journal of Medical Imaging and Radiation Sciences*, 42:15-20.
- Tiwaken, S. U., Caranto, L.C., & David, J.J. 2015. The Real World: Lived experiences of Student Nurses during Clinical Practice, *International Journal of Nursing Science*, 5(2):66-75. DOI:10.5923/j.nursing.20150502.05
- The American Heriatge ® Medical Dictionary, 2007. Houghton: Mifflin Comp.
- United Kingdom Department of Health. CNO Directorate, 2009. Preceptorship framework for nursing, Secretary of State for Health, London.
- Walker, L.O., & Avant, K.O. (1995). *Strategies for Theory Construction in Nursing*, 3rd edition. California: Appleton & Lange.
- Whitmore, R. & Knafl, K. 2005. The integrative Review: updated method. *Journal of Advanced Nursing*, 10.1111/j1365-2648.2005.03621.x
- Yamardas, S. & Ota, K. 2012. Essential roles of clinical nurse instructors in Japan. A Delphi Study. *Nursing and Health Sciences*, 14, 229-2397.
- Yonge, O. Billay, D., Myrick, F. & Luhanga, F. 2007. Preceptorship and Mentoring: Not merely a matter of semantics. *International Journal of Nursing Education Scholarship*, 4(1), 1-13, <http://dx.doi.org/10.2202/1548-923x.1348>, PMID; 18052917.
- Young, S., Vos, S., Cantrell, M. & Shaw, R. 2014. Factors Associated with Students' Perceptions of Preceptor Excellence. *American Journal of Pharmaceutical Education*, 78 (3):1-6 Article 53.

Zilembo, M. & Manterosso, L. 2008. Towards a conceptual framework for Preceptorship in clinical nursing education of undergraduate nursing students. *Contemporary Nurse*, 30 (1): 89-94.

APPENDIX A: INFORMATION SHEET TO PARTICIPANT / RESPONDENTS

Title of Research: A Preceptorship Model to facilitate clinical Nursing Education in Botswana

Investigator: Antonia Dube

You are requested to read and understand the explanation of the study before you can agree to voluntarily participate in the study.

Explanation of the Procedures

You are requested to participate in a mixed method study to develop a Preceptorship Model to facilitate clinical Nursing Education in Botswana. You will be asked some questions on preceptorship as a clinical teaching strategy for students' nurses. You will also complete a questionnaire that will take between 30 and 45 minutes of your time.

Data collection will be done through use of Group Discussion (FGDs) and self-administered questionnaires. A FGD) is a small group of about five (5) to eight (8) people who meet to provide answers, suggestion and opinion to questions asked by the researcher. The FGDs s will be audio taped using a voice recorder and transcribed. FGDs will last between 45 minutes to an hour.

Risks and discomforts

There are no anticipated physical or psychological risks or discomfort associated with this study.

Benefits and Payments for participation

There are no individual benefits to participants. No direct benefits or imbursement shall be offered for participating in the study. However it is expected that this research will yield knowledge on facilitating preceptorship to improve the quality of clinical nursing education.

Alternative Procedure

No alternative procedures will be used for participants who chose not to participate or who opt out during the study.

Confidentiality

The data obtained from the participants' responses will be kept confidential. Your identity as a participant will not be disclosed to unauthorized persons. The materials used during data collection will be kept in a locked cabinet and password locked researcher's computer which will only be accessible to the researcher. Any references to your identity that could prejudice your anonymity will be removed prior to preparation and publication of the research report.

Withdrawal without Prejudice

Participation in the study is voluntary; participants are free to opt out should they feel uncomfortable to continue participating. Withdrawal from the study will incur no penalty.

Questions and concerns

If you have any questions or concerns related to the study please contact Professor M.A Rakhudu at 0027 18 389 2025 /0027 82 200 8004 (my research promoter). My contact details are as follows: E-mail dubantie@gmail.com. Telephone: + 267 5441070 (w) / 5441449 (h) 72174540 or 73425713 cell.

Agreement

This agreement is proof that you have understood the explanation given about participation in the study. By signing this information sheet you indicate your voluntary agreement to participate in the study.

Signature of Participant_____ Date_____

Participant's Name (Printed) _____

Signature of Researcher Date_____

APPENDIX B CONSENT FORM

A Preceptorship Model to facilitate Clinical Nursing Education in Botswana

I----- (Names in full) hereby confirm that I am willingly participating in the study; A preceptorship model to facilitate clinical nursing education in Botswana. The purpose, objectives, procedures to be followed, risk and benefits of the study have been fully explained to me verbally and in writing as indicated in the information sheet given to me. I have been given the opportunity to ask questions where I needed clarification. I therefore have no objections to participate in the study. The following issues regarding the study have been explained to me. That:

- I shall be requested to complete the questionnaire which might last between 30 to 45 minutes
- I will be a member of a Focus Group Discussion which will take between 45minutes and 1hour
- A voice recorder will be used to record the group discussion session of which my contributions will also be reordered
- Should I wish to withdraw from the study I can freely do so without fear of prejudice
- The results from the questionnaires and Focus Group Discussions will be anonymously processed as the final findings in the research report without disclosing any personal information linking to identification of participants.

Signature of participant_____ **Date**-----

Signature of Researcher_____ **Date**-----

APPENDIX C NURSE EDUCATORS QUESTIONNAIRE

Dear Colleague / Participant

The researcher is conducting a study to develop a model to facilitate preceptorship in clinical nursing education in Botswana. The data obtained from your responses will be kept confidential in a locked cabinet and password locked researcher's computer. No name shall appear on the data collection instruments or final research report. Data will be analyzed as group findings. Feel free to opt out of the study should you feel uncomfortable to continue participating. Withdrawal from the study will not prejudice you in any way. There are no anticipated risks associated with this study. No tangible benefits or reimbursement shall be offered for participating in the study. Findings from this study and the model developed based on your perceptions and recommendations shall assist in improving the quality of clinical nursing education and preceptorship support in the training of competent nurses. You have been selected to participate in the study because of your rich knowledge and experience on preceptorship as you interact with preceptors and students. Your participation will be greatly appreciated. Permission to carry out the study and ethical clearance has been granted by the Health Research Unit of the Ministry of Health (Botswana) and the North West University Ethics Regulatory Committee. The questionnaire is divided into two parts. Part I: Demographic and work related characteristics of the preceptor. Part II is further divided into three (3) sections namely: Structure, Process and Outcomes of a preceptorship.

Thank you for agreeing to participate in this study and for your valuable contribution to improve Botswana's clinical nursing education system. You will be requested to sign this consent letter and the information sheet as an indication of your voluntary consent to participate in this study.

Researcher: Antonia Dube

PhD in Nursing Student: North West University (NWU): Republic of South Africa

Supervisor: Dr. M.A. Rakhudu: North West University (NWU): Republic of South Africa

Signature of Participant

PART 1: Demographic Information

This section requires your personal information as a nurse educator interacting with preceptors and level three nursing students during clinical teaching and learning (Preceptorship). Indicate by either a **tick** or filling in the required information as applicable.

Indicate your age: _____

1. Indicate your gender

Male ☐ Female ☐

2. Academic qualification

Bachelor of Nursing Science ☐

Bachelor of education (Nursing) ☐

Master's Degree ☐

Doctoral Degree ☐

Other (please specify including combinations) _____

3. Do you possess any qualification in education?

Yes ☐ No ☐

If not, what orientation have you received to enable you to perform the role of teaching and supervising students and preceptors?

6. Indicate years of experience as a nurse educator in the Health Training Institutions

7. Indicate your clinical specialty of any _____

8. Indicate duration of time you been following students and preceptors during preceptorship?

9. Indicate the Health training institution you are working at:

Institute of Health Sciences (I.H.S). Francistown ☐

Institute of Health Sciences (I.H.S.) Gaborone ☐

Institute of Health Sciences (I.H.S.) Molepolole ☐

Kanye Seventh Day Adventist College of nursing ☐

Institute of Health Sciences (I.H.S.) Lobatse ☐

PART II

SECTION A Structure: Resources, preceptor selection and preparation

Please consider each statement with reference to your experience and observation as a nurse educator following level three (3) student nurse and preceptors during preceptorship clinical nursing education. Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

1. I know and understand the preceptorship model used for clinical nursing education used during preceptorship	1	2	3	4
2. The model of preceptorship used in Botswana's nursing education is known and well understood by all nurse educators, students and preceptors involved in preceptorship activities	1	2	3	4
3. I would recommend development of a model of preceptorship to facilitate clinical nursing education in Botswana	1	2	3	4
4. Guidelines for preceptorship are availed to preceptors and student at the beginning of internship /preceptorship	1	2	3	4
5. Selection criteria for preceptors should be revisited	1	2	3	4
6. The workload of the preceptor allows the preceptors to execute the preceptor role efficiently	1	2	3	4
7. Preceptors have adequate time to perform the guide students during their clinical learning	1	2	3	4
8. Getting nurses to serve as preceptors is not a challenge	1	2	3	4
9. Preceptorship should be re-structured if it is to meet its intended objectives	1	2	3	4
10. Preceptors do not need any special preparation, any professional nurse is a competent preceptor	1	2	3	4
11. The roles of a preceptor, student, and nurse educator are clearly defined during preceptorship	1	2	3	4
12. Clinical setting (s) management provide preceptors with resources need for clinical teaching and learning	1	2	3	4
13. I mobilize all resources needed by students and preceptors at the beginning of preceptorship.	1	2	3	4
14. I experience no challenges to meet and discuss preceptorship issues and challenges with:				
a. Preceptors	1	2	3	4
b. Preceptor's supervisors	1	2	3	4
c. Clinical setting managers	1	2	3	4

SECTION B Process: Selection of preceptors' communication and support

Please consider each statement with reference to your experience and observation as a nurse educator following level three (3) student nurse and preceptors during preceptorship clinical nursing education. Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

15. All preceptors are trained / orientated for the preceptor role	1	2	3	4
16. Duration of preceptor training/ orientation is adequate to equip preceptors with teaching and students' assessment skills	1	2	3	4
17. Preceptor training is well structured and coordinated across all health training institutions	1	2	3	4
18. The preceptor (s) are able to plan students' learning activities appropriately	1	2	3	4
19. Preceptors have autonomy to manipulate preceptorship objectives in order to align them with learning activities in the clinical setting	1	2	3	4
20. Preceptors are confident to evaluate students' clinical activities objectively	1	2	3	4
21. The number of students allocated to a preceptor allows effective clinical teaching and supervision of students	1	2	3	4
22. Preceptors are always with students the clinical setting (same shifts with the students) to facilitate their learning	1	2	3	4
23. The preceptor selection criteria is consistent with what is spelt out in preceptorship literature	1	2	3	4
24. A great number of nurses are willing to serve as preceptors for the health training institutions	1	2	3	1
25. Preceptors' co-workers and clinical setting management are conversant with preceptorship, its objectives and expectations	1	2	3	4
26. Preceptors' co-workers and supervisors are supportive of the goals of the preceptorship program.	1	2	3	4
27. Management of health training institution provide me and preceptors with the support need to make preceptorship a success	1	2	3	4
28. Preceptors' workload is reduced to allow them to carry out the preceptorship roles	1	2	3	4
29. The visits I make to the clinical settings to meet preceptors, and students and discuss their needs, concerns and challenges are adequate to assist them achieve preceptorship objectives	1	2	3	4
30. Due to time constraints and workload I only follow students and preceptors for assessments and seminars	1	2	3	4
31. Communication between nurse educators and preceptors is adequate to facilitates effective clinical teaching and learning	1	2	3	4

SECTION C Outcome: Challenges and Benefits of a preceptorship

Please consider each statement with reference to your experience and observation as a nurse educator following level three (3) students and preceptors preceptorship. Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

32. There are no challenges associated with implementation of preceptorship	1	2	3	4
33. There are no benefits associated with preceptorship as clinical teaching and learning strategy	1	2	3	4
34. Students and preceptors experience frustration and stress during preceptorship period	1	2	3	4
35. There is role ambiguity between preceptors and nurse educators	1	2	3	4
36. Preceptorship is an added responsibility to the nurse	1	2	3	4
37. Preceptors are not allocated time to perform the preceptor role	1	2	3	4
38. Preceptorship is meeting its intended objectives	1	2	3	4
39. Preceptorship increases the preceptor's teaching and students' evaluation skills	1	2	3	4
40. Students gain competences in clinical skills and decision making	1	2	3	4
41. Preceptorship has more benefits for students clinical learning than the traditional faculty- student model of clinical teaching	1	2	3	4
42. Preceptorship provides profession growth and development for preceptors	1	2	3	4
43. Preceptors keep abreast with current issues and trends in nursing and education because of the demands of their role	1	2	3	4
44. Students who have undergone preceptorship during their training excel in the professional role upon completion of training	1	2	3	4

Adapted from Dibert & Goldenberg, (1995). Adapted By A. Dube (2015)

Suggest how preceptorship can be improved to facilitate effective clinical learning and teaching or students

Thank you for taking time to complete this questionnaire.

APPENDIX D PRECEPTORS QUESTIONNAIRE

Dear Colleague / Participant

The researcher is conducting a study to develop a model to facilitate preceptorship in clinical nursing education in Botswana. The data obtained from your responses will be kept confidential in a locked cabinet and password locked researcher's computer. No name shall appear on the data collection instruments or final research report. Data will be analyzed as group findings. Feel free to opt out of the study should you feel uncomfortable to continue participating. Withdrawal from the study will not prejudice you in any way. There are no anticipated risks associated with this study. No tangible benefits or reimbursement shall be offered for participating in the study. Findings from this study and the model developed based on your experiences and recommendations shall assist in improving the quality of clinical teaching and learning in nursing education and preceptorship support in the training of competent nurses. You have been selected to participate in the study because of your rich knowledge and experience on preceptorship. Your participation will be greatly appreciated. The questionnaire is divided into two parts. Part I: Demographic and work related characteristics of the preceptor. Part II is further divided into three (3) sections namely: Structure, Process and Outcomes of a preceptorship

Thank you for agreeing to participate in this study and for your valuable contribution to improve Botswana's clinical nursing education system. You will be requested to sign this consent letter and the information sheet as an indication of your voluntary consent to participate in this study.

Researcher: Antonia Dube

PhD in Nursing Student: North West University (NWU): Republic of South Africa

Supervisor: Dr. M.A. Rakhudu: North West University (NWU): Republic of South Africa

PART I: Demographic Information

Please answer the following questions about yourself for statistical purposes by checking X in the box or writing the appropriate responses.

1. Indicate your age _____
2. Gender M ☐ F ☐
3. What is your highest nursing qualification?

Diploma in General Nursing	☐
Diploma in Nursing and Midwifery	☐
Diploma in Family Nurse Practitioner	☐
Bachelor of Nursing Science	☐
Bachelor of Education (Nursing)	☐
Master's Degree	☐
Doctoral Degree	☐
- Other (please specify) _____
4. Years of nursing experience _____ (years)
5. Years of experience as a preceptor: _____
6. Indicate the clinical area (department) you work in the past 12 months:

General ward (Medical / Surgical) ☐
 Intensive Care Unit ☐
 Pediatric ☐
 Accident and Emergency ☐
 General outpatient patients ☐
 Maternity ☐
 Other (please specify) _____

PART II

Please consider each statement with reference to your experience as a preceptor.

Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

SECTION A Structure: Resources, preceptor preparation and selection

1. I feel I have been adequately prepared/ trained for my role as preceptor.	1	2	3	4
2. I am confident with students' assessments and evaluation of clinical learning activities	1	2	3	4
3. There is a clear model to guide preceptorship in clinical nursing education	1	2	3	4
4. I recommend development of a preceptorship model specific to the Botswana context of preceptorship	1	2	3	4
5. Preceptorship need a lot of restructuring for it to meet its objectives	1	2	3	4
6. The guidelines for preceptorship clearly outline the responsibilities of the preceptor, student and nurse educator	1	2	3	4
7. My co-workers and supervisors are conversant of the goals of the preceptorship program.	1	2	3	4
8. I understand my role as preceptor	1	2	3	4
9. I become a preceptor by:	1	2	3	4
a. voluntarily opting to become a preceptor	1	2	3	4
b. being selected by my supervisor	1	2	3	4
10. Criteria for preceptor selection need to be revisited	1	2	3	4
11. I have sufficient time to discussion learning objectives with each individual student on daily basis	1	2	3	4
12. Nursing supervisors and Nursing superintendent / Matron (s)/ Principal Nursing officers are committed to the success of the Preceptorship	1	2	3	4
13. Nurse educators provide clear learning objectives for the students and expectations for the preceptor at the beginning of clinical placement of students	1	2	3	4
14. The clinical setting management provides resources needed to facilitate preceptorship in the clinical setting.	1	2	3	4
15. I have sufficient time to provide patient care while I function as a preceptor	1	2	3	4
16. The Health training institutions' management provides me with adequate teaching and learning resource to execute my preceptor role	1	2	3	4
17. Nursing supervisors and Managers are available and willing to help me develop in my role as a preceptor.	1	2	3	4
18. My other responsibilities / assignments besides patient care activities allow me time to attend to the students' learning needs	1	2	3	4

SECTION B: Process: communication and support

Please consider each statement with reference to your experience as a preceptor.

Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

19. My co-workers and supervisors are supportive of the goals of the preceptorship program.	1	2	3	4
20. Nurse educators' visits to the clinical setting are adequate to accord me the support I need	1	2	3	4
21. My workload is appropriate to allow me to function as a preceptor.	1	2	3	4
22. The number of students I supervise during each clinical learning-teaching is adequate to allow for adequate student- preceptor interaction	1	2	3	4
23. I am always in students accompaniment in the clinical setting (same shifts with the students) to facilitate learning	1	2	3	4
24. I have sufficient time to discussion learning objectives with each individual student on daily basis	1	2	3	4
25. My supervisor and management (Nursing superintendent / Matron (s)/ Principal Nursing officer) are committed to the success of the Preceptorship	1	2	3	4
26. Nursing Managers are available to help me develop in my role as a preceptor.	1	2	3	4
27. There is always clear and easy communication between preceptors and nurse educators during preceptorship	1	2	3	4
28. Nurse educators are always available for me to share information on my experiences during preceptorship	1	2	3	4

SECTION C: Outcome: Challenges and Benefits of a preceptorship

Please consider each statement with reference to your experience as a preceptor. Using the scale below, please circle the number which best describes your response to the statement:

1 2 3 4

Strongly Disagree Agree Strongly

Disagree Agree

29. I still do not understand what the role of a preceptor entails	1	2	3	4
30. I find that my values and the values of the preceptor program are different	1	2	3	4
31. My perception of the preceptor role is different from what I 'am expected to do	1	2	3	4
32. Deciding to be a preceptor was a definite mistake on my part.	1	2	3	4
33. The preceptorship role is stressful and frustrating	1	2	3	4
34. I am motivated to put in a great deal of effort beyond what is normally expected in order to help the students' clinical learning be successful.	1	2	3	4
35. Students gain competence and proficiency in clinical skills during preceptorship	1	2	3	4
36. Socializing students to the professional role of a nursing is fulfilling for me	1	2	3	4
37. By Being a preceptor I keep up-to-date and remain stimulated in my professional role	1	2	3	4
38. I gain personal satisfaction from the preceptor role	1	2	3	4
39. I have improved my teaching and students assessment skills by being a preceptor	1	2	3	4

40. Being a preceptor has improved my organizational and leadership skills	1	2	3	4
41. My analytic and critical thinking skills have greatly improved	1	2	3	4

Adapted from Dibert & Goldenberg (1995). Adapted By A. Dube (2015)

Suggest how preceptorship can be improved to facilitate effective clinical teaching for students

Thank you for taking time to complete this questionnaire.

APPENDIX E: ETHICAL CLEARANCE TO CONDUCT RESEARCH

29th March 2016

Kanye Seventh Day Adventist College of Nursing
P.O.Box 11
Kanye

Health Research Unit
Ministry of Health
Private Bag 0036
Gaborone

Dear Sir / Madam

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

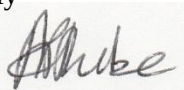
I am a student pursuing a Doctoral degree (PhD) in nursing at the North West University (Mafikeng campus) in South Africa. I am a Zimbabwean national who has been granted a permanent residence status for the past 16 years. One key requirement to obtain this degree is to undertake research project.

I am therefore, requesting for permission to carry out such a project in order to fulfill my degree requirement. The purpose of this study is to develop a Preceptorship Model to facilitate clinical nursing education in Botswana. Data will be collected from preceptors (clinical settings staff) who supervise nursing students' clinical learning activities and nurse educators who guide preceptors and students during preceptorship activities. The impetus for this study emanates from lack of documented evidence on the existence of a preceptorship model used for clinical nursing education system despite the use of preceptorship as a clinical teaching strategy by all institutions offering diploma in general nursing in the country and challenges entailed therein.

The information obtained from respondents will be used as the basis for developing a contextual model that will guide effective implementation of preceptorship in clinical nursing education to improve the quality of nursing education and ultimately the nursing services in the country's health facilities. It is also hoped that findings and the model developed will inform policy makers on critical issues relating to the importance of collaboration between nursing education and nursing service in training competent future nurses. The proposal for this study has been presented, accepted and ethical clearance given by the North West University Ethics Committee. **(Find attached evidence)**. The study will take place between April 2016 and December 2017. Data collection is intended to commence in May 2016 or as soon as your office grants clearance.

Your assistance in this regard is greatly appreciated

Yours faithfully



Antonia Dube (Miss)

Contact details 72174540/ 73425713 (cell) / 5441070 (w) / 5441449 (H)



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

**Institutional Research Ethics Regulatory
Committee**

Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by the **Health Science Ethics Committee (FAST)**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: A preceptorship model to facilitate clinical nursing education in Botswana																													
Project Leader: Dr MA Rakhudu																													
Student: Ms A Dube																													
Ethics number:	<table border="1"> <tr> <td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>2</td><td>5</td><td>0</td><td>-</td><td>1</td><td>5</td><td>-</td><td>A</td><td>9</td> </tr> <tr> <td colspan="3">Institution</td> <td colspan="6">Project Number</td> <td colspan="2">Year</td> <td colspan="2">Status</td> </tr> </table> Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation	N	W	U	-	0	0	2	5	0	-	1	5	-	A	9	Institution			Project Number						Year		Status	
N	W	U	-	0	0	2	5	0	-	1	5	-	A	9															
Institution			Project Number						Year		Status																		
Approval date: 2015-12-30	Expiry date: 2017-12-31																												
Category:	N/A																												

Special conditions of the approval (if any):

- All queries regarding this application received from the Health Sciences Ethics Committee (FAST) must be addressed and clarified.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-IRERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-IRERC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC for any further enquiries or requests for assistance.

Yours sincerely

**Prof LA
Du Plessis**

Digitally signed by Prof LA Du Plessis
DN: cn=Prof LA Du Plessis, o=North-
West University, ou=Campus Rector,
email=Linda.DuPlessis@nwu.ac.za,
c=ZA
Date: 2016.02.19 15:59:56 +0200

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

TELEPHONE: 363 2766
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD



Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REFERENCE NO: HPDME 13/18/1 X (523)

26 May 2016

Health Research and Development Division

Notification of IRB Review: **New application**

Ms Antonia Dube
Kanye Seventh Day College of Nursing
P O Box 11
Kanye
Botswana

Protocol Title:

**A PRECEPTORSHIP MODEL TO FACILITATE CLINICAL
NURSING EDUCATION IN BOTSWANA**

HRDC Approval Date:	26 May 2016
HRDC Expiration Date:	25 May 2017
HRDC Review Type:	Expedited review
HRDC Review Determination	Approved
Risk Determination:	Minimal risk

Dear Ms Dube

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested

via e-mail from Mr. Kgomoitso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A 7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomoitso Motlhanka, e-mail address: kgmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Lemphi Moremi at lamoremi@gov.bw or Tel: +267-3632754. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours faithfully



P. Khulumani
For /Permanent Secretary



Vision: *A Model of Excellence in Quality Health Services.*
Values: *Botho, Equity, Timeliness, Customer Focus, Teamwork.*



APPENDIX F: APPLICATION AND PERMISSION LETTERS FROM HTIs

29th May 2016

Kanye Seventh Day Adventist College of Nursing

P.O.Box 11

Kanye

The Principal

Institute of Health Sciences Francistown

P.O.Box 267

Francistown

Dear Madam

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

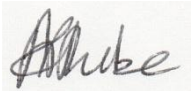
I am a lecturer in the general nursing programme at Kanye Seventh Day Adventist College of Nursing pursuing a doctoral degree (PhD) in nursing at the North West University (Mafikeng campus) in South Africa. One key requirement to obtain my degree is to undertake research project.

I am therefore, requesting for permission to include nurse educators from your institution who guide and follow up preceptors and level three (3) higher diploma in general nursing students clinical activities as participant for the study. Informed consent for voluntary participation in the study will also be sought from individual nurse educators. Preceptors will also participate in the study. The purpose of this study is to develop a Preceptorship Model to facilitate clinical nursing education in Botswana.

Findings from the study and the model developed will inform policy makers on critical issues relating to the importance of collaboration between nursing education and nursing service in training competent future nurses. Permission to conduct the study and ethical clearance has been granted by the Health Research Unit Ministry of Health Botswana. (**Find attached evidence from HRU**). Data collection will place between June 2016 and December 2016 and may be extended to April 2017 based on any unforeseen challenge that maybe encountered and the validity of permission from HRU. Ethical Principles of Beneficence, Justice, Autonomy, Respect, Privacy and confidentiality shall be observed throughout the study.

Your assistance in this regard is greatly appreciated

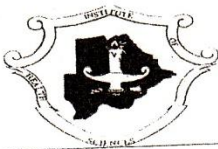
Yours faithfully



Antonia Dube (Ms)

Contact details 00267 72174540/ 73425713 (cell) 5441070 (w) 5441449 (h)

Telephone: 2412037
Telegram: SABAOKI
Fax No: 241532
Reference: S. N.



Institute of Health Sciences
P. O. Box 267
Francistown
Botswana

REF: FHI/COM/023 I (80)

24th June 2016

Ms Antonia Dube
Kanye SDA College Nursing
Kanye

Dear Sir/Madam

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

Reference is here made to your letter dated 29th May 2016, in which you were requesting for permission to carry out research on some nurse educators at the Institute of Health Sciences – Francistown.

This letter serves to inform you that your request has been acceded to.

Thank you.

Yours faithfully

Ruth Moncho-Kwartin
for/Principal

29th May 2016

Kanye Seventh Day Adventist College of Nursing
P.O.Box 11
Kanye

The Principal
Institute of Health Sciences Serowe
P.O.Box 684
Serowe

Dear Madam

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

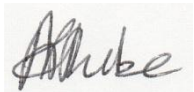
I am a lecturer in the general nursing programme at Kanye Seventh Day Adventist College of Nursing pursuing a doctoral degree (PhD) in nursing at the North West University (Mafikeng campus) in South Africa. One key requirement to obtain my degree is to undertake research project.

I am therefore, requesting for permission to include nurse educators from your institution who guide and follow up preceptors and level three (3) higher diploma in general nursing students clinical activities as participant for the study. Informed consent for voluntary participation in the study will also be sought from individual nurse educators. Preceptors will also participate in the study. The purpose of this study is to develop a Preceptorship Model to facilitate clinical nursing education in Botswana.

Findings from the study and the model developed will inform policy makers on critical issues relating to the importance of collaboration between nursing education and nursing service in training competent future nurses. Permission to conduct the study and ethical clearance has been granted by the Health Research Unit Ministry of Health Botswana. (**Find attached evidence from HRU**). Data collection will place between June 2016 and December 2016 and may be extended to April 2017 based on any unforeseen challenge that maybe encountered and the validity of permission from HRU. Ethical Principles of Beneficence, Justice, Autonomy, Respect, Privacy and confidentiality shall be observed throughout the study.

Your assistance in this regard is greatly appreciated

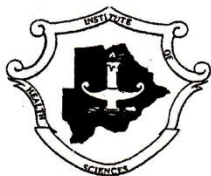
Yours faithful



Antonia Dube (Ms)

Contact details 00267 72174540/ 73425713 (cell) 5441070 (w) 5441449 (h)

TELEPHONE: 4630416/394
TELEGRAMS: SABAOKI
FAX: 4631531



INSTITUTE OF HEALTH SCIENCES
P. O. BOX 128
SEROWE
BOTSWANA

REFERENCE NO: IHSS 4/32 III (18)

14 June, 2016

Antonia Dube
Kanye Seventh Day Adventist College of Nursing
Box 11
Kanye

**RESEARCH STUDY: A PRECEPTORSHIP MODEL TO FACILITATE
CLINICAL NURSING EDUCATION IN BOTSWANA**

Permission is granted, to conduct the study. You are however reminded
to seek consent prior interview from the nurse educators.

I wish you all the best in your endeavor.

Yours faithfully

T. S. Gwaila
Principal



Vision: *A Model of Excellence in Quality Health Services.*
Values: *Botho, Equity, Timeliness, Customer Focus, Teamwork.*



APPENDIX G: APPLICATION AND PERMISSION LETTERS FORM CLINICAL SETTINGS

29th May 2016

Kanye Seventh Day Adventist College of Nursing
P.O.Box 11
Kanye

The Hospital Superintendent
Kanye Seventh Adventist Hospital
P.O.Box 11
Kanye

Dear Sir

RE: PERMISSION TO CARRY OUT A RESEARCH STUDY

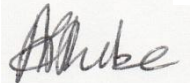
I am a lecturer in the general nursing programme at Kanye Seventh Day Adventist College of Nursing pursuing a doctoral degree (PhD) in nursing at the North West University (Mafikeng campus) in South Africa. One key requirement to obtain my degree is to undertake research project.

I am therefore, requesting for permission to include nurse educators from your institution who guide and follow up preceptors and level three (3) higher diploma in general nursing students clinical activities as participant for the study. Informed consent for voluntary participation in the study will also be sought from individual nurse educators. Preceptors will also participate in the study. The purpose of this study is to develop a Preceptorship Model to facilitate clinical nursing education in Botswana.

Findings from the study and the model developed will inform policy makers on critical issues relating to the importance of collaboration between nursing education and nursing service in training competent future nurses. Permission to conduct the study and ethical clearance has been granted by the Health Research Unit Ministry of Health Botswana. **(Find attached evidence from HRU)**. Data collection is scheduled to take place between June and December 2016, may be extended within the validity of the permission letter and the circumstance encountered during data the collection process. Ethical Principles of Beneficence, Justice, Autonomy, Respect, Privacy and confidentiality shall be observed throughout the study.

Your assistance in this regard is greatly appreciated

Yours faithful



Antonia Dube (Ms)

Contact details 00267 72174540/ 73425713 (cell) 5441070 (w) 5441449 (h)

Kanye Seventh-day Adventist Hospital

P O Box 11
Kanye Botswana

Tel: +267 5441107 / 5440333
Fax: +267 5440224



REF:KSDAH/11/07/2016/AO/kno

11 July 2016

Ms. Antonia Dube
Kanye Adventist College of Nursing
P O Box 11
KANYE

Dear Madam;

**RE: RESEARCH TITLED, A PRECEPTORSHIP MODEL TO FACILITATE
CLINICAL NURSING EDUCATION IN BOTSWANA**

With reference to your letter closed 2nd June 2016 requesting for Permission to carry out the above research study in Kanye Adventist Hospital, noting that prior approval had been obtained from the health research unit of Ministry of Health Botswana.

We have granted you permission from the Management to conduct the study within the indicated period until 25 May 2017.

You will be required to provide us with a hard copy of the study on completion.

Thank you.

Yours Faithfully

Dr. Andrew Ojuka
HOSPITAL RESEARCH COMMITTEE CHAIRPERSON

CC: Hospital Superintendent
KANYE ADVENTIST HOSPITAL

12

TELEPHONE: 5332100/5305500
TELEFAX: 5332174
REFERENCE:



REPUBLIC OF BOTSWANA

SBRANA PSYCHIATRIC HOSPITAL
Private Bag 30
LOBATSE

SPH 4/2/1 2 (36)

15th June 2016

Kanye Seventh Day Adventist College of Nursing
P O Box 11
Kanye

Dear Madam,

REQUEST FOR PERMISSION TO CONDUCT A STUDY AT THE HOSPITAL

Reference is made to your letter dated **2nd June 2016** in which you sought permission to carry out a research study.

Permission is granted for you to carry out the study at Sbrana Psychiatric Hospital, subject to the following:-

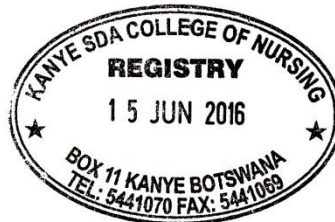
1. The research should strictly be carried out as outlined in your proposal and as per the permit from Ministry of Health Research and Development Division.
2. All individuals who will be interviewed as part of your study should give valid voluntary consent before involvement in the study.
3. You will be expected to make your own arrangements to identify study participants and for administering any questionnaires.
4. After completion of the study, you shall be required to submit a hard copy and an electronic copy of the report to the Sbrana Psychiatric Hospital Management through the Hospital Superintendent.

Kindly show this letter to any participant whom you approach in the hospital for the study.

Yours Sincerely

A handwritten signature in black ink, appearing to be 'Mpho A. Thula'.

Dr Mpho A. Thula
Hospital Superintendent



APPENDIX H: PRECEPTORS' SEMI - STRUCTURED INTERVIEW GUIDE

Research Project Title: A Preceptorship Model to facilitate Clinical Nursing Education in Botswana

Name of Researcher: ANTONIA DUBE

1. Introduction and explanation of in the study objectives and Focus group session

- Emphasize on voluntary participation in the study and focus group in particular
- Review and answer questions in relation to the letter of consent
- Explain and justify the types of data collection methods (transcribing and voice recording)
- Reassure participants the information will be kept confidential, no individual names will appear on the report.
- Inform participants that a copy of findings will be availed electronically (by email) to individual participants per request and provide email to those interested in individual copies, otherwise copies will be availed to DHMTs, hospitals and training where participants were recruited from and health training institutions.

2. Gather descriptive information (Provide paper for registration before commencement of actual discussion session no names)

- Asks if participants agree to give their demographic profile:(provide registration list exclude names)
- Age and gender,
- Years of experience in nursing,
- Years of experience as a nurse educator
- Highest qualification
- Type of clinical facilities where preceptor is working.
- .Preceptorship Overview and specific research questions
- Overview and back ground knowledge

Research Questions

Tell me about your perceptions' regarding preceptorship for level three (3) Higher Diploma in General nursing students' in the clinical setting

- Ask in general
- Ask both positive and negative experiences

I Structure of preceptorship:

Ask: Preceptors about their perceptions on the following:

- Selection criteria for preceptors. Explain your response and make suggestions if any.

Preceptorship guidelines and objectives

- Availability of preceptors and nurse educators to facilitate preceptorship activities

Request them to explain their responses and make suggestions for improvement

II Processes that facilitate preceptorship

A. Support for preceptors and preceptorship from:

- Support from nurse educators,
- colleagues of preceptors ,
- preceptors' supervisors and
- any other support given

B. Training / preparation of preceptors for their role.

C. Communication during preceptorship

D. Suggest key stakeholders in planning preceptorship and why

I.Outcomes of preceptorship: Ask about:

- Benefits
- Challenges and barriers

II.Strategies to improve preceptorship;

Ask for suggestions to improve preceptorship to meet clinical learning and teaching objectives (strategies to improve preceptorship and factors facilitating preceptorship)

NB. Ask for any other input or suggest (s) participants have to improve implementation of preceptorship in Botswana's clinical nursing education?

NB Probing questions will be asked to get more clarity or in-depth information if need arises. Thank participants their time and participation

APPENDIX I: NURSE EDUCATORS' SEMI - STRUCTURED INTERVIEW GUIDE

Research Project Title: A Preceptorship Model to facilitate Clinical Nursing Education in Botswana

Name of Researcher: ANTONIA DUBE

1. Introduction and explanation of in the study objectives and Focus group session

- Emphasize on voluntary participation in the study and focus group in particular
- Review and answer questions in relation to the letter of consent
- Explain and justify the types of data collection methods (transcribing and voice recording)
- Reassure participants the information will be kept confidential, no individual names will appear on the report.
- Inform participants that a copy of finding will be availed electronically (by email) to individual participants per request; and provide email to those interested in individual copies and provide them with own email address and contact number).

2. Gather Descriptive information (Provide paper for registration before commencement of actual discussion session)

- Request participants to give their demographic profile (provide registration lists):
- Age and gender,
- Years of experience in nursing,
- Years of experience as a nurse educator
- Highest qualification
- Type of clinical facilities where preceptor is working.

3. Preceptorship overview and specific research questions

- Overview and back ground knowledge

Research Questions What are your views / perceptions regarding your experiences about preceptorship for level three (3) Higher Diploma in General nursing students' in the clinical setting?

Ask in general

Ask both positive and negative experiences

I. Structure of preceptorship:

Ask: participants' experiences / perceptions about the following:

- Selection criteria for preceptors.
- Key stakeholders involvement in preceptorship

- Availability of preceptorship guidelines
- Availability of preceptors and nurse educators to facilitate preceptorship activities

Ask them to explain their your response and make suggestions if any

II Processes that facilitate preceptorship

Ask about support given / availed to preceptors to facilitate effective preceptorship in clinical nursing education for:

- nurse educators,
- colleagues of preceptors ,
- preceptors' supervisors and
- any other support given

B Training / orientation of preceptors for their role.

C. Communication during preceptors

D. Preceptorship implementation monitoring

E. Suggest key stakeholders in planning preceptorship and why?

III Outcomes of preceptorship

- Benefits
- Challenges and barriers

IV Strategies to improve preceptorship:

Ask how best preceptorship can be structured for it to benefit students and preceptors and meet clinical learning and teaching objectives (strategies to improve preceptorship)

Ask for any other input or suggest (s) participants have to improve implementation of preceptorship in Botswana's clinical nursing education?

NB Probing questions will be asked to get more clarity or in-depth information if need arises

Thank participants for their time and valuable contributions

APPENDIX J: NURSE EDUCATORS' TRANSCRIPT

Mixed Group of Nurse Educators from different training Institutions

Transcript Two (2)

Date: 05/09/2016

Venue: Kanye Seventh Day Adventist College of Nursing Office 7

Time 12.45pm

Duration 45 minutes 55

Participants Prolife:

Number: Six (6)

Gender : Five (3) females and three (3) males

Age range: 39 to 47 years

Highest Qualifications: Bachelor of Nursing Science one (3)

Master Arts (Child and Family Health Studies (1)

Master of Nursing Science (2)

Teaching experience: Minimum 7 years maximum 15years

Interview	Code
Interviewer Introduction Interviewer: Good afternoon colleagues. My name is Antonia Dube. I am aware that you all know but today I 'am wearing a different hat from that of being a lecturer. I come as a student from North West University as I told you yesterday when I distributed questionnaires to you. I am conducting a study on nurse educators and preceptors about their experiences with preceptorship. The main purpose of the study is to develop a preceptorship model to facilitate clinical nursing education in Botswana. I would like to thank you for yielding to my invitation to this focus group discussion as per our agreement yesterday. Kindly fill in your particulars on the paper that I have just passed to circulate. Please feel free to contribute, no one will gain access to information discussed here. The information will be kept confidential. It will be used by the researcher in compiling the research report. You are the second focus group of nurse educators. I will record our discussion if you agree mind. The reason for recording being to make sure every aspect of the discussion is captured. The purpose of this focus group is for us to discuss your preceptorship experiences. Interviewer: Ok We can start the discussions. I will ask you a question to start our	

discussion What were your experiences as nurse educators while you were following preceptors and level three Diploma in General Nursing students? Participants: Silent for some seconds, not responding looking at each other. Interviewer: Anyone of us can respond, positive or negative experiences. G2NE1: <i>I think “a-a-a- gone” (meaning as a matter of fact) we need preceptors. But the problem that we are facing a..a..a..a.... is that we are not able to use preceptors. “Nna” (meaning myself) I think one of the - -the -- problems with preceptors is the marks allocation to students. You find that even students that you know they are weak, they will still score 100 they will still score 90. So I think that is a problem. I don’t know whether to call it inconsistent of giving marks or what? That is one of the areas where I think preceptors need to improve.</i> G2NE2: <i>There is a problem in that ----- preceptors are not trained, most of them, we just select them basing on their years of experience. We say someone who has been working at least for 2 years can be a preceptor. So that makes them to do trial and error when they assess our students to the extent that “ga go ngwe” (translated to mean at times) these students are their friends’ gareke. Somebody who is 2 years in service go ra a gore (literary meaning; it means) she left someone doing first year ko sekolong (at school), so obviously they are going to assess one another basing on friendship or whatever. I think that contributes to the higher marks that they give to their colleagues. We can call them their “colleagues” gakere (meaning is it not so) when they meet at the clinical area. The other thing is that after telling them “gore” (that) now you are 2 years in service and you are supposed to assess my students, we (referring to nurse educators) don’t even try and do a follow up as to how they give the marks. I think we keep on complaining that they are giving the students higher marks but we have never gone to an extent that we call them as a group and tell them or discuss these tools with them. Even us as lecturers “kana” we give different marks based on different things. Even if the guide is there, it doesn’t tell me “gore” (That) if the student does this; this way you are supposed to give such a mark “wa bona” (meaning, you see). So even with them, I think they are just confused. If you tell them you are giving more marks they are just going to slightly reduce the marks or sometimes others will continue giving the marks the way they have been giving the marks.</i> I think our main problem is we are not training our preceptors. G2NE3: <i>Ok thank you. The other thing is that if we are still taking preceptorship, we</i>	Problems with students assessment by preceptors Untrained preceptors Selection criteria inappropriate Lack of support or follow up to guide preceptors Challenges with assessment of students by preceptors Lack of training for preceptors Increased workload
--	--

should see it as an additional activity on the preceptors' normal day- to- day workload and to a certain extent there is no remuneration for that. Though sometimes we say professionally money is not a motivation, but if you are doing something that you know --- -"yes," I have an extra benefit they will make it to a point that they do it at least to the nearer level that we are expecting. The other thing is that; I will probably stress on the issue of training, "we don't train them." We should bear in mind that they train at different schools of thought. It is not everybody who trained with the curriculum that is near to what we are using now; but we expect them to jut carry on and follow "the band wagon" and do the same. We do not give clear guidance or guidelines to preceptors The other thing is that even us sometimes we are never available for them to make a reference point because "le rona" (meaning even us) sometimes we are not positive as to how we are using the tools to generate students' marks. The other thing is that the institutions that we are using, being the teaching hospitals that we are using, the- - -the, I would say the management do not consider the issue of preceptorship because it's not well aligned just from the word go from ministry. They have the leeway-to rotate preceptors to any ward. Let me just give an example, probably I had a good preceptor out of interest not out of training in the ICU but next time, I find that person working in female surgical ward for example. That probably is not a very good area for her and even then —because-- preceptors they base on knowledge and the – -the - - fact that I have been working in that area they gain experience, and most of them they are just doing it. "Yes you find a few preceptors or nurses who are interested in teaching. But it's not everybody who feels that; they feel that students are a burden to them because they have never been inducted into that. But the little that they are doing I think we need to appreciate them, especially for level three (3) semester six (6). We really need to appreciate them; otherwise we won't be having any marks to assess the students or to grade the students for the final semester for that matter. Interviewer: Anything else about training and selection of preceptors? One nurse educator G2NE4 says: The selection of preceptors is normally done by----the-- eee---unit managers. They are the ones who select preceptors. Normally one of the criteria that they use is the one that was mentioned previously the one of 2 years of experience in clinical services then you are considered to be a preceptor. Of course, there are certain areas where some managers they do choose looking at the qualities of that particular individual but you find that they are rare. The problem will come with the	No incentives for preceptorship No guidelines for preceptors Unavailability of nurse educators to support preceptors No consideration for preceptorship by health setting management and MoHW In appropriate placement of preceptors in clinics settings Lack of interest in teaching by some preceptors Need for recognition and appreciation of preceptors Selection for preceptors not appropriate
--	---

rotation like the previous speakers said. They (preceptors) will be rotated anyhow not looking at what they do and the contributions they make to students. G2NE5: Another one apart from the rotation is the shifts; because they do shifts. Sometimes the students will be doing 4:30 that preceptor is doing night duty preferable or during that time the preceptor is off duty. It means if it's one preceptor per unit or two it becomes a challenge, because they also have to take offs. Maybe if selecting preceptors there could be good collaboration between the units or the hospitals or clinics as well as institution of health training so that when students are in the clinical area we can have those preceptors doing shifts as per students." If the students are doing 4:30 let them (referring to preceptors) be doing 4:30 as well- Thank you. Interviewer: Any more comments about your experiences and observations? G2NE1: Training; initially we did, but people still drop out of preceptorship, actually it depends on the person. People should actually volunteer to "fall out". Preceptors were trained but they ended up not doing what they were trained to do. Sometimes you find that it's all about interest and commitment. "Am I interested? Do I see this thing as something I need to do as an extra load? Because training yes, people have been trained but, I think people should actually volunteer. Ummm--- Then incentives; "yes," we need incentives for preceptors. But I don't know how we can hide that incentive so people that are taking incentives they are not actually influencing others to take the post because now there is some incentives. I don't know how to do that, because you may find that other people now volunteer knowing that there is money or any other form of incentive that can be given. Some preceptors actually are not committed to this preceptorship. They seem not to care what students do. They just leave students without proper guidance or cannot even discipline students waiting to report to the lecturer. Some do not even report when students misbehave and have no time to teach and supervise students. One wonders what type of professional socialization and role modeling is that. At times even students complain that the preceptors have no interest in assisting them and are not patient with students as such; students get scared to ask for help. I think it is not right if nurses are just chosen without considering their interest and commitment to teaching students. Of course there are others who do show commitment and interest in preceptorship. Period of silence observed (about 30 seconds)	Placement of preceptors without considering their role Preceptors and students duty shifts not aligned Need for collaboration during selection of preceptors Students and preceptors work on different shifts Nurses to volunteer to be preceptors Lack of interest in preceptorship Need for giving incentives for preceptorship and possible negative impact Lack of commitment for preceptorship
--	---

G2NE3: <i>I think we have something in common, especially the criterion used to select our preceptors. If it is just the manager, we never know other things that are influencing selection. But if we (nurses educator) could meet with the managers from health facilities because “nna” the problem I see is that we are supposed to be working together, but we are a distance, the schools and the training hospitals we have distanced ourselves even our management is so distant, such that the collaboration is not that very strong. If the collaboration is very strong we would be able to all sit as a panel and identify preceptors all of us. I might be a hard worker in the ward, but unable to transfer skill to the next person. Therefore if we collaborate, I think it will be of benefit, like the previous speaker is saying; “nna” I would say we need to give an incentive. Probably that person is in the hospital but she would love to go into the institution to teaching. We should be saying after this experience of preceptorship probably now we take them to the higher level that if they qualify, they can be further trained just as a developmental a—a—a--a plan for somebody to progress to the formal teaching at the institution.</i> <i>Much as we are not collaborating, is going to be really difficult and much as we are not doing our training periodically because if we can ask ourselves when did we last train preceptors? I think maybe we won’t even remember when; and yet people change, they go on transfer others quit service. There is a lot of movement. What are we doing to match the movement so that we don’t lose the trained personnel and don’t lose the skill?</i> <i>The other thing is that we should bridge the gap of the level of that person was trained and the current level of training and current expectations because the curriculum change, the trends of medicine change so we need to keep on updating how are we going to do that.</i> Interviewer: What can you say about nurse educators’ support to our preceptors, the communication between nurse educators and preceptors? Can we comment on that? G2NE2: <i>To some extent I would I say it’s true we do not support them. We realize that in most of our institutions we are facing “this shortage of staff. This makes us not available to follow students and preceptors. So it’s more like when we get to semester six (6) it’s more like when we allocate our students to these units; it’s more like it’s a relief on us. We (meaning nurse educators) become busy with other things. You find that one person will be teaching and following some other levels (level one and two) and at the same time have to go and follow the preceptor and the level three (3) students she is with. So when you prioritize your activities you end up saying “at least those ones are with the preceptors” and you will prefer to go to the other levels or to class rather than going</i>	Inappropriate selection criteria Weak collaboration between HITs and health facilities Recognition of preceptorship role in professional development (incentives) Lack of collaboration and training impact on preceptorship Transfer of preceptors Pedagogical empowerment of preceptors Shortage leads to unavailability of nurse educators to provide support Increased workload
--	---

there (there; meaning to the clinical setting). <i>There is very limited time to follow up for internship.</i> <i>Probably you end up following them once after in 2 after weeks. You can imagine if the preceptor is there with the students and she is confused experiencing some challenges. Who is she going to communicate those? How is she going to manage those problems alone when we are not there? So “nna” (meaning myself), to me I would say; to some extent we are not giving them enough support. The other thing is that we have said that the training is really poor “we are not training them, we are not guiding them. I happen to go and see her (preceptor) after two weeks when the students are left with only three (3) days to finish up even if I’m querying the marks I can’t tell her to lets re-do this thing because the time has already lapsed “ga kere”. Yes we experience a lot of time pressure as well with other responsibilities just like the preceptors. “Go thata”(meaning it is tough).</i>	Time pressure No regular visits to preceptors and students Ineffective communication and lack of support Minimal support and poor training preceptors Time pressure
Interviewer: Any other comments in that regard? G2N5: <i>Yes as the previous speaker said’ to some extent we do not support them (preceptors) but others are being supported. Like for us what we do is that, we do follow up after every 2 weeks for students in the clinics during internship in semester six (6). You find that we give them (preceptors and student) our phone numbers as well as the Coordinator’s (Level coordinator’s / clinical coordinator’s) so that whenever they experience any challenges they should call us so that we can assist there and there. Some of them do call; we assist them over the phone. Others they don’t call, but you find that when you go there thus when they will try to tell you the challenges they experience. But there is nobody there to help them, or to guide them.</i> <i>I think the main problem is the issue of interest. That is the issue they say they are not being supported from some but not all of them.</i> Interviewer: Preceptors phone at whose expense? Do they use their money and phoning us? Maybe that is where the concern is. G2NE4: <i>So normally when they call, when the experience any challenge they use the government line. They don’t use their personal phones, but of course some will go to that extent to use their personal phones to call. But most of the times they use government lines.</i>	Lack or minimal support provided Suggested means of improving communication Lack of interest in preceptorship Ineffective and lack of clear communication

G2NE3: The other thing is even if we try to give them (meaning preceptors) the support, uu-hh--mm-- the mandate or the job description; when it comes to their relationship with students it ends somewhere very low, for example even if we say they call about the challenges in the clinical area there with students; to what extent will they be able, because they cannot discipline students. Most of the times, what I have experienced is that; most of them (referring to preceptors) are not even familiar with the curriculum and expectation of the curriculum. Again there are no clear guidelines for preceptors. So students normally play around with what they should be doing. They (students) twist everything and it appears to be. Thus why at times they end up “over scoring them” because students will say; “no thus no longer the expectation” simply because they have little knowledge the students now will take advantage of that. “Ee-ee”, they will manipulate the system. Even when it become to discipline because training we are not only looking at the marks, but we are looking at shaping behavior of an aspiring professional, so that tomorrow they will be able to be people of discipline. But to what extent can that poor individual that preceptor discipline the students? It will wait until students play it around and write letters and they get away with whatever that uncalled for behavior. But what I will stress is that,; the issues of support; support through training, support giving them material or equipments, support through availing ourselves is very important. Like I said, if we don’t collaborate, our management doesn’t see that there is a gap it is a challenge. I will be allocated level one to three, sometimes it’s not that we don’t want to give them the support, but the fact is that where do we get time to squeeze yourself in between, and yet at the same time when we get to the boards (Institutional and national examination results approval boards) you find that we say, these guys are dishing marks. They had to dish marks and you have to have marks on the table. Until we take it (referring to preceptorship) seriously, until we formalize it, until there is remuneration or incentives as somebody has just said, we are still going to be continuously facing challenges. More so that we know that “tota hela” (meaning honestly) nursing in our country there is no progression, there is no much of incentives that we get, but to some extent we need to have a motivator. We need to support them, to give them the base. . Interviewer: From what you have said both on the preceptor side and the nurse educator, what do you think are challenges to effective preceptorship? G2NE6: The issue of training like we have said, they are not being well trained. So they	Preceptors not conversant with expectations during preceptorship. No clear guidelines Manipulative behaviours of students No collaboration and support Increased workload and time pressure Problems with allocation of marks by preceptors Need to formalize preceptorship No incentives Need for preceptor support Inadequate training of preceptors and lack of confidence
---	---

(preceptors) <i>don't</i> really know what they are supposed to be doing they are not confident with handling manipulative students, and doing students' assessment. Even the knowledge, for me even these 2 years is not enough. Kana (meaning by the way) at two years, the first year you are still learning yourself. Even after learning after 2 years you are being told gore (Means; "that") you should teach somebody else who is almost same age with you. Even these guys nowadays (our students) some are from work, they are working, others are soldiers, and other is police officers. You can imagine somebody comes there and finds a 23 year old preceptor who has just graduated and the student 26 years old. You can say the other one (student) is more knowledgeable than the other (preceptor). He has the experience of the workplace more than the preceptor. Like somebody was saying, it might be easier for the student to manipulate the preceptor and the preceptor will be forced to give the students the marks that the student wants. G2NE3: The other thing that "a- a -a-h" probably when I see it, I see as sensitive but is true. As educators, "sometimes you find us having an upper hand over people in the service. That thing makes it difficult for us to work harmoniously. And at the same time, when we are there as nurse educators most of us we just "pocket our hands". We don't seem to be there practical wise to be helping the students". If I'm just there sometimes even myself; will just be there to generate marks. Just going to the student who is doing the procedures. But when we don't have procedures; we never or we don't spend most of the time in the unit so that we can appreciate that we are all nurses just like the preceptors. The difference is that the other one is providing service in the inpatients, the other one is at the teaching institution, the other one in the outpatient department. As long as long as we have fragmented these and the other one seem to be superior to others we will never go through very easily. We need to work as partners with preceptors Interviewer: So when we (referring to nurse educators) go to the clinical area make the preceptors feel intimidate? G2NE3 continues; sometimes we intimidate them the way we do things, and (we referring to nurse educators) we appear not to be interested, we never just nurse a patient or we nurse a patient indirectly when the students is doing a procedure. Most of us don't have the "hands-on" so that at least show we have read as an educator and exhibit knowledge and that transfer it on the day to care of the patient. "I think that way we have to upper our hands" because we don't have academic practicals we don't do anything but we just go there. We appear in the wards only when we have practicals with students. Then they "feel intimidated that they are giving us their work load but they cannot take ours and relieve us in a way"	Selection criteria not appropriate Manipulation of young preceptors by mature or older students Lack of support from nurses educators Need to foster positive collegial working relationship Need for partnership between preceptors and nurse educators (avoid superiority complex)
--	---

Interviewer: Anybody more comments on what has been said so far? G2NE1. To me to some extent the support that probably the nurses the preceptors are looking for; really is lack of - lack of what? I would say lack of leadership in their part because, if you know what you are expected to do as a mentor, as a supervisor then a student is not going to be able to cheat you and tell you that “we no longer do this, this is old method ee—e-e or what- what.” Because it’s like parenting “kana” nowadays as parents; we want the schools or somebody else to take responsibility of our parenting. To me sometimes I feel that people don’t want to be seen as supervisors. They want to transfer responsibility to somebody else. I don’t see anything that stops a nurse at the clinical area to discipline the students. Interviewer’s Response. Preceptors say they are not empowered. G2N1 responds by asking: “by whom?” Group member responds; by us (referring to nurse educators). G2NE1 continues: Your post as a nurse there at the clinic, it is your responsibility, I mean a student who comes not properly dressed, as a preceptor you are not going to phone me and tell me that your student is here with inappropriate uniform or is coming late and you are reporting to me to take action on those things. Why are others able to do those things? Because other units you send the student there if the student is not properly dressed, if the student comes late; they will take action. They are not going to be phoning anybody anywhere. To me it’s “modern things anywhere or lack of commitment.” Even parents are doing the same they even report the kid to the school not taking discipline at home level. So yes I think they need to be supported but sometimes it’s a shift of responsibility. Nurses should know that if they are there and they are managers of those units they should manage students. Interviewer: We have mentioned challenges what can we say about benefits of preceptorship? G2NE4: The benefits are that students experience hands on nursing care supervised by a nurse as a mentor. Students have opportunities of seeing new disease and their treatment, ask nurses and doctors for learning purposes. So they learn a lot especially those who are eager to learn and this helps them in tests and examination because they remember what they saw. The preceptors by supervising and teaching students they are sort of forced to read more nursing literature, so it helps them to grow in knowledge too.	Lack of leadership and mentoring skills from preceptors Transferring preceptorship responsibility to nurse educators and Lack of commitment by preceptors Professional growth for preceptors and students again competency in nursing skills
---	--

G2N3: <i>Even preceptors or nurses if I can put it in general terms, they learn from students as well. A preceptor in one clinic when we followed students told us how that group of students she had at the clinic had taught her how to write nursing diagnoses for community nursing as she assisted them with their community study. She really appreciated it.</i>	Professional growth for the preceptor
G2N1: <i>Another fact is that; these students increase staffing especially with these shortages. At level three, semester six (6) they are almost staff nurses so it also relieves the nurses. But they have to supervise them because they are still students. Most of the procedures they do and only ask for guidance here and there.</i>	Students increase staffing in the clinical setting
G2NE2: Yaa it's true. <i>Students benefit and also preceptors do, but it also depends with the commitment of both parties.</i> The challenges are many. Like we said; <i>preceptors are not trained. We do not give them much support because we are also busy with other teaching responsibilities. At times the preceptors are not there. I mean you just can't get a nurse who can be a preceptor in some clinics. They are not interested. They will tell you that I can't manage; I have a lot of work. Some say; no these students are a problem; they need you their lecturers who can manage them.</i> <i>It is only because of these CPD points needed by the Nursing Council for renewal of practice certificates that people start wanting to assist students.</i>	Lack of support by nurse educators and no training for preceptors Lack of interest for preceptorship by some preceptors Nurses gain CPD points
G2NE3: <i>The other challenge is that of transfers which we have mentioned. Nurses are transferred anytime to anywhere including preceptors. To me; it is a major concern just like lack of incentives. People need to be appreciated for the good things they do. On the issue of support; most health facilities are not supporting preceptorship, both the management and other nursing staff. The preceptors will still be expected to do her full workload as a nurse in the ward and also attend to students. Also time constraint for both nurse educators and preceptors. Both preceptors and nurse educators; we need to be given time, we should be allowed to focus mainly on preceptorship and less on other responsibilities. We work under a lot of pressure, time is very limited.</i>	Challenges: --Transfer of preceptors -Lack of incentives -Lack of support - increased workload -Time pressure
Interviewer: Thank you colleagues. What do you suggest we can do to improve preceptorship? Who should be the key players to ensure that preceptorship takes up and becomes effective? G2NE2 responds: <i>I think it involves both the institution managers and hospital managers.</i>	Need for collaboration

Until and unless we collaborate, in trying to make preceptorship as effective as possible, I think we are going to fail. If hospital and institution managers can come together, talk about it, select basing on quality and proper training, effective one be done for the preceptor and at the same time agree on where to post the preceptors. Even their rotation be well planned so that if I take out one preceptor from one unit, I make sure I bring another one who can replace that preceptor. Otherwise if it continues to be the way it is, we end up losing them. You come to the ward you realize that the person has been transferred to a place where no student goes to that place and in the place where you need the preceptor you realize that there is no preceptor. We find we have gone back to taking the experience part “ya” two years experience. We are going to end up with the same problem. So I think collaboration and proper training can help us a bit. The other thing “I think 2 years it’s just too low. “Nna I’m still concerned about selecting a person who is having 2 years. I think at least we should up it to 4 years or so,” because at that at that age, at that year of experience; when somebody has been working for 4 years), I think the person has learnt a lot of things that she can transfer to the next person, (Whisper by other two participants) G2NE2 continues; and there is a bit of immaturity at that time otherwise you are “telling students to mentor other students”. Other Participants respond by nodding and laughter in support of G2NE2’s suggestion. G2NE3: Just briefly I would say we need all the stakeholders on board. Most of the training institutions, we are institutions of Ministry of Health and wellness (MoHW). It has to start from MoHW who is the employers. The employer is the one who just designate and transfer and can give us the mandate even when you say there has to be incentives, MoHW is the major player there. And we have to again include the professional body. The professional body. I mean NMCB. I think NMCB has to be taken on board so that preceptorship goes with responsibility and accountability and its part of the practice. I think even the association or the union. We have a union. It should be involved so that we know that this individual yes though employed as this, but has an as extra role to play so that this person is protected by all means and that every stakeholder is aware of this. Further when we talk of training it will involve MoHW. We don’t want to take a preceptor and take them to “Xanagase” (name of one remote area) just by transferring where students are never placed. So I’m saying the MoHW, who owns all institutions even as our employer. I think it will be the best way if we all collaborate as stakeholder leading being the MoHW.	between hospital and training institution management Preceptorship to be considered during transfer and rotation of nurses Need to revisit selection criteria for preceptors HTIs, MoHW, NMCB, BONU to be stakeholders for effective preceptorship Consideration for preceptorship role during transferring of preceptors
--	--

Interviewer: Any comments or responses or additions to what has been said in relation to stakeholders and suggestions to improve preceptorship? G2NE1: Yes; <i>I think a-a-a..aa what can I say, health facilities e-e-e hospitals, clinics, they should also accept that they are part of the training. The same students they are calling “students of health training institution, they are their future employees that they would want a better service from them”. So the best thing is to assist in training them. Today they belong to IHS (Institute of health Sciences / Health Training Institution), tomorrow they will belong to their institutions (referring to health facilities as institutions) as workers that represent the same uu—hh—mm institutions that actually probably didn’t even think that they needed to guide them properly. Sometimes nurses forget that today he is a student or she is a student but tomorrow she will be a colleague that you would want a responsible colleague that you probably didn’t mentor properly. So that is very- very important. Tota (meaning: truly) Incentives are very important but we should also remember that yes; I have a responsibility in shaping this person; so that tomorrow as a colleague, I will be having a colleague that I can depend/rely on. So to me that is very- very important. It’s all about responsibility; what is my role? Thank you.</i> GINE6: <i>I think basically those are key stakeholders. In addition I would say; students should be involved because they are the ones most affected either positively or negatively. They can suggest improvements based on their experiences with preceptors, our supervisors and nurse educators during internship.</i> Interviewer: Thank you colleagues. Is there any question that you would like to ask me in relation to this discussion? Anything that you wanted to ask or added to what we have discussed? Participants: Shake heads and whisper “No” G2NE2: <i>We have discussed all basic issues and important issues of preceptorship I think.</i> G2NE3: <i>It was a good and fruitful discussion.</i> Interviewer continues: Thank you so much. You have been an open and active group in your contributions. Our session has come to an end. Participants respond: Thank you too.	Partnership of health facilities and training institutions Students’ involvement as partners planning for preceptorship.
--	--

REFLECTION: This was a diverse group with a least one representative from each HTIs. The group was very interactive. Discussion atmosphere was enabling for all members to discuss openly and freely without fear of criticism among the members. There were few instances where the group discussion paused for a few seconds when members would be looking at each other as if to say who will start? Which institution? G2NE3 was very talkative, almost dominating the conversation, contributing to every aspect of the conversation with a lot of confidence and exhibiting lot of knowledge about preceptorship. G2NE2 was also a very active participant, though calm and collected. G2NE2 also exhibited vast experiences with preceptorship.

G2NE1 was a bit emotional at times; felt that some preceptors are generally not performing their roles as expected and, there were not committed to preceptorship. However, he was able to control his emotions without intimidating other participants in their contributions to the same matter. G2NE was of the opinion that preceptors do not want to take responsibility in guiding and disciplining students even the trained preceptors were not exhibiting knowledge that they were trained. G2NE5 was also an active participant but not very outspoken like G2NE1, G2NE 2 and G2NE3. G2NE4 and G2NE6 were less active compared to other members, though they also shared their experiences and suggestions. The two participants were rather on the quiet side compared to the other 4 participant. The environment used for the discussion provided privacy. There was no interference throughout the discussion. The room temperature was comfortable because there was an air conditioner. Participants expressed their appreciation to participate in the discussion and the relevance of the study to the current situation of preceptorship. Lack of training, support and in appropriate selection of preceptors were issues that came up over and over again in the discussion.

APPENDIX K: PRECEPTORS' TRANSCRIPT

Nyangabwe Referral hospital and Greater Francistown clinics

Venue: Male Surgical ward Conference room

Date 07/09/ 2016

Transcript Two (2)

Time 2pm

Duration 59 minutes 25 seconds

Participants Prolife:

Number: Eight (8)

Gender : Six (6) females and two (2) males

Age range: 34 to 52 years

Highest Qualifications: Bachelor of Nursing Science one (4)

Diploma in General Nurse three (4)

Experience as preceptor: Minimum 6 months and maximum 10 years

Interview	Code
Interviewer:	
Introduction Good afternoon colleagues. Thank you for your time. You are the second focus group in this study. I'm Antonia Dube from Kanye college of nursing that is where I'm working but I come here as a student from North West University in Mafikeng. The purpose of my visit is to discuss with you as your experiences as preceptors, the support that you need as preceptors and possible suggestions that you have to improve preceptorship. Kindly fill in the forms I just distributed. This is confidential information that I will use to compile the report or findings of the study. You are free not to write you name if you fill uncomfortable but fill in all other details. The same ethical principles I explained earlier on when you filled questionnaires still apply. Pleased be assured that you are protected as far as confidentiality about your contributions is concerned. I'm going to ask you to tell me your experiences since you have been preceptors and record our discussion. Ms Stella Kamanga will be writing our discussion as we discuss. In addition I will use the voice recorder to record all of us as we speak including me so that we capture everything we have discussed. Thank you for agreeing that we	

use the voice recorder. Without wasting anytime please feel free, to discuss your feelings, experiences, opinions and suggestions about preceptorship. I am sure all of us have something to contribute Interviewer: Tell me about your experiences as preceptors. Since you are preceptors you have had experiences whether positive and negative. What can you say about preceptorship? Participants: Silence, no immediate response, a bit of uncertainty observed amongst some members. <i>Dumelang</i> (a greeting in the local language) by another participant joining the group. <i>Dumelang mma</i> (group responds to greeting). Interviewer: Anybody to start the ball running? I mean your experiences as an individual Participants look at each other as if to say who will start, some whisper, one participant (G2P1) asks for the voice recorder to be brought closer and says “<i>pass it to me</i>”. Responses: G2P1: <i>Nna</i> (meaning myself) <i>I have noticed that sometimes you</i> (referring to preceptor) <i>will be having a student asking you to mark for him or her and maybe wena</i> (vernacular translation for “you”) <i>during that week you only came for one day shift ene</i> (herself / himself) <i>will be there the whole week then it becomes difficulty for you to mark for him or her because you were not monitoring her throughout the week.</i> Interviewer: ehhmmm! Any other experiences? G2P2: <i>Aa-aa-hmm, I think basically it starts from the selection of preceptors. Eee –mm—mm, I think the major problem is that we haven’t had a very good criteria of selecting who is a preceptor from the first word go. I have been a preceptor for the past 5 years but eee...mmm my being a preceptor was on voluntary basis and later it was acknowledged that I could be part of the preceptors. The other challenge is that the preceptors on their own do not receive much training as to what is expected of them, even though there is a meeting we hold for a few hours with the lecturers from the institutes of learning, it is not so detailed as to what a preceptor is supposed to do. There are no proper</i>	Unavailability of preceptors affects students learning Inappropriate selection criteria for preceptors Preceptors not trained No proper guidelines
--	--

of clear guidelines for preceptorship Another challenge that we encounter is that; ee- ee-- hh-mmm as a preceptor most of the time you are not always there in the unit with the students to see how they are doing. You only maybe meet them only once in a week, maybe they come for a week and you meet them once, so it really becomes difficult for you to have an impact on their learning, what their objectives of coming to learn and for the institution and all those, How to meet their objectives and assist them to meet their objectives. I think that is one of the things that have been a challenge. ' G2P2 continues to say, but generally there is a good working relationship with the lecturers from institutions that we usually work with. The only major challenge I think is the training of the preceptors is the one that is still lagging. 'I think it is ideal to have preceptors that have eeemm--, eemmm-- you know-- Botswana Qualification Authority certification of some sort either as a trainer of trainers or as an assessor, because if you assess those students without having a lot of information what you are going to assess them on not knowing the standards in the country regarding education --eeemm-- you know regarding their learnership I think it becomes a problem too. I think selection and training of preceptors needs to be looked into as well. Interviewer: hhhmm! What else can we say? G2P3: Hhhmmmm-- the other thing ke gore (meaning-it's because) this is a referral hospital we are not based in one ward we keep on changing. You might find that sometimes you are precepting, what might happen is that you might find that maybe you are familiar with say male medical ward and you know what is suppose to be there, then from there you are moved maybe surgical ward. When you go to surgical ward you are being expected to assess students, then you are just blank, you don't know what to do, so which means it becomes very difficult for you to assess the students. So to them (students) they will be wondering what kind of a preceptor is this one. They are fresh from the class; they know that underwater seal drainage. I don't know, I have forgotten 1, 2, 3" but I have been a nurse for long. I'm familiar with the skill so this becomes a problem." G2P3 continues the discussion, then other things, those students I don't know if they don't know what is expected of them during their practice work. Sometimes they do the procedures. When they do the procedure they just come with that	Unavailability of preceptors Good working relationship with lecturers Need for preceptors to be accredited by regulatory bodies Improve training and selection criteria Inappropriate placement of preceptors in units Inadequate knowledge of preceptors Need for clear guidelines and expectations
--	---

assessment tool and give it to you and say “may you please mark for me here I did procedure 1, 2, 3” but there was no pre-arrangement with me that I have to assess. Some time we used to talk to them that when you are doing a procedure you have to consult me so that I know and I should be in a position to assess what you are doing. Even if other procedures they just meet them immediately but when I’m there we can do. We need clear guideline to assist and monitor students.	Manipulative behaviours of some students
One other thing we are not always in the ward. What is happening is everyone who is there takes over and assists the students of which it becomes a challenge. The other thing, sometimes it’s like we volunteer to become preceptors “there was no training” but we use only that manual. That manual guides us there and there it guides what to do but I think training is also important together with guidelines.	Unavailability of preceptors No training of preceptors Need for guidelines
Interviewer: Ehhh--hmmmm. Another contribution about experiences? Brief silence by group G2P4: A-a-a-a, the other thing, I think the national institute of health or NHI (former name for health training institutions in this study). Correction by researcher; health training institution or schools of nursing. Preceptor’s response to correction, “yaa” (positive response to correction) the schools of nursing should formalize or make their preceptorship manual and guideline be uniform. We always receive students from different institutions, i.e. Molepolole, Serowe, Francistown but mostly the people (nurse educators) who engage us are from Francistown. But these one from Molepolole, Serowe we just find the students there. And we were are not yet informed about their coming, we just find the students there. You now have a challenge to get accustomed to assessing the students whom the lecturers didn’t tell you their expectations and maybe you use the guidelines from Francistown to assess them. I think they should meet and formalize and make them similar.	No uniformity in preceptorship guidelines across HTIs
Interviewer: Who are the “they”, you are referring to? G2P4: Lecturers, nurses and midwives should meet and make the guide to be uniform. G2P5: <i>hmmmm....</i> I think eemm—mmm, mixing our routine duties with	Lecturers and nurses to jointly develop guidelines

<i>preceptorship is impacting negatively on the students and how we follow them up</i>, because for us to know that they are doing the right thing we have to follow them up. But then leaving them and doing the ward routine is impacting negatively. Maybe we should <i>be given time</i> when they are around so that we follow them up fully.	More time needed for preceptorship activities
Interviewer: Any other contribution? G2P4: <i>At least with Francistown they have met us. We had two meetings. We had one in January and March at least tutors they meet us, telling us when students were coming first year, and third years and what do they expect from us. They meet us together with our management. The first meeting was with senior nurses then the second they called us to the institution so that we could share freely”.</i>	Ineffective communication about expectations
Interviewer: So you say they involved your supervisors in the first meeting? Participants (Group response: Yes—yes!!) G2P1: and <i>it was a good thing because they</i> (Referring to supervisors) <i>should know what is expected from us for them to support us</i>. With emphasis and others nodding to show appreciation.	Need for supervisor involvement in planning preceptorship activities
G2P8: coughs first then says; <i>hh--mmm I have flue today that is why I am a bit quiet. Continues to say; yes those are the problems we face. Also some students are not committed or they are manipulative. Like Ms..... has</i> (name withheld for anonymity) <i>mentioned they</i> (referring to students) <i>don't want to work or to follow the right procedures; but they will want you to give them marks ee----mm---hhh that is wrong. Others are not interest to learn, they are not committed you have to push them. Also we do not get support from some supervisors.</i>	Students not interested and not committed to learning
Interviewer: Tell me more about support. What type of support do you get as preceptors, either from the health training institutions or from your supervisors? G2P4: <i>We get little support from training institutions apart from that we don't get support?</i>	No support from supervisors
Interviewer: Are you saying training institutions or nurse educators do not give much support? G2P4: continues, <i>“No support”</i> (with more emphasis)	Minimum support from educators and HTIs No support

G2P5: <i>Maybe because we are not trained we don't know what support we should get. We are just doing it according to our experiences in the field. So we just teach them what we know from school.</i>	No training for preceptors
G2P1: I think <i>there isn't any support that is there at all besides interactions that we have with them when they (referring to nurse educators) visit their students, but there isn't any formal meeting that we have with them (referring to nurse educators) to say ok this is what I expected to do, how far are you with students, did they manage to accomplish the objectives that they set out to come and do when they came. So there isn't anything like that. They just come to see the students and then just go like that. My thinking is that; for somebody to be a preceptor they should be a linkage between the education institution and clinical part because we are in the clinical set up. Most of the times we don't have access to journal articles and all these kind of things like educators. If they come with what they (nurse educators) teach in the learning room and bring them to the clinical area and say these are current trends of managing these conditions, these are the current trends in nursing care so are you doing it in the environment. That kind of interaction would eventually help us. But unfortunately there isn't anything like that. All in all we don't have any help; we don't have any help (repeated). It just what we know, that individuals on their own get to dig out aa--hh--mm from different areas maybe from Journal articles and come and bring them to the clinical area.</i> G2 P6: responds: <i>"hmmmm all in all, I would say maybe there is support there and there", like when there is a meeting sometime the IHS they might want to see the preceptors. The message is routed through the management of our facilities and so on, but they do release us to meet them but not always. The other thing lecturers according our assessments they do appreciate what we do. They do allow us to deal with the students of which sometimes they never blames us, but where we have gone wrong they always correct us like here you have to do 1,2,3 which is part of support.</i> <i>The reason why there is not much support is just because, there is no-oo, maybe there are no guidelines or qualification for that.</i>	No formal meetings between preceptors and nurse educators Need for pedagogical support and educational literature for preceptors Minimal support and interaction with nurse educators
<i>The reason why there is not much support is just because, there is no-oo, maybe there are no guidelines or qualification for that.</i>	Minimal support No guidelines for preceptorship

Interviewer what are you referring to as “that” can you clarify further? G2P6 continues. <i>I mean preceptorship. It is just there; just because there should be preceptorship it’s in the curriculum or what. It is not formalized or there is no training or; “I don’t know what to say, “There is not much support”.</i> Interviewer: Anything more about support? G2P7: <i>clears the throat</i> then responds, <i>I not sure; I’m new in that thing. I don’t know much. I just attended their first meeting when students came. I have been a preceptor for just one semester. I can’t say much. I’m still waiting for students, the second group. laughs and other group members join in the laughter. But I think training of preceptors is important. I am not trained myself.</i> Again, <i>there is no time to be with students, from the short time I was with them; I realised there is no time. The workload and students combined like someone said, it’s a big problem.</i> Observation: Two of the group members wanted to make contributions / comments at the same time (participants now very actively all wanting to contribute). G2P2 responds: <i>The other thing also I can say there is no support looking at the fact that we once requested that why is it that preceptors cannot be 4:30 during students’ attachment. They (referring to clinical setting managers or supervisors) we are just looking at the staffing that is; patient care and so on and that part of preceptorship is not being taken into consideration. We need to be 4.30 so that so that we can be able to have them (students) the whole week or so of which that is also lack of support. At the end of the day you just meet the students once. So even the objectives you can’t see all the objectives of the students; maybe you are going to meet only two. The time you try to sit down there is something you have to do of which at the end you are exhausted. Maybe you will take some times to sit down with the students, review their work and try to help but the work is waiting for you as well. Other nurses will not do the work because you are with students. They say it is your choice to be with students. I can really say support is not there</i>	Preceptorship not formalized Minimal support provided Improving training of preceptors Time pressure and increased workload No support from managers and supervisors Preceptorship not given consideration by supervisors Exhaustion due to increased workload No support from other nurses
---	--

G2P8: From my personal view I have been a preceptor for the past 10years. I have noticed quite a difference in the way preceptorship is done here in Botswana. The first 5 years I have been preceptoring in another country and the last 5 years I have been here. They (nurse educators) give us support but it is minimal, especially for the IHS training schools.	Minimal support from nurse educators
They rarely visit the hospital or clinical area. They visit when we are expecting students that is to come and lay their objectives and after the clinical period. During the attachment period sometimes they do visit but not frequently. And at times when you in the clinical area you find you have a challenge, like the one they are mentioning and no one from the training institute is there to help you as a preceptors.	No regular visits to preceptors and students from nurse educators
Students may come to do management which could be a week and you as a preceptor are there for 2 days implying those other days you are not there to assess even to witness the management but you are expected to sign for that student management at the end of the week of preceptorship. Where you fail to do so giving the reason that you were not there, you cannot support or sign for the student its like “you are going against their expectations.	Preceptor blamed
Then the other area is the support from the supervisor is very- very minimal. It's like they don't value preceptorship that much because when you are in the ward, you are expected to do your expected activities which are patient care and mostly these are demanding you are not excused from those duties. Students are expected also to be mentored during the same period, so it's quite a challenge in support.	Minimal supervisor support, preceptorship not valued Increased workload
And also in giving feedback, if you do not give feedback to the school, the school does not even follow up. I understand when students finish their attachments in the clinical area, there should be communication between the preceptors and the school on how the group performed in general, is there any loophole where there they should improvement, where the school should pull up also or is there any where there is need for further improvement. But at times we don't have such communication between the school and the clinical area.	No provision for feedback Need to improve communication
Interviewer: Are saying training institutions just take their students back	

there is no forum to sit down and discuss challenges or the whole process or experience of preceptorship with preceptors? G2P8:’s response “YES - Yes (with emphasis) and others nodding to agreed. Interviewer: Emm—hhh--mmm (Acknowledging the concern). What suggestions do you have to improve the success of preceptorship? (Both from the Health Training Institutions and clinical settings) G2P4: <i>The first one is support for preceptors. Maybe the training of preceptors as second suggestion.</i> G2P2: I think <i>change of shifts to align our shifts with students’ shifts.</i> Interviewer: Can you explain further on that? G2P2: <i>Let’s say maybe you are AM; them from 7.30 to 3.30 from there is another shift from 12.30 to 8.00 pm, then there is night duty. So I think when the students are in the units it should be 7.30 to 4.30 so that we can be able to supervise and asses the students unlike whereby you will be not having same shifts and then you just met with the students once and sometime not. This will be an incentive as well because there is no incentive for it.</i> <i>We are not being given anything for recognition, but just that 7.30 to 4.30 shift will be ok. We know teaching students is part of the nurses’ role.</i> G2P4: <i>we fragment our teaching we teach them for two days the other two you are not there. It’s really fragmented. Preceptors should be available for students and be given time discuss objectives and to teach them nursing.</i> G2P8: The other point is maybe to <i>increase the frequencies we meet with the training schools because to discuss issues once a semester seems to be too long.</i> Interviewer: So nurse educators should interact more with preceptors on how you are faring with students so that you can also share the challenges, is	Need to improve support and training for preceptors Need for aligning preceptors’ and students’ shifts Lack of recognition for preceptors Need for recognition of the preceptor role Need for more time for preceptorship and to avail preceptors Need for regular meetings between preceptors and nurse educators
---	--

that what you are saying? G2P8: “Yes’ not only challenges it is also for us to identify the strengths that school is already having and identify the weakness while there is time to improve on them. Even for us to get feedback on how we are performing with the student. G2P4: The other support we need is on budgetary terms. The other time we were that side they had hiccups of monetary problems or economical issues that they can’t have a workshop because of limited budget. But if schools of nursing can plan in advance that maybe they are going to have a workshop for preceptors this year then they put in their budget. But we want them from the school of nursing to be able to plan ahead so that they can accommodate maybe two workshops for preceptors or one workshop per semester. The other day when we were that side we were told that the challenge is money. Interviewer: You were told that the challenge why you could not be trained is because there is no money? G2P4: Yaah that is what we were told. Interviewer: What can you say to the lecturers / nurse educators specifically about your observations, experiences or suggestion to them? G2P1: I don’t know. Maybe I will ask for advice ee- ee- (clears throat) the—the-- the lecturers that side they can build trust and cooperation within them and the students. Sometimes it’s difficult to work with them (interviewer asks, with the?) G2PI: with the students. They will be having some issues there. When they come this side it’s another issue from what they were taught by the lecturers now we are trying to teach them the real field. Uhhmm. It becomes a problem. They will give all sorts of excuses and stories not wanting to do things the correct well. You have to be firm or call the lecturer to ask how they taught the students about a procedure only to find that the student just wanted to be tricky. G2P4: Maybe we talk in terms of improvisation. Students are taught ideal things. Here when there come there is no NG tube there is no trolley for dressing. They use a feeding table to prepare for the dressing. It becomes confusing to student.	Need for monitoring, evaluation and feedback on preceptorship activities Training institutions to budget and plan for workshops Problems with student lack of commitment and manipulation Inadequate resources/ equipment in the clinical settings
---	--

They should be told at the school that reality is different from ideal. When students see reality in the ward or clinic they think we don't know, we are not good nurses. We do not have the right equipment or resources. (Participants laugh, and all support of G2NE4). Interviewer: What they find in the wards or clinics is different from what they are taught in the skills lab? Participants: yes –yes (all in agreement) Interviewer: Ummm---hahm. I see. Anything else about that? G2P8: Yes. Supporting that statement; when students are coming for management we have a challenge. They were informed they were to come and do management. Their main area was medication, ordering and supervisory. Those were the three main tasks they were expected to do and they would even say “I’m not supposed to put my hands on a patient.” But what type of a manager are you going to be? This is a clinical area; we are training you to be realistic. So it will be more of a challenge between the schools having set their expectation what is really on the ground. So I will not know the truth because the lecturer is not there, we have not met for me to know exactly what the students should do or not do. It becomes a big challenge. Interviewer: Yaa! But remember colleagues, students can be tricky! Do you just hear from them not verify with nurse educators? G2P8: Continues; Ee- hh-ee the whole group (meaning the whole group of students) will say that. We went to the extent to follow up on the lecturers to say; is this expectation? They (lecturers) emphasized it was like the students had said. But we talked and agreed up to a term that they (students) will do other activities. They can not only do supervisory duties. Even as a leader when you are in the ward you find that the staffing is not permitting, you do not only perform your managerial duties. You also end up doing patient care and other duties. This is what makes guidelines and objective important. G2P1: The other thing is that at the end the attachment there is evaluation that is being done. So it was going to be better if at all at the end of the evaluation , they (students and lecturers) do evaluate the preceptors or the institution with the	Need for educators to clearly communicate clinical expectations to preceptors and students No clear expectations and guidelines to preceptors fro nurse educators Need for to give preceptors feedback
--	---

students from there they give feedback so that we know our strengths and weaknesses. We also should evaluate the internship. Last time there were some students from Norway, they said they will give us a feedback but now it's a couple of months and we have not yet received any feedback, we don't know whether they were comparing the setting or what. I think we need to be given a feedback by the institution the one they get from the students. I think there is a situation whereby those students who are performing well I think that are taken outside to other countries (exchange program attachment) so they should come back to us say while we were there we saw 1,2,3, so that we also know if we can able to implement that or do something so that we improve and come to that standard as also. Interviewer: So you would appreciate if they come back and share their experiences with preceptors? Participants respond as a group- Yes (all concurring). G2P3: Yes that will help us to improve and grow in this preceptorship. Interviewer: Do you have something else to add on that? Response: <i>All say No. others shaking heads.</i> Interviewer: Who are the key stakeholders to be involved in preceptorship planning so that we do not continue having all these problems or challenges we have indicated?	Feedback improves effectiveness of preceptorship and professional growth for preceptors
G2P1: I think the management for the health training institutions and hospital should be involved otherwise when training comes the ones in the hospital should be informed so that they know how to arrange the training together with the staff from the institutions of health sciences (Health Training Institutions). Interviewer: Emmmhhh, who else should be involved? G2P2: I feel with the current certification standards we should involve HRDC or BQA because it matters most on what the students have at the end of the day. Them being people who are certifying or accrediting courses being offered, they should also look at preceptorship how it is being done. Is it up to scratch or the areas we they need to work on because nursing is more practically than	HTIs and hospitals to partner in training preceptors Collaboration with Accreditation bodies (HRDC,BQA, UB)

academic. At the end of the day you are going to have students who are not practically oriented outside there. It's going to be a challenge. So they also should take part in looking at the preceptorship. When they evaluate the courses they should look at the preceptorship component. How is it being done? Is it something that is up to scratch or they need to overhaul some few things over there? Eeee-hh-mm should be taken on board. I also feel there should be a kind of a champion that eee--hhh- mmm that leads and guides on preceptorship. A kind of national structure whether inclusive of the University Of Botswana, Institutions of Health Sciences so that they can be able to say ok this what we expect in a preceptorship program for a diploma level, degree level or masters' degree level so that eventually the output being the students that out are of a higher quality.

Interviewer: Uhhmmm. You have suggested Health training institutions and facility management, HRDC, UB, BQA. Who else?

G2P2: We can also include our customers because they are the major beneficiaries of our services.. They need to know that ok; this is what happens in a nursing programme. Students are taken for preceptorship to practice nursing activities on them. They need also to look through the components and say "ok" is this what we expect as the users of facilities or as beneficiaries if this service that this individual when they exit the studies they are going to bring to us? The need to be taken on board we will have like open days, Pitso (s) those kinds of things. I think they should also be taken on board when IHS (s) have open days they can add on and say this is what we expect can be done as communities or customers.

G2P8: I think the nurse. Since they are the cadres who are supposed to be precepting student nurse they should be actively involved in the planning phase because you find that not all nurses are interested in precepting. So if one ward has one preceptor it means the other students are not going to receive quality clinical attachment. So all nurses should be taken aboard. They may not all be preceptors like qualified preceptors. But they should be meeting at least the standards and expectations of a leader because every nurse in the long run is a leader. They should be able to teach and mentor their juniors.

Healthcare service users as stakeholders

Nurses as stakeholders

Interviewer: who else? Nurses yes I agree. Let's put it this way. Who should represent the nurses or how will all nurses be included? G1P4: <i>The nursing charge body or Botswana Midwifery Council even the union also</i> (low voice not audible enough) Interviewer: <i>Your voice is faint.</i> G2P4: Repeats: <i>I'm saying the Botswana Midwifery Council and also the unions (Nurses association now it's BONU). Botswana Midwifery Council as the licensure body it can also be involve as a key stakeholder.</i> Interviewer: All stakeholders you have mentioned have also come up from the first group and from lecturers; although you have a difference of only one stakeholder you have not mentioned. Maybe to you that is not a key stakeholder. Have you mentioned all? G1P3: <i>Which one did we forget? Remind us then we can discuss if we support other preceptors about it or not.</i> Interviewer: Maybe to you that is not a stakeholder. Others mentioned the ministry of health. What can you say about it? Participants: Big laughter in response to researcher's comment. Yes- yes- yes members nodding their heads all in agreement that they made an omission of a major stakeholder. Interviewer: You actually mentioned Ministry earlier on G2P1: <i>Laughs again and says; how come we forgot? Ministry of health is the major one, and a sponsor of training schools financially. It is even our employer; I mean us the nurses / preceptors.</i> Interviewer: Laughs as well and says if we say there is no money we mean the Ministry of Health has not given us money both at HTTs and health facilities. Thank you so much. Interviewer: Let us request Madam Kamanga in a nut shell to summarize what we have been saying. Madam recorder, just tell us the key points so	Professional Regulatory Body and Nurses Union to represent nurses as stakeholders MoHW as a major stakeholder and sponsor
--	---

that we know that they have been well captured and the rest you can correct where there is need.

Recorder: Ok and good day. In a nut shell we initially discussed the experiences that everyone has experienced during their preceptorship. Some of them were positive and some were negative. Amongst them are:

- Time limitation to assess students especially where preceptors' preceptors and students work different shifts in the clinical area.

receptor role due to routine work load

- Need to review the selection of preceptor because according to us the criteria has been faulty

- The preceptors do not receive much training on what they are expected to do with students

- There is good relation between the IHS lecturers and hospital preceptors which is a positive experience.

- Limited time for students in the clinical area

- Need for preceptors to have Botswana accreditation certification

- Guidelines and expectations for preceptorship to be uniform or standardized across training institutions

- Rotation of staff has a negative effect. Preceptors are also rotated in the hospital and it affects their preceptorship assessment. At times it is abruptly and often they may not have experience in the new clinical setup or transferred to areas where students are not placed and this affects both the preceptor and the students.

- Lack of pre arrangement by students for clinical assessments by preceptors. They just come if they want their forms signed.

G2P2 makes a correction: Forms for assessment or procedures.

Interviewer: Emmmhhh, you should just add if she omitted something. You are free to correct at the end when she has finished recapping.

Recorder continues:

- IHS should standardized/formalized their expectations with preceptors because it not uniform. We are coming from different backgrounds and it affects the way we precept on our students.

-Preceptors are expected to perform nursing duties and also to be precepting students. This impact negatively on student follows ups. There is need for preceptors to be excused from other duties and have reduced workload so that they have time with students.

- Preceptors to be scheduled same shifts with students

Support: What type of support do preceptors get from facility management/ supervisors and health training institution (s) staff / nurse educators?

Recorder's recap:

-The main one was that there is lack of support

-No formal meetings between nurse educators and preceptors on assessing students' objectives, feedback and follow up in the clinical area

-IHS staff (being; nurse educators) appreciate our efforts and they also offer support. They come and highlight objectives. and offer support at times

-No guidelines or qualification on preceptorship

-Lack of support from clinical setting supervisors and management at times because they don't value preceptorship.

-No forum for lecturers and preceptors to meet and discuss after clinical assessment of students (no feedback).

The other questions was, what should be done to improve preceptorship

- The main area were to **train of preceptors**, it helps to standardize

- Support for preceptors and preceptorship by all other stakeholders

-Need for change of shifts for preceptors when students are on clinical attachment either 4.30 shift to accommodate students supervision and assessments

-Nurse educators to meet more often with preceptors to identify strengths and weakness which may have been encountered during clinical experience.

-Need to build trust and cooperation between preceptors, nurse educators and student and more communication

-To evaluate or give feedback to preceptors by nurse educators and students at the end of the clinical period it will help to motivate them

Last question was: Who should be key stakeholders in preceptorship planning?

Amongst them were: <i>Hospital management, health training institutions, BQA, HRDC which is essential to evaluate the preceptor qualification, National Nurses association / union, NMCB, UB and customers.</i> <i>A national structure maybe set up for training of students.</i> <i>Nursing staff should be represented by the licensing body which is Nursing and Midwifery Council of Botswana and also BONU.</i> <i>Ministry of health is the greatest stakeholder.</i> Interviewer: Uhhhhmmm. Thank you very much madam. Anything that she left out or is there anything that you want to correct from what she has captured because this is what will appear in the report (quotations) contributions from you preceptors. Group: Silence, looking at each other if there was someone who had something to say Interviewer: Silence means consent or concern. Anything left? <i>G2 P7: From what she has read, she captured everything we said.</i> Interviewer: She has captured everything? (Repeats the comment by P7) Everything will be here (referring to voice recorder) At the end of the study there is going to be a copy which I will avail to the institution, to Nyangabwe hospital management. I'm sure they will give you and you will have a look at it but it will be sometime, maybe a year and half from now. Hopefully you will not have been transferred since you have mentioned about being moved from one area to the other. I have seen that there are massive transfers going on already. Participants' responses: <i>Laughter then G2 P3 says: I will be in Phikwe. G2P4: to Lobatse, G2P6: to Gaborone G2P2: in Serowe. G2P3: continues to say, and there will be no students in Phikwe and other places and districts where some of us will go.</i> Interviewer: Anywhere you are still going to precept if there are students where you will go. Thank you very much for your time, unless you have any comments or anything that you would like to say to me. Participants (G2P3) : <i>No; we have discussed all what is important to us about this preceptorship</i> Interviewer: Thank you so much!!! Have a good day.	Confirming transfer of preceptors to clinical settings across the country
---	--

Participants: Thank you End of session	
REFLECTION: The group was large. The conference room was spacious with a comfortable temperature and well ventilated. G1P1, G1P2, G1P4, G1P3, GIP5 were very interactive contributing more than other members. G1P8 compared preceptorship with her experiences from a different country and showed some discomfort about the way preceptorship is done in Botswana by way of shrugging shoulders to show a bit of discontentment. G1P6 had the least experience as a preceptor and contributed minimal. G1P2 was more knowledgeable about the importance of involvement of regulatory bodies as stakeholders. Participants expressed their feelings without showing emotional distress even when they were relating challenges. Where disapproval or expressions wherein difficulties were encountered during preceptorship, emotional control was exercised although unhappiness was expressed. There was no incidence where a need for handling of emotions occurred throughout the discussion. Discussion atmosphere showed openness by all participants as they were free to share their experiences. Lack of training and support were highlighted most of the times. Lack of guidelines and ineffective communication were also mentioned frequently. Several stakeholders and strategies to effective preceptorship were suggested. A lot of smiling and laughing was observed and jokes shared in relation to experiences were shared indicating an atmosphere of relaxation and a non threatening environment.	

APPENDIX L: LANGUAGE EDITING LETTER

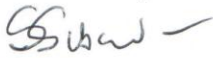
Sifiso Sibanda
Language editing
Cell numbers: 0782295700 /0837999206
Email: Sefiso.sibanda@nwu.ac.za /
thulani.sifisosibanda@gmail.com

17 February 2018

TO WHOM IT MAY CONCERN

This letter serves to inform you that the thesis by Antonia Dube, entitled: **A Preceptorship Model to facilitate Nursing Education in Botswana** was language-edited by me. Please feel free to contact me should there be a need to do so.

Yours faithfully



S. Sibanda

(MA in Eng.; BA Honours in Eng.; B of Edu; Dip in Edu)