The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators

Kimberley Ann Tucker

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

THE LIVED EXPERIENCE OF CLINICAL NURSE
EXPERTS TRANSITIONING TO THE ROLE
OF NOVICE EDUCATORS

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Natural and Health Sciences
School of Nursing
Nursing Education

December 2016
This Dissertation by: Kimberley Tucker

Entitled: The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators

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The national nursing shortage is compounded by a critical shortage of nursing faculty. Despite a growing interest in nursing, thousands of qualified applicants are turned away primarily due to lack of faculty to teach. The recruitment of expert nurses from clinical practice is one strategy being utilized by many colleges and universities to fill faculty vacancies. Many novice educators enter academia lacking formal preparation in teaching and learning; orientation and mentoring programs vary greatly between institutions, making the transition challenging. The purpose of this qualitative phenomenological study was to gain insight into the experiences of clinical nurse experts transitioning to the role of novice educators. Nine novice educators from associate degree nursing programs in the Pacific Northwest region of the United States participated in this study. In-depth interviews using open-ended questions were conducted, recorded, and transcribed verbatim. Data analysis and manual coding resulted in five themes: (a) anticipating the transition, (b) starting out, (c) learning to teach, (d) factors influencing the transition, and (e) getting there. Findings from this study revealed the transition experience from expert clinician to novice educator to be complex and challenging. Participants lacked knowledge about how to teach and were ill-prepared for the role of nurse educator. Many experienced shortened orientations
and inadequate mentoring and had to navigate academia on their own. Informal mentoring and support by co-workers was found to play a critical role in facilitating the transition. Novice educators also reported that their nursing expertise and experience was helpful in increasing their comfort level in the clinical setting. Despite many challenges, participants exhibited perseverance and started to identify growth, recognize rewards, find satisfaction in their role, and a desire to continue. Findings from this study support previous findings in the nursing literature. This study uniquely contributes to the body of knowledge by filling in a research gap: the transition experience in full-time appointments in the community college setting. Implications for nursing education include identifying educators earlier in their careers, integrating pedagogical training in graduate education including a teaching practicum, developing evidence-based orientation and mentoring programs, and advocating for funding to make faculty salaries more competitive with industry and advanced practice.
ACKNOWLEDGMENTS

“I can do all things through Christ who strengthens me” (Philippians 4:13).

First and foremost, I want to thank God for opening up this opportunity and giving me the strength and courage to complete it; I give Him all the glory.

To my husband and best friend Jake, you have believed in me and supported me every step of the way. Thank you for reading countless papers, taking the kids to movies when I needed quiet time, and picking up slack! I love you all the way around, and I promise I won’t make you read about the nursing faculty shortage anymore!

To my three children, Ryan, Korey, and Rachel, thank you for being patient with your mom, reminding me to not procrastinate, and for being all-around great kids! I hope that someday you will look back at the last five years and understand the value of education and be inspired to reach for your dreams.

To my parents and parents-in-law, thank you for believing in me and supporting my crazy idea to get a Ph.D. Thank you for everything from grammar assistance to chauffeuring me around for interviews. It truly took a village to help me cross the finish line.

To my research advisor, Dr. Faye Hummel, and committee members, Dr. Lory Clukey, Dr. Vicki Wilson, and Dr. Jill Bezyak, thank you for your guidance, expertise, and support throughout this process; you have been wonderful mentors. I also want to
acknowledge and thank Dr. Debbie Nogueras for your mentorship and qualitative advice.

To my colleagues, specifically Mary and Tracy, thank you for listening to me, reading drafts, and supporting me through this journey. Thank you to the administration at Columbia Basin College for your encouragement and financial support of this endeavor; I am extremely grateful.

To the nurse educators who graciously chose to participate in this study, I appreciate your willingness to share your personal transition stories which were the foundation of this study.
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CHAPTER I

INTRODUCTION

Introduction to the Problem

The United States is currently facing a nursing workforce shortage that is expected to intensify as the population ages, the need for healthcare grows, and the nursing workforce ages and retires. The role of the nursing workforce is being redefined as new healthcare delivery models are developed and reimbursement strategies are amended. The emphasis that the Affordable Care Act has on health maintenance and illness prevention is providing new opportunities for nurses and is expected to increase the demand for registered nurses (RNs) over the next decade (United States Department of Health and Human Services, Health Resources and Services Administration, & National Center for Health Workforce Analysis, 2014).

The reality of the nursing shortage exacerbates stress in the healthcare system and is compounded by a critical shortage of nursing faculty. Despite a growing interest in nursing, thousands of interested, qualified applicants are turned away annually due to limitations in clinical sites, classroom space, clinical preceptors, budget constraints, and insufficient numbers of nursing faculty. Nursing school administrators cite the lack of qualified faculty as one of the primary reasons for not expanding student enrollment (American Association of Colleges of Nursing [AACN], 2013; National League for Nursing [NLN], 2012). Underlying factors contributing to
the faculty shortage include an aging faculty (with a large number of those retiring over the next decade), decreased recruitment pool of younger replacement faculty, increased age of doctoral recipients and time to degree, increased tuition and loan burden of graduate study, limited pool of doctorally-prepared faculty (AACN, 2013), heavy faculty workloads, and non-competitive salaries compared to clinical and private-sector settings (AACN, 2013; Beres, 2006; Brady, 2007). These factors indicate that the future of nursing is at a precarious point, and strategies need to be developed to address the faculty shortage in order to increase student capacity in all levels of nursing education.

The recruitment of expert nurses from clinical practice is one strategy being utilized by many colleges and universities to fill faculty vacancies. Many new educators enter academia lacking formal preparation in teaching and learning, despite having graduate degrees and expertise in clinical practice (Anderson, 2009; Brendtro & Hegge, 2000; Clark, Alcala-Van Houten, & Perea-Ryan, 2010; Cleary, Horsfall, & Jackson, 2011; Cranford, 2013; Diekelmann, 2004; Siler & Kleiner, 2001). In addition, many associate degree programs are forced to hire nurses with bachelor degrees in order to fill faculty vacancies (Weidman, 2013). Most nurse educators go into the field of education because of a desire to share knowledge and help shape the next generation of nurses (Clark et al., 2010; Evans, 2013; Penn, Wilson, & Rosseter, 2008; Schoening, 2013). The literature suggests that these new nurse educators are often surprised when faced with challenges related to the differences between clinical practice and academia (Anderson, 2009; Clark et al., 2010; Cranford, 2013; Duphily, 2011; Schoening, 2013; Siler & Kleiner, 2001). Faculty moving from the role of clinical expert to novice educator may experience stress from the changes in
expectations for faculty compared to clinicians (Clark et al., 2010; Cranford, 2013; Weidman, 2013), the unique culture of academia, and confusion regarding how to design and implement effective nursing curriculum (Dunphy, Suplee, & Garner, 2009).

The challenges facing nursing and nursing education have created a vicious cycle that is concerning. The need to increase the number of nurses in the workforce is clear; however, in order to educate more nurses, nursing programs require more qualified faculty. Recruiting faculty from clinical practice, in which there is already a deficiency, further intensifies the nursing shortage. It is my hope that this study may contribute to an increased understanding of the experience an expert clinician encounters when transitioning to the role of novice educator. Future new nurse educators may benefit from information collected about the thoughts and feelings experienced by new nurse educators during the transition period and the skills that they utilized to become competent in academia. These findings may assist in the recruitment and retention of qualified faculty in the future and eventually help ease the nursing faculty shortage.

**Background**

**Nursing Faculty Shortage**

“The nurse faculty shortage involves a convoluted set of issues—academic and clinical—that have evolved over time concert with changes in nurse education and practice” (Proto & Dzurec, 2009, p. 87). There is no simple explanation for the nursing faculty shortage, and there are no easy solutions. A report by the National Advisory Council on Nurse Education and Practice (NACNEP) (2010) to the Secretary of the United States Department of Health and Human Services and United
States Congress provided a comprehensive examination of the background and scale of the current nursing faculty shortage. Their findings included four key challenges at the root of the faculty shortage:

1. Recruitment challenges.
2. Provision of adequate educational preparation specific to teaching.
3. Funding and sustaining nursing faculty programs.
4. The aging and imminent retirement of current nurse faculty.

Each of these challenges and contributing factors will be explored below.

Factors contributing to challenges with recruitment include attracting and retaining qualified faculty. Over the last few decades there has been an increase in career choices such as advanced practice for graduate-prepared nurses which have drawn them away from careers in education. Fang (as cited in NACNEP, 2010) noted that 63% of doctor of philosophy graduates and 67% of doctor of nursing practice graduates do not pursue careers in academia. Job dissatisfaction with faculty roles includes heavy workloads, long hours, demands for research and scholarship, and non-competitive salaries make recruitment and retention difficult.

In a Special Survey on Vacant Faculty Positions for Academic Year 2014–2015 done by the AACN (2015d), 1,328 faculty vacancies were identified by 651 nursing schools with baccalaureate and/or graduate programs in the United States (82.9% response rate). Of the schools that responded, it was noted that an additional 98 positions would be needed to accommodate increased student demand. The current national nurse faculty vacancy rate is 9.6%, and most open positions require or have a preference for a candidate with a doctoral degree (58.9%). The limited pool of doctorally-prepared faculty and noncompetitive
salaries were the most common reasons listed by schools having difficulty in filling positions.

Nurse educators typically enter academia much later in life. Many wait to start graduate degrees, and this delays the start of an academic career (Allan & Aldebron, 2008).

According to the AACN (2015a) *Nursing Faculty Shortage Fact Sheet*, the average ages of doctorally-prepared nurse faculty holding the ranks of professor, associate professor, and assistant professor were 61.3, 57.7, and 51.5 years, respectively. For master’s degree-prepared nurse faculty, the average ages . . . were 57.2, 56.8, and 51.2 years, respectively. (Factors Contributing to the Faculty Shortage section, para. 1)

A substantial percentage of nurse educators are poised to leave the profession in the next decade. Those nurses currently in the pipeline will not be able to fill these vacated positions, let alone add to the positions needed to increase capacity.

Challenges related to providing adequate educational preparation for teaching include the high cost of graduate education, the burden of graduate loans and lost income while seeking a graduate degree, and salary differentials between those in academia and clinical practice (NACNEP, 2010). Many nurses pursue advanced degrees leading to roles in nursing administration, research, or advanced clinical practice (NACNEP, 2010).

Prior to the 1970s, most master’s degree programs in nursing focused on preparation for education or administration. A 1969 position statement on graduate education from the American Nurses Association (n.d.) called for graduate programs to shift their focus to clinical specialization and “the preparation of nurse clinicians capable of improving nursing care through the advancement of nursing theory and science” (p. 4). This led to a decrease in the number of graduate programs offering
nursing education as a specialty area, a trend that has continued until the present. There has been a surge of practice-focused master and doctor of nursing practice programs with 269 schools now offering a practice doctorate and 18,352 students compared to 5,290 students enrolled in research-focused doctoral programs (AACN, 2014). Despite a recent increase in the number of doctoral programs, graduates of both practice- and research-focused programs spend little time preparing graduates for the role of nurse educator (Lewallen & Kohlenberg, 2011).

The role of nurse educator is complex and multifaceted. Preparation as expert clinician does not necessarily ensure an effective educator (Starnes-Ott & Kremer, 2007). “Becoming a nurse educator is not an additive process; that is, it is not a matter of adding the role of educator to that of the nurse” (Infante, 1986, p. 94). The educational preparation and skill sets required by nurse educators have been studied for decades. The 2002 Position Statement by the NLN affirmed that,

> there is core knowledge and skills that are essential if one is to be effective and achieve excellence in the role. That core knowledge and skills entails the ability to facilitate learning, advance the total development and professional socialization of the learner, design appropriate learning experiences, and evaluate learning outcomes. (p. 2)

In 2005, the NLN clearly identified and defined eight core competencies for nurse educators in The Scope of Practice for Academic Nurse Educators and was the first national nursing organization to assert that the nurse educator role requires specialized preparation. In 2005 the NLN (n.d.) also started the Academic Nurse Educator Certification Program, recognizing that the role of nurse educator is an “advanced professional practice discipline with a defined practice setting and demonstrable standards of excellence” (para. 2).
New faculty entering academia often find the transition to be challenging, with many feeling inadequately prepared and overwhelmed (Anderson, 2009; Anibas, Brenner, & Zorn, 2009; Bailey, 2012; Chapman, 2013; Cooley, 2013; Dempsey, 2007; Dunham-Taylor, Lynn, Moore, McDaniel, & Walker, 2008; Duphily, 2011; Gwin, 2012; Mann, 2013; McDonald, 2004; McDonald, 2010; Parslow, 2008; Paul, 2015; Rich & Nugent, 2010; Sawatzky & Enns, 2009; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013; Wilson, Brannan, & White, 2010; Young & Diekelmann, 2002).

Although clinical expertise is a critical component to the success of the nurse educator, knowledge of teaching and learning, curriculum design and evaluation, assessment, scholarship, and functioning within the educational environment are essential competencies necessary to develop proficiency in the faculty role (NLN, 2005). Typically, the transition process requires a period of adjustment (Danna, Schaubhut, & Jones, 2010), socialization into the academic community, and development of the tripartite expectations of teaching, research, and service (Jacobson & Sherrod, 2012). However, students expect novice faculty members to immediately function as competent or expert educators and clinicians (McDonald, 2010).

Nursing faculty find themselves in the unique position of balancing the demands of the academic role: attending to the requirements of the college or university, remaining clinically current, integrating theory into clinical experiences for students, and trying to keep up with changes in technology and the healthcare environment. This balancing act is a daunting task for any faculty member and leaves many feeling dissatisfied with the position and possibly leaving the profession (Roughton, 2013). Preparation and support for nurses for the faculty role is essential.
to achieve professional fulfillment (Danna et al., 2010) and a healthful work environment (NLN, 2006).

**Demand for Enrollment**

As colleges and universities across the United States struggle to fill vacancies for nursing faculty positions, the demand for expanded enrollment capacity increases. Employment of RNs is projected to grow 19% from 2012 to 2022, faster than the average for all occupations (United States Department of Labor, Bureau of Labor Statistics, 2014); they also project the need for 525,000 replacement nurses in the workforce, which brings the total number of job openings for nurses due to growth and replacements to 1.05 million by 2022. Findings in the AACN (2014) *2013-2014 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing* report demonstrated a strong interest in nursing; however, 78,089 qualified applicants were turned away primarily due to inadequate numbers of faculty, clinical sites, clinical preceptors, and budget constraints. The NLN (2012) data from the *Findings from the Annual Survey of Schools of Nursing: Academic Year 2011–2012* included data from practical nurse and associate degree in nursing programs and cite similar findings with lack of clinical placements and lack of faculty as the two primary obstacles to expanding capacity in pre-licensure programs.

The nation relies on graduates of both two- and four-year institutions for the majority of its RN workforce. Both types of programs contribute “individually to collectively building a strong nursing workforce” (American Association of Community Colleges, 2011). The majority of new RNs are educated in associate degree in nursing programs; however, due to the shortages of faculty and clinical sites, associate degree in nursing programs rejected 46% of qualified applications, compared
with 37% of baccalaureate applicants and 21% of diploma applicants in the 2009–2010 academic year (American Association of Community Colleges, 2011). Clearly, enrollment capacities need to be expanded in all levels of RN education to meet current and future demand.

**Strategies to Increase Supply**

The recruitment of clinical experts into academia is one strategy utilized to ease the faculty shortage. Opportunities for teaching positions are being offered to expert clinicians by both community colleges and universities (Bonnel, Starling, Wambach, & Tarnow, 2003; Cangelosi, Crocker, & Sorrell, 2009; Clark et al., 2010; Diekelmann, 2004; Penn et al., 2008). Many nursing schools report utilizing expert clinical practice nurses who may lack formal academic preparation in nursing education to fill vacancies (Anderson, 2009; Brendtro & Hegge, 2000; Cleary et al., 2011; Diekelmann, 2004; Siler & Kleiner, 2001). Novice nurse educators entering academia today have less preparation in formal nursing educational theory than a generation ago (Schoening, 2013). Several reasons are cited for the lack of preparation: decreased enrollment in formal nursing education programs, decreased number of nursing education programs, and increased interest in advanced practice programs (Bonnel et al., 2003; Brendtro & Hegge, 2000).

**Statement of the Problem**

The nursing faculty shortage has reached a critical point and is expected to worsen as current faculty reach retirement age. Recruiting bachelor- and master-prepared clinical experts into academia may be a human resources solution to the nursing faculty shortage; however, many expert clinicians lack formal preparation or
orientation to the role. Nursing programs have a responsibility to assure that novice faculty are competent to teach and to help them progress in their roles as educators.

**Purpose of the Study and Research Question**

The primary purpose of this research study was to explore and describe the lived experience of clinical nurse experts transitioning into the role of novice educator. This study sought to gain insight into the real-life experiences of novice nurse educators and understand their perceptions and meaning of their transition experience. The paradigm of hermeneutic phenomenology addressed the central research question:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

Sub-questions included:

Q1a Why did the practicing nurse choose a career in academia?

Q1b What factors helped or hindered the transition process?

Q1c What knowledge, skills, and attitudes do practicing nurses bring from a clinical setting that helped in the transition to academia?

Q1d How does a novice nurse educator learn the teaching role during the first three years?

The goal of this study was to present a rich, composite description of the experience, which is important for understanding the meaning of role transition through the stories of expert clinical nurses as they have transitioned to the role of nurse educators.

**Significance of the Study**

In 2007, the NLN (2007b) issued a position statement outlining the urgent need to support research to build the science of nursing education, including faculty preparation and development and recruitment and retention strategies among others.
The 2013 NLN Board of Governors’ *A Vision for Doctoral Preparation for Nurse Educators* called “for new ways to value the complex role of the nurse educator and to promote the practice of expert clinicians who can translate their knowledge and skills for students at all levels through evidence-based teaching” (p. 4).

The reality of the current and projected nursing faculty shortage makes the timing of this study both relevant and significant. This shortage of full-time nursing faculty in all levels of nursing education means that thousands of qualified applicants are turned away from nursing schools around the country each year because there are simply not enough educators to teach. To address this problem, many expert clinicians are being recruited from the practice setting to academia who lack the knowledge and formal preparation about the responsibilities of the nurse educator that are critical to effectively teach pre-licensure students. As a result, many novice educators feel inadequately prepared and overwhelmed by their new role which, in turn, may lead to decreased satisfaction and intent to leave the profession (Roughton, 2013).

Describing the transition experience of the expert nurse to novice educator is imperative to the development of strategies, which may help those who are making the transition. A successful and healthy transition experience from clinical practice to academia will facilitate the progression of the nurse educator from a novice to an expert. In turn, this will improve the recruitment and retention of qualified faculty and eventually help ease the nursing faculty shortage.

**Theoretical Framework**

The theoretical framework for the study was based on “Experiencing Transitions” theory by Meleis, Sawyer, Im, Messias, and Schumacher (2000), which
provided a comprehensive perspective on the transition experience while considering the individual and the context of the transition. Transitions theory is a middle-range theory which evolved from the Chick and Meleis (1986) original concept analysis of transition. Transitions theory has evolved over the four decades since the Chick and Meleis initial conceptualization and has been tested and supported by Meleis and others examining the transition experiences of diverse groups in a variety of transition experiences (Im, 2006).

A common definition of transition noted by Meleis (2010) is the,

passage from one fairly stable state to another fairly stable state . . . a process triggered by a change. Transitions are characterized by different dynamic stages, milestones, and turning points and can be defined through processes and/or terminal outcomes. (p. 11)

Meleis’ (1986) definition of transition provided an appropriate conceptual definition of transition for this study. Transition is,

the period in which a change is perceived by a person or others, as occurring in a person or in the environment. Commonalities that characterize a transition period: 1) disconnectedness from usual social network and social support systems; 2) temporary loss or familiar reference points of significant objects or subjects; 3) new needs that may arise or old ones not met in a familiar way; and 4) old sets of expectations no longer congruent with changing situations. A transition denotes a change in health status, role relations, in expectations, or in abilities. (p. 42)

Regardless of the type of transition, Schumacher and Meleis (1994) identified three indicators of a positive transition or healthy outcome: subjective well-being, role mastery, and well-being of relationships. Nursing interventions can then be “aimed at assisting clients to create conditions conducive to a healthful transition” (p. 47).

Experiencing transitions theory provided a suitable lens to explore the meaning of the lived experience of transition from clinical expert to novice nurse educator. The
meaning of this experience may aid in the development of nursing interventions that facilitate a positive transition experience.

A transition occurs when moving from the role of a novice to an expert and vice versa. Benner’s (1984) seminal work, *From Novice to Expert,* applied the Dreyfus and Dreyfus (1980) model of skill acquisition in nursing practice and provided a context for defining the concepts of expert and novice nurse. Benner’s (1984) research and subsequent theory posited that in the acquisition and development of a skill, one must pass through five levels of proficiency: beginner, advanced beginner, proficient, competent, and expert.

Beginning nurses have no experience in the situations in which they are expected to perform; their actions are guided by context-free rules, they are unable to use discretionary judgment, and their focus is on pieces rather than the whole. Advanced beginner nurses can demonstrate marginally acceptable performance, are able to recognize recurrent meaningful components, need help setting priorities, and are unable to see the entirety of a new situation. Proficient nurses have two to three years of experience and are aware of all relevant aspects of a situation, are able to plan based on consideration of the whole problem, are able to set priorities, and exhibit developing critical thinking skills. Competent nurses are able to perceive situations as wholes rather than aspects and can begin to see patterns; decision-making is less labored as the nurse has perspective about important aspects. The expert nurse has an intuitive grasp of situations, uses highly skilled analytical tools, and performs holistically, not fractionally. The decision-making process of expert nurses is difficult to describe because they operate from a deep understanding of the total situation (Benner, 1984).
Although Benner’s (1984) model identified characteristics of novices and experts within the context of clinical practice and focused on the progression from novice to expert, Benner (1984) asserted that any nurse entering a new setting where she has no experience with the population may be limited to the novice level of performance. There is a convincing parallel drawn in the literature that supports the utilization of the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) in the field of education in the works of Berliner (1988), Dempsey (2007), Lyon (2015), Poindexter (2013), Ramsburg and Childress (2012), Siler and Kleiner (2001), and Weidman (2013).

**Research Design**

The methodology for this study was a qualitative phenomenological approach. Qualitative researchers seek a holistic understanding of social phenomenon in the real world from the viewpoint of the individual being studied. “Phenomenology aims to bring these experiential realities to language” (van Manen, 2014, p. 69) through the creation of descriptive and interpretive text (van Manen, 2014). The phenomenon of interest is the transition experienced by expert nurses who move from the role of expert clinical nurse to novice nurse educator. A phenomenological method was an appropriate choice for this study because it afforded this researcher an opportunity to explore the lived experience of novice nurse educators in order to create a deeper understanding of meaning of the experience.

Phenomenology is not only a methodology but is a philosophy with epistemological and ontological aspects (Mackey, 2005). Two main phenomenological approaches (descriptive and interpretive) are rooted in philosophies of Husserl and Heidegger and examine the lived experience of individuals and the
meaning of that experience (Polit & Beck, 2012). Each approach has unique philosophical underpinnings which differ in relation to their philosophical values, how findings are generated, and how those findings are utilized to build nursing knowledge (Lopez & Willis, 2004).

Researchers using descriptive or Husserl-inspired phenomenology seek to reveal the meaning of the intentional relationship between the subject in philosophy (the experiencer) and the object in philosophy (the something that is experienced) (Vagel, 2014). Descriptive phenomenologists are primarily interested in answering the question, “what do we know as persons” (Polit & Beck, 2012, p. 495) through rich descriptions of the phenomenon as it is experienced by the individual. Descriptive phenomenologists seek to describe everyday conscious experiences in their pure form through a process of bracketing or setting aside all presuppositions or preconceived opinions (Reiners, 2012).

Heidegger, a student of Husserl, challenged some of his mentor’s philosophical assumptions and moved away from a focus on experiential epistemology to interpretive phenomenology or hermeneutics. Heidegger stressed understanding and interpreting meanings found in experiences, not just describing phenomenon as they are found in the world. Heidegger rejected the theory of knowledge or epistemology and adopted ontology, the science of being. The central question of interpretive phenomenology is, What is being? The goal of interpretive phenomenology is to enter another individual’s world in order to interpret and describe human experience (Converse, 2012; Lopez & Willis, 2004; Polit & Beck, 2012; Reiners, 2012; Vagel, 2014). Heidegger believed it was impossible to negate one’s own experiences and prior understanding of the phenomenon under study; therefore, hermeneutics allows
the researcher to describe and interpret the participant’s experience with the phenomenon without bracketing one’s own biases and prior knowledge (Reiners, 2012).

The modified hermeneutic approach of van Manen (1990) informed this study of the lived experiences of expert clinicians transitioning to the role of novice nurse educator. Van Manen’s (1990) hermeneutic phenomenology combines both descriptive and interpretive approaches. Van Manen (1990) used the term human science research interchangeably with phenomenology and hermeneutics to study “persons or beings that have consciousness and that act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world” (p. 4). Human science attempts to describe and interpret the meanings of lived experience with depth and richness through language (van Manen, 1990).

Assumptions, Limitations, and Delimitations

Assumptions

To address the main purpose of this study, the researcher utilized a qualitative phenomenological method. Assumptions acknowledged in this study included:

1. Participants are truthful and able to recall the events of their transition experiences with accuracy.
2. The researcher also assumed that the utilization of a qualitative method is the appropriate choice to produce rich, comprehensive findings to fill in existing gaps in the existing body of knowledge in nursing education.
3. Role transitions take place for all expert clinical nurses assuming positions as novice nurse educators.
4. There are a fundamental set of competencies and skills required to be an effective, expert nurse educator.

5. Benner’s (1984) model for defining the concepts of novice and expert nurses in clinical practice has similarities in the context of nursing education.

Limitations

The following limitations are noted as inherent in the research design:

1. The main data collection technique is interview which may lead to misinterpretation of data by the researcher.

2. A small convenience sample of nurse educators does not allow findings to be transferable to the larger population of nurse educators.

Delimitations

The scope of this study was narrowed to focus on full-time nursing faculty members teaching pre-licensure students who had been teaching less than three years. The study did not include part-time or adjunct faculty employed by academic institutions.

Definition of Terms

Expert clinical nurse: Benner (1984) described the expert in clinical practice as an individual with extensive experience who is able to intuitively comprehend a situation and make rapid decisions. Experts operate out of a deep and holistic understanding of a situation and no longer rely on rules or guidelines to connect that understanding to action. For the purpose of this study, an expert nurse had a requisite of five years of clinical experience (Anderson, 2009; Benner, 1984).
**Full-time nurse educator:** Those nursing faculty who are hired to work on a full-time appointment according to the definition of the institution (tenure track or non-tenure track position). This was determined by participant self-identification since each community college had a different academic calendar and formula for calculating full-time workload.

**Lived experience:**

Active and passive living through experience. Lived experience names the ordinary and the extraordinary, the quotidian and the exotic, the routine and the surprising, the dull and the ecstatic moments and aspects of experience as we live through them in our human existence. (van Manen, 2014, p. 39)

**Novice nurse educator:** Benner (1984) described a novice as an individual who lacks experience or knowledge in the situation he or she is expected to perform in. For the purpose of this study, a novice nurse educator included bachelor- and master-prepared nurses who had been in the academic setting less than three years (Cooley, 2013). Novices, in this study, had no formal academic preparation for the nurse educator role and had been in their academic roles.

**Phenomenological research:** An inductive, subjective, and dynamic research approach/method developed from phenomenological philosophy that focuses on gaining a deeper understanding of the nature or meaning of the lived experiences of persons (Flood, 2010; Polit & Beck, 2012; Reiners, 2012; van Manen, 1990).

**Organization of the Remainder of the Study**

Chapter I provided an introduction to the problem and an overview of the background, context, and theoretical frameworks underpinning this study. The purpose, chosen methodology, and relevance and significance to nursing was
discussed. Chapter II will provide an in-depth review of the literature and discussion of the theoretical frameworks as they relate to the phenomenon of interest. Chapter III will introduce the chosen methodology for the study. Chapter IV will provide the details of the data collected, data analysis, and results. Chapter V will present the conclusions and recommendation for future research relevant to the transition experience of expert clinical nurses to novice nurse educator roles.
CHAPTER II

LITERATURE REVIEW

Introduction to the Literature Review

The purpose of this chapter is to present a review of the scholarly literature pertaining to the transition of nurses from clinical practice to academia. This chapter is organized as follows: First, the Meleis et al. (2000) experiencing transitions theory is introduced as the theoretical framework for this study. Second, the concepts of novice and expert are explored using Benner’s (1984) novice to expert model. Third, factors contributing towards the shortage of nursing faculty are presented to provide context for this study. A review of the literature pertaining to the transition of nurses from clinical to academia and gaps in the literature are identified.

An extensive review of the literature was performed utilizing a variety of databases, including: Cumulative Index to Nursing and Allied Health (CINAHL), Ovid Technologies, Inc. (OVID), ProQuest Direct (Dissertations and Theses), and Elton B. Stephens Co. (EBSCO). Electronic databases were searched for articles, unpublished dissertations, and published articles between 2000 and 2015. Search terms used included nursing instructor, nurse educator, nursing faculty, nursing programs, educational preparation, nursing shortage, transition, nursing role transition, novice, expert, and skill acquisition. Classic works, which were frequently cited in the literature, were also included. Decision-making for inclusion in this review was based
on an appraisal of the abstract for significant content related to the topic and a lack of serious methodological flaws. This chapter presents research and theoretical literature on the transition theory, skill acquisition, nursing shortage, and transition from practice to academia.

**Theoretical Framework**

**Experiencing Transitions Theory**

The purpose of this study was to examine the lived experience of the clinical expert’s transition to the nurse educator role. The theoretical framework for this study utilizes experiencing transitions theory by Meleis et al. (2000) which provides a holistic perspective on the transition experience while considering the individual and the context of the transition (Im, 2006). All humans experience transitions during their lifetime; for example, getting married, becoming a parent, starting a career, changing careers, moving, or suffering a loss. Nurses have always played a pivotal role in caring for individuals experiencing transitions in their lives, such as during periods of illness or when transitions themselves cause health-related behaviors (Meleis, 2010). Transitions can trigger changes in roles, relationships and support systems, and create periods of instability (Meleis, 2010). Meleis (2010) contended that transitions are of central concern to the discipline of nursing because of the “potential risk that the transitional experience may place on them [the individual]. Preventing these risks, enhancing well-being, maximizing function, and mastering self-care activities are outcomes that nurses strive for in their interventions” (p. xv).

Meleis’ earliest work with transitions began in the 1960s when she focused on the phenomena of developing and mastering parenting roles and spousal communication in planning pregnancy (Im, 2006). However, her early work did not
include the investigation of transitions between significant events. Meleis’ subsequent research focused on ineffective role transitions and nursing interventions that help individuals make healthy transitions. This work led Meleis to the conceptualization of role insufficiency and then later, role supplementation (Im, 2006). Role insufficiency was defined as “the perception of role performance as inadequate by the self and/or by a significant other, and the behavior and sentiment associated with such perception” (Meleis, 1975, p. 266). Role supplementation was defined as,

any deliberative process whereby role insufficiency is identified by the role incumbent and significant others, and the conditions and strategies of role clarification and role taking are used to develop a preventive or therapeutic intervention to decrease, ameliorate, or prevent role insufficiency. (Meleis, 1975, p. 267)

Meleis met Chick in the mid-1980s, and together they developed transition as a concept and published this work in 1986. Building on the work of Chick and Meleis (1986), Schumacher and Meleis (1994) completed a review of the literature to find out how extensively transition was used as a concept or framework. Schumacher and Meleis reviewed 310 articles on transition and continued to develop the transition framework started by Chick and Meleis (Im, 2006).

“Experiencing Transitions” (Meleis et al., 2000) evolved from the Chick and Meleis (1986) original concept analysis of transition and the Schumacher and Meleis (1994) transition framework. Over the last four decades this middle-range theory has been tested, refined, and supported by Meleis and others who have examined the transition experiences of diverse groups in a variety of settings (Im, 2006). The following sections provide a description of the experiencing transitions theory components, beginning with definitions, structure and characteristics, properties,
types, conditions, process indicators, outcome indicators of transition, and nursing therapeutics.

**Definitions of transition.** Transition is a multi-dimensional concept that occurs over a span of time and denotes a passage from “one life phase, condition, or status to another” (Chick & Meleis, 1986, p. 239). A common definition of transition noted by Meleis (2010) is the,

> passage from one fairly stable state to another fairly stable state . . . a process triggered by a change. Transitions are characterized by different dynamic stages, milestones, and turning points and can be defined through processes and/or terminal outcomes. (p. 11)

Meleis (1986) also offered the following definition of transition:

> Transition is the period in which a change is perceived by a person or others, as occurring in a person or in the environment. Commonalities that characterize a transition period: 1) disconnectedness from usual social network and social support systems; 2) temporary loss of familiar reference points of significant objects or subjects; 3) new needs that may arise or old ones not met in a familiar way; and 4) old sets of expectations no longer congruent with changing situations. A transition denotes a change in health status, role relations, in expectations, or in abilities. (p. 19)

Meleis and Trangenstein (1994) discussed the difference between transition and change. Change is defined as “the act or instance of making or becoming different; the substitution of one thing for another, an alteration or modification” (Change, n.d.). Meleis and Trangenstein cited three differences between transition and change. First, changes tend to be abrupt, where transition “occurs over time and have a sense of flow and movement” (p. 257). Transition incorporates aspects of change but also includes flow and movement. The nature of change in transition is different than just change in general. Change (as a result of transition) at the individual and family level occurs in “identities, roles, relationships, abilities, and patterns of behavior. At the organizational level, changes occur in structure, function, or the
dynamics of an organization” (Meleis & Trangenstein, 1994, p. 258). Finally, “internal processes usually accompany the process of transition, while external processes tend to characterize change” (Meleis & Trangenstein, 1994, p. 258).

**Universal structure of transition.** Chick and Meleis (1986) posited that individuals experience transitions differently even when the context is the same; for example, when a person becomes a first-time parent. Despite differences in individual transition experiences, there are commonalities and a universal structure to transitions. Transitions consist of three phases: entry, passage, and exit. Although the length of time spent in each phase may vary, the sequence is the same (Chick & Meleis, 1986). In addition, certain conditions may inhibit the passage through a phase at any given time, and phases are more likely to merge together rather than be discrete (Chick & Meleis, 1986).

**Entry phase.** This phase begins when the transition is first anticipated. Antecedents to transition include but are not limited to events such as illness, loss, hospitalization, pregnancy, and retirement (Chick & Meleis, 1986).

**Passage phase.** The transition itself occurs in this phase. There are five commonalities that characterize a transition:

- **Process.** Transition is a process that may vary in length, intensity, and the boundary-related behaviors (a transition is a bounded phenomenon which implies there are limits to the process) for each individual. There is “a sense of movement, a development, a flow associated with it” (Chick & Meleis, 1986, p. 240).

- **Disconnectedness.** Transition produces a disruption in the connections that an individual depends on for stability and security. Being connected is important to
health and requires individuals to actively relate to one another (Chick & Meleis, 1986).

**Perception.** The meaning that an individual ascribes to a transition event varies. Perceptions may influence responses and reactions to events making them less predictable (Chick & Meleis, 1986).

**Awareness.** Transition events are individual and non-structured. Chick and Meleis (1986) posited that in order to be in a transition, an individual “must have some awareness of the changes that are occurring” (p. 241).

**Patterns of response.** Individuals have different patterns of response (observable and non-observable behaviors) during a transition event. These responses may include positive responses, such as happiness and elation, or negative responses, such as irritability, depression, anxiety, and distress (Chick & Meleis, 1986). Chick and Meleis (1986) contended that “pattern recognition would be an important part of developing a taxonomy of transitions” (p. 242). Pattern recognition is important in helping to guide nursing assessment, but Chick and Meleis went on to say that in order for planning and implementation of nursing interventions to be effective, one must look at how the transition and related events are perceived by the individual. This statement has important implications for advancing nursing science, because it provides a starting place to be able to recognize commonalities in transition experiences, examines meaning in those experiences, and then plans for nursing interventions.

**Exit phase.** The exit phase occurs when a new status is attained and a period of stability is achieved (Chick & Meleis, 1986). Meleis et al. (2000) stated that in all transitions there is “a subjective element of achieving a sense of balance in one’s life”
Meleis et al. added that determining the end of a transition must remain flexible and depends on the type of change or what brought about the transition as well as the nature and pattern of transition.

**Properties of transition.** Building on the conceptual analysis of transition by Chick and Meleis (1986) and Schumacher and Meleis (1994), Meleis et al. (2000) examined the results of five studies that utilized the transitions framework to refine and extend this work. Using an integrative concept analysis strategy, “Experiencing Transitions” was developed. Meleis et al. further identified five emerging properties of transition experiences:

*Awareness.* Chick and Meleis (1986) included awareness as one of the defining characteristics of transition. However, Meleis et al. (2000) contended that individual awareness of transition is an important factor, although a lack of awareness does not prevent transition. The debate about how awareness affects transition has yet to be resolved.

*Engagement.* “Engagement is defined as the degree to which a person demonstrates involvement in the processes inherent in the transition” (Meleis et al., 2000, p. 19). Examples of engagement include seeking out resources and information, utilizing a mentor, and preparing for the transition. An individual’s level of awareness influences his or her engagement (Meleis et al., 2000).

*Change and difference.* “All transitions involve change; however not all change is related to transition” (Meleis et al., 2000, p. 19). Change may be related to critical events, disruptions to routines or relationships, perceptions, or identity. The authors posited that in order to completely comprehend the transition process, one must “uncover and describe the effects and meaning of the changes involved” (Meleis
et al., 2000, p. 19). Another essential property of transition is confronting difference which means feeling different or being perceived as different or unmet or different expectations than reality (Meleis et al., 2000).

**Time span.** All transitions are characterized by flow and movement over a period of time (Chick & Meleis, 1986; Meleis & Tranengstein, 1994). Meleis et al. (2000) added that it “may be difficult or impossible, and perhaps even counterproductive, to put boundaries on the time span of certain transition experiences” (p. 20). The authors stated that some long-term transitions have latent states of disconnectedness and change which may reactivate periodically necessitating a reassessment of outcomes (Meleis et al., 2000).

**Critical points and events.** Meleis et al. (2000) found that some transition events involve an identifiable marker such as a birth or death but others are not as readily identifiable. The authors also found most of the studies involving multiple transitions (two types of transition at the same time) included critical turning points or events and final critical points. Critical turning points were identifiable markers in time that are characterized by increased awareness of and engagement in the dealing with the change (Meleis et al., 2000). Final critical points were “characterized by a sense of stabilization in new routines, skills, lifestyles, and self-care activities” (Meleis et al., 2000, p. 21).

**Types of transition.** Chick and Meleis (1986) identified three types of transition relevant to the context of nursing: developmental, situational, and health–illness. Schumacher and Meleis (1994) later added a fourth type of transition: organizational. Examples of developmental transitions include transition to parenthood, menopause, midlife, and adolescence. Examples of situational transitions
include moving in and/or through educational or professional roles. The transition from clinical practice to academia is a type of situational transition. Health–illness transitions include discharge from the hospital, recovery after surgery or illness, or rehabilitation. Organizational transitions represent changes in the environment and may be preceded by larger changes in the economic, social, or political environment. A change in leadership in an organization is an example of such a change. Smaller changes within an organization such as policy or procedure changes are also examples of organizational transition (Schumacher & Meleis, 1994). Subsequent research by Meleis et al. (2000) supported the four types of transitions as central to nursing but added that individuals could experience more than one type of transition at one time and stated “transitions are not discrete nor mutually exclusive” (p. 18).

**Transition conditions.** Transition conditions are “factors that influence transitions and include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being” (Schumacher & Meleis, 1994, p. 121). Meleis et al. (2000) added cultural beliefs and attitudes and socioeconomic status. Conditions may aid or hinder the transition process toward a healthy outcome (Meleis et al., 2000).

**Meanings.** “Meaning refers to the subjective appraisal of an anticipated or experienced transition and the evaluation of its likely effect on one’s life” (Schumacher & Meleis, 1994, pp. 121–122). Meanings may be positive, negative, or neutral (Schumacher & Meleis, 1994).

**Expectations.** Expectations are subjective phenomena which are influenced by prior experiences and subsequently influence the transition experience (Schumacher & Meleis, 1994). Prior experiences create perspective which may or may not relate
accurately to the current transition event. When it does not, expectations for the current event may be unclear, unrealistic, and incongruent (Schumacher & Meleis, 1994).

**Level of preparation and knowledge.** The level of preparation and knowledge related to the transition event may affect the outcome and may be insufficient to meet the demand of the new situation (Schumacher & Meleis, 1994). Schumacher and Meleis (1994) cited several studies showing “the need for new knowledge and skill development as a significant aspect of transition” (p. 122). Lack of preparation for a transition has been shown to inhibit the transition process, whereas knowledge of what to expect and having strategies in place for managing transition have been shown to be helpful during transition (Meleis et al., 2000).

**Environment.** Schumacher and Meleis (1994) in an extensive review of the literature cited the “importance of resources within the environment during a transition” (p. 123). Resources may include social support from family, nurses, therapeutic groups, mentors, and role models.

**Level of planning.** “The level of planning that occurs before and during a transition . . . influences the success of the transition” (Schumacher & Meleis, 1994, p. 123). Preparation and planning may help facilitate a smooth transition (Schumacher & Meleis, 1994).

**Emotional and physical well-being.** A wide variety of emotions may be experienced during transitions. Schumacher and Meleis (1994) cited several studies where difficulties in transition manifested as stress, emotional distress, anxiety, feelings of failure, isolation, defeat, and being overwhelmed. Negative symptoms of
physical well-being may inhibit transition, whereas positive symptoms, such as energy and normal operation, aid the transition process (Schumacher & Meleis, 1994).

**Cultural beliefs and attitudes.** Meleis et al. (2000) stated that stigmas attached to cultural beliefs and attitudes may negatively influence the transition experience through the manifestation of psychologic or physiologic symptoms.

**Socioeconomic status.** Meleis et al. (2000) cited several studies showing that participants with low socioeconomic status are likely to have psychological symptoms.

**Patterns of response.** Regardless of the type of transition, Schumacher and Meleis (1994) identified three indicators of a positive or healthy transition: subjective well-being, role mastery, and well-being of relationships. Characteristics of subjective well-being include effective coping, a sense of dignity, integrity, role satisfaction, growth, liberation, self-esteem, and empowerment (Schumacher & Meleis, 1994). Role mastery is evidenced by the attainment of skilled role performance (the skills and behavior needed to manage their new situation) and comfort in new role-associated behaviors (Schumacher & Meleis, 1994). Relationship well-being may be conceptualized at the family level, organizational level, or broader social network and community level. Relationship well-being at the family and community level may be characterized by adaptation, integration, enhanced appreciation, meaningful interaction, or development of new relationships. At the organizational level it may be characterized by cooperation, effective communication, team work, and trust (Schumacher & Meleis, 1994). Schumacher and Meleis stated that it is critical for nurses to be able to identify healthy transition outcomes in order to evaluate the effectiveness of nursing interventions.
Meleis et al. (2000) replaced indicators of a healthy transition with patterns of response. Patterns of response are characterized by process and outcome indicators. Process indicators include feeling connected, interacting, location (e.g., physical and/or geographical) and being situated (e.g., time, space, and relationships), developing confidence, and coping. Outcome indicators include the mastery of new skills to manage the transition and identifying a new sense of self. Mastery of skills develops over time with experience.

**Nursing therapeutics.** Three nursing measures related to the transition experience were conceptualized by Schumacher and Meleis (1994). The first measure is assessment of readiness for transition. Assessment of readiness is a multidisciplinary effort which requires a comprehensive understanding of the individual. Each of the transition conditions mentioned previously should be assessed in order to create a profile of the individual’s readiness for transition and to identify patterns of the transition experience (Im, 2006; Meleis et al., 2000). The second measure is preparation for the transition. Education is the primary method for preparing for the transition and creating optimal conditions for transition (Im, 2006; Meleis et al., 2000). The third nursing therapeutic is role supplementation which was introduced earlier in Meleis’ (1975) concept analysis of role insufficiency and role supplementation. The middle-range experiencing transitions theory (Meleis et al., 2000) did not expand the concept of nursing therapeutics any further (see Figure 1).

Transition is the passage from “one life phase, condition, or status to another” (Chick & Meleis, 1986, p. 239). When nurses transition from the role of clinical expert to novice educator they experience a situational transition which includes different expectations, roles, skills, and role relationships. Experiencing transitions
theory (Meleis et al., 2000) provided a suitable lens to explore the meaning of the lived experience of transition from clinical expert to novice nurse educator. Understanding the meaning of this experience may aid in the future development of nursing interventions that facilitate a positive transition experience.


**Benner’s Novice to Expert Model**

Benner’s (1984) seminal work, *From Novice to Expert*, applies the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) in nursing practice and provides a context for defining the concepts of expert and novice nurse. Although new nurse
educators are experienced and skillful clinicians, they begin new roles in academia as novices. Although Benner’s original model described the transition of the novice nurse in clinical practice, Benner, Tanner, and Chelsea (2009) posited in a subsequent study that “this work has proven itself relevant for other practice disciplines such as medicine, social work, teaching, occupational therapy, physical therapy, and others” (p. xxiii). These authors were hypothesizing that it would serve well as a model for describing the concepts of novice and expert in academia.

Mathematician Stuart Dreyfus and philosopher Hubert Dreyfus studied the acquisition of skills in airline pilots, chess players, automobile drivers, and adult learners of a second language and noted a common pattern of skill development in all cases (Dreyfus & Dreyfus, 1980). The Dreyfus research and subsequent model posited that in the acquisition and development of a skill, a student must pass through five levels of proficiency: beginner, advanced beginner, proficient, competent, and expert (Dreyfus & Dreyfus, 1980). Dreyfus and Dreyfus (1980) posited that individuals acquire a skill through instruction and experience and that there are “qualitatively different perceptions of his task and/or mode of decision-making as his skill improves” (p. 19). They also maintained that not all individuals will reach an expert level in skill acquisition. A description of each of the phases as applied by Benner (1984) and Benner et al. (2009) to nursing practice is summarized below.

In three studies spanning two decades, Benner applied the Dreyfus model to the acquisition of skills in nursing practice. In 1984, Benner published findings from a study aimed at exploring experiential learning in nursing practice, skill acquisition based on clinical learning, and accrual of knowledge in the practice of nursing. Using a Heideggarian phenomenological methodology, Benner drew conclusions from
interviews of expert and novice nurses and formed the purpose and conceptual foundation of the book, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. The aim of Benner’s (2004) second study was “to describe skill acquisition in critical care nursing practice and describe the practical knowledge embedded in expert practice” (p. 188). This research resulted in the publication, *Expertise in Nursing Practice: Caring, Clinical Judgement, and Ethics* (Benner et al., 2009). Building on the 1984 study, Benner and colleagues revealed new aspects of each stage of skill acquisition and provided a “thicker description of the acquisition of clinical expertise . . . and a much more extended examination of the nature of clinical knowledge, clinical inquiry, clinical judgement, and expert ethical comportment” (Benner et al., 2009, p. xix). The third study (Benner et al., 2009) expanded the sample of the second study to include nurses in other critical care areas such as the emergency department and post anesthesia care unit.

The Dreyfus model “is developmental, based on situated performance and experiential learning” (Benner, 2004, p. 188) in a complex environment over time. The Dreyfus model is not intended to focus on talents or traits of the individual or specific competencies, but looks at actual performance and outcomes of a given situation (Benner et al., 2009). The model allows for an individual to be at different stages of skill in different areas of practice. For example, a nurse may be an expert in critical care and a novice in obstetrics because of differences in experience and knowledge in the two areas.

Benner (1984) distinguished between practical knowledge and theoretical knowledge and stated that the two are often misunderstood and that practical knowledge has been largely unstudied and undocumented. Practical knowledge is the
skills that are acquired in clinical practice; this type of knowledge or “knowing how” is differentiated from “knowing that” (p. 2). Benner (1984) went on to say that one cannot always theoretically account for practical knowledge of common activities and that it is possible in “knowing how” without “knowing that.”

Benner (1984) described experience as the refinement of theory through encounters with actual practice situations. It is not meant to convey a sense of time passing or longevity in a position. Experience is defined as “refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory” (Benner, 1984, p. 36). Benner (1984) stated that there is a relationship between experience and expertise and that “experience is a requisite for expertise” (p. 3). This difference is attributed to the practical knowledge that is acquired through experience when the expert nurse is able to perceive a situation holistically and move to an accurate decision without wasting time on a large number of irrelevant options.

The five stages of skill development reflect changes in three different aspects of skilled performance:

1. Movement from reliance on abstract principles to the use of past concrete experience as paradigms.
2. From learning pieces to a complex whole with the ability to focus on relevant components at a time.
3. A passage from detached observer to involved performer. (Benner, 1984, p. 13)

**Novice.** Benner et al. (2009) classified the novice nurse as the individual beginning the first year of nursing education. Beginning nurses have no experience in the situations in which they are expected to perform; their actions are guided by context-free rules, they are unable to use discretionary judgment, and focus is on
pieces rather than the whole (Benner, 1984). The rules which govern their practice must not require prior experience and must provide a safe starting point for learning in a given situation (Benner, 2004). The novice nurse utilizes theoretical knowledge in the practice of nursing; however, Benner et al. (2009) stated that even in this beginning stage, theoretical knowledge can require some ability to apply assessments based on prior experience in other domains. “For example, any adult beginning nursing school can identify a state of high agitation, even though no formula applied to objective features such as heart rate can consistently do this job” (Benner et al., 2009, p. 10).

**Advanced beginner.** Benner et al. (2009) classified the nurse transitioning from nursing school to professional nursing practice as an advanced beginner. Advanced beginners demonstrate “marginally acceptable performance” (Benner, 1984, p. 22), are able to recognize recurrent meaningful components, need help setting priorities, and are unable to see the entirety of a new situation. Advanced beginners have enough experience with real situations to note meaningful situational components (Benner, 1984). Dreyfus distinguished situational components from context-free elements which may be recognized without reference to the overall situation (Dreyfus & Dreyfus, 1980). Benner et al. (2009) noted that advanced beginners have a new level of responsibility and entitlement brought about by full legal and professional responsibility for patients. This new responsibility brings an increased attentiveness to different aspects of situations; however, there is a lack of integration of information and the advanced beginner tends to pay close attention to the practice of colleagues and may seek out good and trustworthy sources of information. Advanced beginners may experience anxiety and fatigue because they
have difficulty prioritizing all of the tasks required of a given situation because they seem to share equal priority (Benner et al., 2009).

**Competent.** The competent stage is reached by the nurse who has been on the same job or a job with similar situations for two to three years (Benner, 1984). (In the subsequent study, Benner et al. [2009] stated one to two years in practice). The competent nurse is able to perceive situations as a whole, rather than separate or distinct aspects, and can begin to see patterns; decision-making is less labored as the nurse has perspective about important aspects (Benner, 1984). Benner et al. (2009) posited that the competent nurse is able to plan for “what are now more predictable futures” (p. 193). Since the competent nurse has more experience with different clinical situations, the competent nurse analyzes and tries to predict the needs of the immediate future in order to reduce the unexpected. With more experience, the competent nurse recognizes that there are many relevant aspects to a given situation and realizes there are no rules that will help predict what may happen in that situation. A more focused anxiety replaces the generalized anxiety which characterizes the advanced beginner (Benner, 2004). The competent nurse copes with this anxiety by choosing which elements can be addressed and which can be ignored. There is a greater sense of responsibility at this stage as the competent nurse can no longer rationalize that she has not been “given good enough rules” (Benner et al., 2009, p. 12). The nurse feels responsible and emotionally involved as a result of his or her choices.

**Proficient.** Proficient nurses have two to three years of experience and are aware of all relevant aspects of a situation, are able to plan based on consideration of the whole problem, are able to set priorities, and exhibit developing critical thinking
skills (Benner, 1984). In 2009 Benner et al. stated that the proficient stage is said to be the transition to expertise in which the nurse is able to recognize the changing relevance of a situation, know what needs to be done, and respond appropriately. Benner et al. (2009) posited that this stage is characterized by an increase in perceptual acuity and responsiveness to a particular situation. This stage is also characterized by a qualitatively different way of being as the nurse moves from “knowing how” to “knowing that” through experience (Benner et al., 2009).

**Expert.** The expert nurse has an intuitive grasp of situations, uses highly skilled analytical tools, and performs holistically, not fractionally. “Expert practice is characterized by increased intuitive links between seeing the salient issues in a situation and ways of responding to them” (Benner et al. 2009, p. 137). The decision-making process of the expert nurse is difficult to describe because he or she operates from a deep understanding of the total situation (Benner, 1984). Benner et al. (2009) and Dreyfus and Dreyfus (1980) illuminated the concept of intuition, stating that “it is neither wild guessing nor supernatural inspiration but is the sort of ability, explainable in physiological terms, that we use all the time as we go about our everyday tasks” (Benner, 1984, p. 11). Dreyfus and Dreyfus used the term intuition synonymously with know-how and added that it is “understanding that effortlessly occurs upon seeing similarities with previous experiences” (p. 28). A phrase associated with expertise is “seeing the big picture.” The big picture includes a grasp of the present situation as well as a sense of the future: recognizing anticipated courses and possibilities for the patient and family as well as seeing and understanding the needs of other patients and nurses on the unit (Benner et al., 2009).
Application of novice to expert model in the field of education. The novice to expert model is considered a seminal work of Benner (1984). The understanding of what makes an expert nurse has been instrumental in creating clinical ladder systems in hospitals, developing preceptor and mentor roles, and establishing transition programs for new graduates (Altmann, 2007; Dracup & Bryan-Brown, 2004). It has also been used as a professional excellence model for hospitals (Marble, 2009) and a curricular framework for nursing education programs (English, 1993) and nursing courses (Carlson, Crawford, & Contrades, 1989). Altmann (2007) acknowledged the value of Benner’s contribution to nursing in her evaluation of the novice to expert model, stating it has become “widely used in nursing practice, research, education, and administration” (p. 114).

Although Benner’s model identifies characteristics of novices and experts within the context of clinical practice and focuses on the progression from novice to expert, Benner (1984) posited that any nurse entering a new setting where he or she has no experience with the population may be limited to the novice level of performance. There is a convincing parallel drawn in the literature that supports the utilization of the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) in the field of education in the works of Berliner (1988), Dempsey (2007), Lyon, (2015), Poindexter (2013), Ramsburg and Childress (2012), Siler and Kleiner (2001), and Weidman (2013). Each of these works is described below.

Berliner (1988) applied the Dreyfus and Dreyfus (1980) model of skill acquisition to education, stating that in the development of expertise in teaching, individuals pass through five stages of skill development. Berliner’s descriptions of novice, advanced beginner, and competent teachers mirrored those of Dreyfus and
Dreyfus and Benner (1984); however, there were differences noted in the description of proficient teachers. The descriptions for each of the stages of skill acquisition were based on data collected from multiple studies by Berliner and colleagues in the following areas: interpreting classroom phenomena or events, discerning the importance of events, use of routines, predicting classroom phenomena, judging typical and atypical events, evaluating performance, and responsibility and emotion. A summary of the stages is outlined below.

The novice teacher is generally a student or first-year teacher. Novice performance is rational and guided by a set of theory-based rules and procedures which novices were told to follow (Berliner, 1988). Berliner (1988) suggested that only marginal performance should be expected from novices as they gain experience through real-life teaching.

The advanced beginner begins to utilize accumulated experience and knowledge as a context to guide behavior. The advanced beginner shows more insight but still has difficulty prioritizing (Berliner, 1988). Berliner (1988) stated that there are two characteristics that competent teachers demonstrate: They make conscious choices about what they are going to do, and they set priorities and decide on plans. Competent teachers are more engaged and feel more responsibility for successes and failures, but are “not yet fast, fluid, or flexible in their behavior” (Berliner, 1988, p. 10).

The proficient teacher was described by Berliner (1988) as an individual who uses intuition or know-how to guide behavior, a deviation from the Dreyfus and Dreyfus (1980) and Benner (1984) models, where intuition is seen only at the expert level. The proficient teacher uses his or her wealth of experiences to recognize
patterns and predict events, however, is still analytic and deliberate in decision-making (Berliner, 1988).

The expert teacher primarily uses intuition to guide behavior; however, his/her responses are less analytic and deliberative than the proficient teacher. Expert teachers walk and talk in a fluid and effortless manner (Berliner, 1988).

Berliner (1988) introduced the term postulant teacher to describe individuals who have worked in the industry and were considered subject matter experts but had no pedagogical knowledge or education. Berliner maintained that postulant teachers “anchor the bottom of a continuum going from ignorant to expert in a particular field . . . in terms of the developmental theory just discussed, is that of completely unprepared novice . . . the rawest of raw recruits” (p. 13). Although Berliner was not specifically describing teachers in higher education, the label postulant teacher could aptly be used to describe the new nurse educator moving from clinical practice to academia.

Ramsburg and Childress (2012) utilized the Dreyfus and Dreyfus (1980) model of skill acquisition and the National League for Nursing (NLN) Core Competencies for Nurse Educators (NLN, 2005) as a framework for conceptualizing skill acquisition in nurse educators. In a descriptive study design, 192 nurse educators were surveyed using a researcher developed tool. The survey included 40 statements describing nurse educator activities that were based on the NLN (2005) competency statements which were revised to contain language for each stage of skill acquisition. For the novice level, statements included terms such as identify and determine; advanced beginner level statements included terms such as discriminate and choose; competent level statements included words such as understand and participate; proficient level
statements included words like develop, alter, and design; and expert level statements included terms such as advocate, disseminate, and lead (Ramsburg & Childress, 2012). Results showed experienced nurse educators (those with 20 years or more of teaching experience) reported higher levels of skill acquisition than those with five or fewer years. The relationship between total skill acquisition and application of skills based on all levels of teaching experience was positive and statistically significant. This supported the Dreyfus and Dreyfus assertion that experience increases skill acquisition, because it most effectively leads to knowledge development within the domain. The researchers reported high (.977) internal consistency for the tool.

In a similar national study by Poindexter (2013), nurse administrators of accredited pre-licensure nursing programs were asked to identify essential entry-level nurse educator competencies to teach. Terminology from Benner’s (1984) model of skill acquisition was adapted and incorporated into the design of the survey tool to categorize the level of proficiency required for each of the competencies. The Cronbach’s alpha score for the competency section of the tool was 0.96. Results showed that expected proficiency levels for each competency varied with the institutional type, mission, and position type (tenure versus non-tenure track) (Poindexter, 2013) and helped to shed light on the minimum administrative expectations for competency in an academic position.

Lyon (2015) studied the development of skill acquisition in seven experienced dental educators and three academic deans using the Dreyfus and Dreyfus (1980) model as a theoretical framework for her qualitative study. Using a grounded theory methodology, Lyon sought to explore the “nature of expert educator’s skill and work patterns and to define how they are developed and manifested from the point of view
of the educator” (p. 93). Overall, four main categories describing skill progression were identified: basic knowledge, functional skills, personal and behavioral qualities, and reflection. These categories were also examined using the Dreyfus and Dreyfus model to determine which were significant for the different levels on the continuum. All five levels were recognized. Most notably, Lyon found that educators recruited from practice were at the novice or basic level and brought practical experience to academia but lacked formal education in teaching skills. This finding concurred with Berliner’s (1988) definition of the postulant teacher. Additionally, accumulation of experience was the “primary benefit to the subjects’ earliest teaching, followed by a growing recognition of context, environment, and learners’ response” (Lyon, 2015, p. 100). These findings supported and were consistent with the Dreyfus and Dreyfus and Benner (1984) findings.

A qualitative, phenomenological study designed to uncover the meaning of the experiences of new nurse educators by Siler and Kleiner (2001) revealed that their experiences parallel that of novice nurses described by Benner (1984). Siler and Kleiner asserted that new nurse educators who have little or no experience in academia are actually worse off than new graduate nurses who have had the experience of clinical rotations to relate to their practice. Weidman (2013) applied Benner’s (1984) model to her qualitative study examining the lived experience of eight clinical nurse experts who transitioned to the role of novice nurse educator. Weidman reported that the expert clinical nurses found the transition to novice educator difficult and reported feelings of stress and frustration because where they were used to using their intuition in practice; now new information had to be broken into step-by-step pieces.
Dempsey (2007) conducted a similar qualitative study of six clinical nurses in Ireland who transitioned to the role of nurse lecturer. Dempsey applied Benner’s (1984) model to the new lecturer who had no previous experience with the role. Dempsey found that novice educators reported feeling “daunted, frightened, and stressed by the role transition . . . their initial feelings decreased as they accepted their role change, gained experience with the new role and became familiar with their new environment” (p. 10).

**Critique of novice to expert model.** The majority of the criticism of Benner’s novice to expert model focuses on the qualitative nature of the study and lack of subsequent quantitative validation (Altmann, 2007). There are no operational definitions for the stages which make empiric measurement difficult. Altmann (2007) maintained that Benner’s model is interpretive; thus it is alarming that her model is frequently cited in the nursing literature as if her findings were quantitative. “Interpretation is subjective in nature for both the individual telling the experience and the researcher” (p. 119). Altmann also raised concern regarding the trustworthiness of the value of the narratives and the participants’ ability to articulate their experiences accurately. Altmann posited that these criticisms “do not devalue the model but make it more practical as philosophy” (p. 122).

There is also debate in the literature over the terms intuition and expertise as used to describe the expert nurse. English (1993), in his critique of Benner’s theory, challenged the objectivity and validity of Benner’s model due to its lack of accepted definitions, measurement, and testing. English disputed her definition of intuition and stated that the perceptual awareness possessed exclusively by expert nurses has “communication difficulties which limit the transference of information concerning
crises anticipation between the expert and the non-expert, which mean that the expert cannot explain how she makes deductions” (p. 389). English went on to refute Benner’s definition of experience, stating that no explanation is offered as to why all nurses cannot become experts who have worked for more than five years in one clinical area. English argued that Benner (1984) blurs the matter of experience in nursing, stating “experience is not based on longevity in a position but is the refinement of preconceived notions” (Benner, 1984, p. 36). Darbyshire (1994) responded to English’s critique of Benner’s novice to expert model, emphasizing the philosophical and worldview differences between English and Benner (1984). Darbyshire defended Benner’s work and maintained that English’s critique was based on a pervasive positivist epistemology, where empiric measurement and objective validation are the benchmarks by which a work is measured.

Gobet and Chassy (2007) concurred with English (1993) that “Benner’s theory does not account for the development of expertise and intuition well, when compared to empirical data” (p. 131) and argued that the theory is too simple to account for the complexities of expert intuition. Gobet and Chassy argued that the medical profession has utilized standard quantitative methods, where nursing researchers have limited themselves to qualitative studies. Gobet and Chassy proposed an alternative theory of expertise based on the natural sciences. This theory, referred to as TempT, uses empirical data to explain how “intuitive, perceptual decision-making is linked to more analytical problem solving” (Gobet & Chassy, 2007, p. 129). Gobet and Chassy reasoned that where Benner (1984) limits analytic reasoning skills to the novice stage and not at later stages where the focus should be developing intuitive skills through
experience and interaction with patients, the TempT theory emphasizes the importance of learning analytic methods at all stages.

**The Nursing Faculty Shortage**

The purpose of this study was to explore and describe the lived experience of clinical nurse experts transitioning to the role of novice educator. In response to the national nursing faculty shortage, there are an increasing number of expert clinicians entering into part- and full-time academic faculty appointments. These novice faculty members have extensive clinical experience and skills, but are often lacking knowledge and preparation for the multifaceted role of the nurse educator. The magnitude of the nursing faculty shortage in the United States has created great concern regarding the educational preparation of the next generation of nurses. Nursing programs have the responsibility to assure that novice faculty members are competent to teach and to help them grow into their roles as educators. In order to build and sustain the number of nurse educators needed to meet program demands, consideration must be given to the factors influencing the faculty shortage and more comprehensive strategies developed to address them.

Despite a growing interest in nursing, thousands of interested, qualified applicants at all levels of nursing education are turned away annually with the lack of qualified faculty as one of the primary reasons for not expanding student enrollment (American Association of Colleges of Nursing [AACN], 2013; NLN, 2012). Although researchers cannot point to one single reason or simple explanation for the nursing faculty shortage, there are a number of key factors contributing to the problem, including aging faculty (with a large number projected to retire over the next decade), a decrease in the recruitment pool of younger replacement faculty, increased
age of doctoral recipients and time to degree, increased tuition and loan burden of graduate study, limited pool of doctorally-prepared faculty, heavy faculty workloads, and non-competitive salaries compared to clinical and private-sector settings (AACN, 2013; Beres, 2006; Brady, 2007). The same findings were echoed in the 2010 report by the National Advisory Council on Nurse Education and Practice (NACNEP) to the Secretary of the United States Department of Health and Human Services and the United States Congress. This report also suggested that faculty need to receive adequate educational preparation specific to teaching and that funding be provided to sustain nursing faculty programs. McDermid, Peters, Jackson, and Daly (2012) postulated that the nature of the academic environment and the transition experience of clinical nurses to faculty positions also contribute to nursing faculty shortage. Each of these contributing factors will be examined below. The transition experience from clinical practice to academia, the topic of this study, will be discussed separately.

Aging and Imminent Retirement of Current Nursing Faculty

There is consensus in the literature that the aging and imminent retirement of a large segment of the nursing faculty population is one of the primary factors affecting the nursing faculty shortage. The shortage is expected to intensify as nurse educators from the baby boomer generation approach retirement with fewer younger nurses in the pipeline pursuing a career in academia (AACN, 2005; Brendtro & Hegge, 2000; McDermid et al., 2012; NACNEP, 2010; NLN, 2010b). According to the NLN (2010a) *Findings from the 2009 Faculty Census,*

The percentage of faculty ages 30-45 and ages 45-60 both dropped by three percent between 2006-2009. Simultaneously, the percentage of full-time educators over age 60 grew dramatically from only nine percent in 2006 to
nearly 16 percent in 2009. Overall, fifty-seven percent of part-time educators and nearly 76 percent of full-timers were over the age of 45 in 2009. (p. 1)

Studies show that many nursing faculty nearing retirement would like to continue teaching in some capacity but are unable to due to restrictive institutional policies and retirement plan barriers making retirement an all or none proposition (AACN, 2005; Roughton, 2013). An excerpt from a 2007 Robert Wood Johnson Foundation policy briefing paper stated, “nursing programs will yield a dual loss from the decrease in the total number of faculty available to teach entry-level students and a reduction in the number of seasoned educators who can orient and mentor new faculty and advise graduate students” (p. 1). Kowalski, Dalley, and Weigand (2006) reported on factors influencing the retirement decisions of nurse educators and found the most influential factor affecting the timing of retirement was financial. Workplace issues, personal and family health, and attitudes about retirement were other factors that affected their decision. Williamson, Cook, Salmeron, and Burton (2009) utilized a qualitative approach to study a sample of nurse educators at retirement age who chose to stay in academia. Fifteen factors were identified as deciding whether to remain in teaching or retire. At the top of the list were salary and employee benefits. A second-phase comparative study by Cook, Williamson, Salmeron, and Burton (2011), comparing the 15 critical issues identified in the first study in the decision to retire, identified between retired and retirement-aged nursing faculty. Results showed a significant difference in the importance of these factors between working and retired faculty. Nine factors were found to be predictive of the decision to continue working, and, surprisingly, intellectual stimulation was the strongest factor to continue working, not financial.
A substantial number of current nurse educators are poised to leave the profession within the next decade, and those nurses currently in the pipeline will not be able to fill these vacated positions, let alone add the positions needed to increase capacity. McMenamin (2014), in an article for the American Nurses Association about the faculty shortage, stated,

US Department of Labor Bureau of Labor Statistics (BLS) of Employment Projections for 2012—2022 indicate that there will need to be 35 percent more faculty members to meet the expected increase in demand. In addition, 10,200 current faculty members are expected to retire. Therefore 34,200 new nursing instructors will be needed by 2022. (“Surviving the Transition,” para. 2)

McMenamin went on to present several challenges associated with the current state of the faculty shortage. First, nursing schools collectively would need to recruit over 3,400 new faculty per year to meet the demand by 2022; second, recruiting more nurses from practice into academia leaves less nurses in direct patient care which intensifies the nursing shortage overall; and finally, there is a national push from the Institute of Medicine (2010) to strengthen registered nurse (RN) education, increasing the number of associate degree RNs to baccalaureate education by 2020, which puts pressure on universities to increase the number of doctorally-prepared faculty to meet the demand of students wanting to continue their education.

While universities granting baccalaureate and higher degrees in nursing are under pressure to recruit doctorally-prepared faculty, data from the NLN (2012), *Findings from the Annual Survey of Schools of Nursing: Academic Year 2011–2012*, showed 69% of new hires held a master’s degree, and only 23% held a doctor of philosophy or doctor of nursing practice degree. Graduate programs
are not producing enough nurses with doctoral degrees to meet the demand, which is evidenced by the fact that thousands of qualified applicants to graduate nursing programs are turned away each year. In 2014, the AACN reported that 13,444 qualified applicants were rejected by master’s degree programs, and 1,844 qualified applicants were turned away by doctoral programs. The primary reason cited was a shortage of faculty. Nursing education is in the center of a vicious cycle, which without significant attention, will drastically reduce the ability to educate future nurses and will ultimately increase the cost of healthcare and reduce the capacity of healthcare providers to deliver care.

**Increased Age of Doctoral Recipients**

Nursing faculty typically have long careers in practice and enter academia much later in life than other disciplines in higher education (AACN, 2005; Nardi & Gyurko, 2013; Yordy, 2006). Many wait to start graduate degrees, which delays the start of an academic career (Allan & Aldebron, 2008), ultimately decreasing the number of productive years in academia. In 2002, the median age of doctoral recipients was 47.3 years, with half of new doctorates obtained between the ages of 45 and 54 (Robert Wood Johnson Foundation & U.S. Department of Labor, Employment and Training Administration, 2008). Nursing doctoral students spend an average of 8.8 years completing their degree. Over one-half register as part-time students, which increases the time spent in doctoral programs and delays entry into academia (AACN, 2005). Considering that the mean age for retirement in 2004 was 63.1 years (AACN, 2005), this limits an academic career to approximately 15 years for many new

**Increase in Opportunities Outside Academia**

The increase in career choices for graduate degree-prepared nurses, such as advanced practice nurse practitioners, has drawn nurses away from careers in education. The AACN (2015c) noted growth in the number of doctor of nursing practice programs, with 116 new programs being offered between 2010 and 2014 compared to 10 new doctor of philosophy programs in the same time span. The total number of doctoral graduates climbed from 1,815 in 2010 to 3,808 in 2014; however, this does not translate into a larger number of nurse educators entering academia. The majority of the graduates in 2014 were from doctor of nursing practice programs: 3,665 compared to 743 doctor of philosophy graduates (AACN, 2015c). Fang (as cited in NACNEP, 2010) noted that only 37% of doctor of philosophy graduates and 33% of doctor of nursing practice graduates pursue careers in academia.

**Heavy Faculty Workload**

Faculty workload has been defined by Yuker (1984) as “all faculty activities that are related to professional duties and responsibilities, teaching, research, interacting with students, institutional service, service to community and professional development” (p. 5). This definition appears to encompass the majority of activities in the faculty role; however, it is difficult to operationalize this definition since institutions categorize and weight these activities differently (Kirkpatrick, Rose, & Thiel, 1987). Administrative and organizational structure, size, two- versus four-year, distance education, and instructional resources all affect workload (Ellis, 2013;
Traditional faculty roles in higher education include the tripartite expectations of teaching, scholarship, and service. Gerolamo and Roemer (2011) maintained that it is difficult to quantify nursing workload and do comparative studies because of differences in teaching and clinical responsibilities across nursing programs. Nursing faculty roles vary considerably depending on the type of institution (community college, four-year public versus private institution, or graduate program); however, the traditional faculty expectations of teaching, scholarship, and service exist outside the context of any given institution (Halstead & Frank, 2011).

When one compares faculty roles and workload across other disciplines, nursing faculty have the additional expectation of maintaining clinical expertise and clinical teaching, making the nursing faculty role unique in higher education. The AACN (2005) white paper on *Faculty Shortages in Baccalaureate and Graduate Nursing Programs* added the following expectations of nursing faculty: developing proficiency in distance learning technology and revising curricula to prepare graduates to succeed in a rapidly changing healthcare environment.

Heavy nursing faculty workload has been cited as one issue that is associated with job dissatisfaction and possible intent to leave academia (AACN, 2005; Bittner & O’Connor, 2012; Durham, Merritt, & Sorrell, 2007; Kaufman, 2007c). Findings from a national NLN/Carnegie National Survey of Nurse Educators (n = 8,498) revealed that heavy workload decreased job satisfaction with 44% of respondents reporting that they were dissatisfied with their current workload and 25% citing workload as the primary motivating factor for potentially leaving their jobs (Kaufman, 2007c). The majority of respondents on the survey reported working more than a standard 40-hour
workweek; in many cases they worked more than 56 hours. Some respondents worked more than one non-academic position to maintain clinical practice and keep up with the demands of their faculty role (Kaufman, 2007a). Bittner and O’Connor (2012) found that 57% of respondents had two or more outside jobs, and 19% held three or more jobs outside their primary academic institution. Kaufman (2007c) found that 62% of survey respondents worked an additional 7 to 10 hours per week outside of their primary institutions, and nurse educators most often spent time during school breaks on research and clinical practice. Similar findings were reported by Gerolamo and Roemer (2011).

Many nursing faculty members report that there is never enough time and too much to do (Anderson, 2009; Bailey, 2012; Cooley, 2013; Dempsey, 2007; Duphily, 2011; Gazza, 2009; Poronsky, Doering, Mkandawire-Valhmu, & Rice, 2012). According to Kaufman (2007c), “the average nurse educator works more than 24 hours per week . . . and those with administrative responsibilities exceed 31 hours per week during vacation and break periods” (p. 167). Anderson (2009) reported that nursing faculty who were also nurse practitioners found it difficult to balance practice requirements to maintain licensure and certifications, with some having to cut back clinical hours to fulfill faculty obligations. Gazza (2009) reported some faculty members not wanting to move into a tenure-track position because of the increased expectations of scholarship.

**Non-Competitive Salaries**

Faculty salaries have been identified as a barrier to recruitment, retention, and satisfaction among nurse educators, especially with the lure of higher salaries in clinical practice (AACN, 2005; Bittner & O’Connor, 2012). The United States
Department of Health and Human Services data from 2004 showed that from 1980 to 2004 salaries for full-time RNs in industry tripled, primarily in response to the nursing shortage. Academic salaries did not keep pace with industry and remained flat during this time (Robert Wood Johnson Foundation & U.S. Department of Labor, Employment and Training Administration, 2008). Newer data from the United States Department of Labor, Bureau of Labor Statistics (2014) showed that average nursing faculty salaries were $70,650, close to the average salary for all RNs at $69,970; however, the majority of nurse educators have graduate degrees, whereas most RNs in clinical practice do not.

Nurses entering doctoral education at later stages in their careers may view faculty earnings as a poor return on investment when faced with high tuition costs, lost wages due to time off for education, and other life-related factors such as paying bills and raising children (Cathro, 2011; McDermid et al., 2012). The burden of student loans coupled with non-competitive salaries in education is a disincentive to many nurses who may be interested in seeking doctoral education (Allan & Aldebron, 2008; Brendtro & Hegge, 2000). Master’s degree-prepared advanced practice providers considering moving from a practice setting to academia may find the move unattractive due to the reduction in salary and high tuition costs for additional education (NACNEP, 2010).

Using data from the NLN/Carnegie study, Kaufman (2007b) revealed those teaching nursing in public two-year colleges had the “lowest base salaries and with each incremental increase in the Carnegie classification level, nurse educator salaries in public institutions rose five percent” (p. 223). Salaries for teaching at the pre-licensure level in private institutions were closer to the national level, but those who
taught at the graduate level had salaries 13% over the national mean pay rate (Kaufman, 2007b). This significant gap in salaries between practice and academia serves as a disincentive to enter a teaching career (Robert Wood Johnson Foundation, 2007). The NLN (2007a) Annual Survey of Schools of Nursing, 2006-2007 showed that “41 percent of schools offering associate degrees and 34 percent of schools offering baccalaureate nursing degrees identified the inability to offer competitive salaries as the key obstacle to bring new faculty on board” (p. 1). Data from the AACN (2015d), Special Survey on Vacant Faculty Positions for Academic Year 2014-2015, showed that non-competitive salaries is one of the biggest recruitment barriers for hiring faculty, second only to a limited pool of doctorally-prepared faculty.

When comparing nurse educator salaries to other master’s degree-prepared nurses, educators are paid “33 percent less than nurse anesthetists . . . 17 percent less than head nurses and nurse midwives, and approximately 12 percent less than nurse practitioners and clinical nurse specialists with the same credentials” (Kaufman, 2007a, p. 224). Kaufman (2007b) added that nursing faculty earn only 76% of the average salary earned by faculty in other disciplines; and in private institutions, nursing faculty earn 32% lower than other academic disciplines. Kaufman (2007a) reported that over half of the respondents to the NLN/Carnegie study were “either very or somewhat dissatisfied with their salary . . . and of the faculty who indicated they were likely to leave their jobs in near future, over 50 percent cited more compensation as a reason for departing” (p. 225).

The impact of the salary gap has been supported by a number of other studies. Evans (2013) in a descriptive study ($n = 2,083$) of recruitment and retention factors of nurse faculty in all levels of nursing education found that “98.5 percent of respondents
believed that increased salaries would increase the number of nurse educators” (p. 15). Many respondents \(n = 900\) responses to 12 open-ended questions) voiced “concerns about compensation” (p. 15). Bittner and O’Connor (2012) in a descriptive study examining barriers to nurse faculty satisfaction and retention found that 54\% \(n = 226\) of respondents reported being “dissatisfied or very dissatisfied with their salary” (p. 253). Over one-half of the respondents reported that they were planning to leave in five years and those who were not leaving for retirement cited compensation as one of two main factors (Bittner & O’Connor, 2012).

**Funding and Sustaining Nursing Faculty Programs**

For over 50 years, nursing workforce development programs, contained in Title VIII of the Public Health Service Act, have helped to subsidize nursing education at all levels and provided support for nursing schools and faculty (AACN, 2015a). The focus of the program is to attract more students to nursing, recruit a more diverse population, assist students to complete school, and support faculty and academic institutions to meet the needs of the workforce. Title VIII was expanded and improved by the Nurse Reinvestment Act of 2002 with the following grant programs:

- Advanced education nursing provides grants to schools and other entities to enhance education and practice for nurses in master’s and post-master’s programs including nurse practitioners and educators (American Nurses Association, 2014). Advanced education nursing grants supported 10,540 students in the 2013-2014 year (AACN, 2015b).
- Workforce diversity grants provide grants to increase opportunities for individuals from disadvantaged backgrounds as well as ethnic and racial minorities in the nursing profession (American Nurses Association, 2014).

- Nurse education, practice, and retention grants support schools and individuals at the associate and baccalaureate degree level (American Nurses Association, 2014).

- National nurse service corps provides a nurse education loan repayment program for 60% to 85% of nursing student loans in return for at least two years of practice in a facility designated to have a critical shortage of nurses (American Nurses Association, 2014).

- Nurse faculty loan program establishes loan programs within nursing schools for students pursuing master’s and doctoral degrees. Loan recipients are required to teach at a school of nursing in exchange for cancellation of up to 85% of their educational loans, plus interest, over four years (American Nurses Association, 2014).

- Comprehensive geriatric education provides grants to train nurses who provide direct care to the elderly, to train faculty in geriatrics, and provide continuing education to those nurses who provide geriatric care (American Nurses Association, 2014.).

In 2009, President Obama signed the American Recovery and Reinvestment Act continuing federal support of nursing by expanding the funding of current programs; providing $500 million for health professions training; and creating new opportunities for nursing practice, education, and research (Alexandre & Glazer, 2009; Robert Wood Johnson Foundation, 2009). “Between 2006-2012 alone, Title VIII
programs supported over 520,000 nurses and nursing students as well as numerous academic institutions and healthcare facilities” (AACN, 2015b, p. 3). Title VIII funding has historically been effective, but is not currently adequate (American Nurses Association, 2014). Nurses and nurse educators must continue to advocate for adequate funding and remain watchful to assure that funds are spent on programs that will increase access to education (Alexandre & Glazer, 2009).

**Adequate Educational Preparation of Nurse Educators**

The current healthcare system demands highly educated and skilled nurses who possess the ability to think critically and practice safely and effectively. A 2005 position statement by the NLN called for new models of nursing education “that no longer rely on tradition, past practices, and good intentions . . . designed to involve students as active participants” (NLN, 2005, p. 1). In a seminal study sponsored by the Carnegie Foundation, Benner, Sutphen, Leonard, and Day (2010) contended that nursing education severely lags behind changes in science, technology, and changes in healthcare settings. They called for a radical transformation of nursing education, including preparation for teaching and learning in the curricula of graduate programs. This shared understanding was echoed in the 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*, which has gained widespread support from healthcare leaders in education and practice (AACN, 2015c).

Evidence-based recommendations from the IOM [Institute of Medicine] (2010) report call for preparing at least 80 percent of the RN workforce at the baccalaureate level by 2020 as well as a doubling of the number of nurses with doctorates. (AACN, 2015c, p. 1)
To prepare students to meet these demands, there is a national push to raise the standard for faculty academic credentials to the doctorate level (AACN, 2008; NLN Board of Governors, 2013; Yordy, 2006).

The educational preparation and skill sets required by nurse educators have been studied for decades. Prior to the 1970s, most master’s degree programs in nursing focused on preparation for education or administration. A 1969 Position Statement on Graduate Education from the American Nurses Association called for graduate programs to shift their focus to clinical specialization and “the preparation of nurse clinicians capable of improving nursing care through the advancement of nursing theory and science” (American Nurses Association, n.d., p. 4).

This led to a decrease in the number of graduate programs offering nursing education as a specialty area, a trend that has continued until the present. Currently, 269 schools offer a practice doctorate, with a total enrollment of 18,352 students, compared to 5,290 students enrolled in research-focused doctoral programs (AACN, 2014). From 1976 to 1977, almost 25% of master-prepared nursing graduates were education majors. This number has decreased to slightly over 11% in 1994 and 3.5% in 2002 (AACN, 2005). Despite a surge in the number of practice-focused master’s and doctorate of nursing practice programs, graduates of both practice- and research-focused programs spend little time preparing for the role of nurse educator (Lewallen & Kohlenberg, 2011). In the 1980s there were significant decreases in nursing program enrollments due to more lucrative career choices in the private sector, which led to programs cutting nursing faculty positions (Brendtro & Hegge, 2000). In the 1990s salaries for nurses increased, which opened up a wider variety of opportunities, particularly in community-based settings. This resulted in increased enrollment in
nursing schools. Nursing programs were unable to accommodate the growing demand for placement due to lack of clinical sites, qualified faculty, and inadequate budgetary support (Brendtro & Hegge, 2000). As a result, more part-time faculty, typically master-prepared, were hired and full-time doctoral positions were frozen. This led to a decrease in the number of faculty able to fulfill the academic expectations of teaching, research, and scholarship (Hinshaw, 2001).

In response to the growing nursing faculty shortage, the NLN Board of Governors (2002) issued the *Position Statement: The Preparation of Nurse Educators* in calling for an “immediate and focused effort to provide increased opportunities in graduate programs to prepare faculty and to provide greater support for faculty development activities” (p. 1). The Board asserted that the nurse educator role requires “specialized preparation and every individual engaged in the academic enterprise must be prepared to implement that role successfully” (p. 2).

The NLN Board of Governors (2013) supported multiple ways for nurse educators to attain competencies including master’s degrees, post-master’s certificates, and doctoral preparation. The NLN also supports the Institute of Medicine recommendation to double the number of doctorally-prepared faculty by the year 2020. The AACN (2008) shared this same vision in their *Position Statement on the Preferred Vision of the Professoriate in Baccalaureate and Graduate Nursing Programs*, stating that “courses in entry-level programs will be taught by faculty with graduate-level academic preparation and advanced expertise in the areas of content they teach” (p. 1). The AACN (2008) fully endorsed the doctorate degree as the preferred preparation consistent with other academic disciplines and the Institute of Medicine (2010) recommendation.
In 2005, the NLN clearly identified and defined eight core competencies for nurse educators, “providing a comprehensive framework for preparing new nurse educators, implementing the nurse educator role, evaluating nurse educator practice, and advancing faculty scholarship and lifelong professional development” (Kalb, 2008, p. 217). The eight competencies included:

1. Facilitate learning competency.
2. Facilitate learner development and socialization.
3. Assess and evaluate strategies.
4. Participate in curriculum design and program evaluation.
5. Function as a change agent and leader.
6. Pursue continuous quality improvement as a nurse educator.
7. Engage in scholarship.
8. Function within the educational environment (NLN, 2005).

Each competency contains task statements which emphasize the knowledge, skills, and attitudes needed for mastery of the competency.

The NLN (2005) core competencies delineated expectations for expert nurse educator practice; however, Poindexter (2013) claimed that the expected competencies for novice nurse educators have not been clearly defined. A survey done by the AACN in 2008 of 220 deans and directors of member nursing programs cited five skills, knowledge, and/or characteristics considered to be the most important for new faculty: (a) teaching skills; (b) knowledge, experience, and preparation for the faculty role; (c) curriculum/course development skills; (d) evaluation and testing skills; and (e) personal attributes such as communication skills (Penn et al., 2008). These skills clearly align with the NLN (2005) core competencies for nurse educators. Poindexter
studied the perceptions of nurse administrators about expected entry-level competencies for novice-level nurse educators and found that nurse administrators collectively “expected novice nurse educators to be at least competent to proficient in the ability to perform a majority of the nurse educator competencies” (p. 561).

In 2005, the NLN introduced the Academic Nurse Educator Certification Program, recognizing that the role of nurse educator is an “advanced professional practice discipline with a defined practice setting and demonstrable standards of excellence” (NLN, n.d., para 2). This credential was the first of its kind for nurse educators and was offered to full-time faculty from all levels of nursing education and academic rank who met the educational and experiential qualifications. Data from the exam provide “important information about the nursing faculty knowledge about the Core Competencies of Nurse Educators, as well as the professional development needs of our nation’s faculty” (Ortelli, 2008, p. 121). Nursing research supports the benefits of clinical certification in nursing on nursing outcomes; however, there is a paucity of literature describing the effect of the certification of nurse educators on faculty, student, or program outcomes (Nick, Sharts-Hopko, & Leners, 2013). This is an area ripe for research, including the impact of certification on the broad understanding of the role and scope of practice, personal and professional benefits of certification, effect on salary and promotion, comparison of student learning environments, readiness for the exam, and factors that support or hinder certification of faculty (Nick et al., 2013).

The updated AACN (2011) *Essentials of Master’s Education in Nursing* delineated all the knowledge and skills that all master-prepared nurses must acquire, including competence in “applying teaching/learning principles in work with patients
and/or students . . . preparation in curriculum design and development, teaching methodologies, educational needs assessment, and learner-centered theories and methods” (p. 6). The delineation of the nurse educator role as an advanced practice specialty with specific core content and clinical practice requirements is a change from the 2005 Essentials of Master’s Education for Advanced Practice, which focused primarily on advanced clinical practice. The AACN (2011) advised that master’s level preparation in nursing education prepares the nurse for practice in hospital settings and the community college setting; however, additional education at the doctoral level is needed for faculty teaching in baccalaureate and graduate nursing programs.

Despite the national push to increase the educational preparation of nurse educators, only 25% of full-time nurse faculty at all ranks held terminal degrees (NLN, 2009). One of the primary concerns regarding the nursing faculty shortage is that as vacancies occur, new educators recruited to fill those positions lack formal preparation in teaching and learning, despite having graduate degrees and expertise in clinical practice (Anderson, 2009; Bonnel & Starling, 2003; Brendtro & Hegge, 2000; Clark et al., 2010; Cleary et al., 2011; Cranford, 2013; Diekelmann, 2004; Siler & Kleiner, 2001).

**Transition to Academia**

The transition experience of nurses from clinical practice to academia is the final factor that will be presented relative to the nursing faculty shortage. Many nurses new to the role of educator find the transition to be overly challenging, which has led to job dissatisfaction, a desire to leave, or to actually leave nursing education. Negative transition experiences jeopardize the recruitment and retention of qualified faculty to educate the next generation of nurses. The transition experience was the
focus of this researcher’s study, and a more in-depth review of the literature of this factor was sought to help identify what is known about the experiences of novice educators: their reasons for entering academia, facilitators and barriers to the transition experience, and outcomes of the experience. The majority of the scholarly work examining the experience of nurses transitioning from practice to academia is qualitative, and there is a dearth of quantitative studies. The transition literature included in this review is limited to the last 15 years and will be divided into four sections which correlate with the themes of preparing for the transition, barriers to transition, support strategies for transition, and outcomes of the transition experience.

Preparing for the Transition

The expectation/anticipation phase begins when the clinician decides to become an educator. This aligns with the Meleis et al. (2000) conceptualization of transition in which they stated that a transition begins when it is first anticipated. Several conditions that led practicing nurses to pursue careers in nursing education were identified in the literature, including wanting to make a difference in the profession by influencing the next generation (Clark et al., 2010; Evans, 2013; Penn et al., 2008; Schoening, 2013); wanting to influence nursing through research and policy (Poronsky et al., 2012); desiring a more predictable lifestyle and schedule (Schoening, 2013); and feeling a professional duty to give back (Chapman, 2013) and do it better (Testut, 2013). Several studies noted that nurses moving into a faculty position had a strong desire and motivation to teach (Bailey, 2012; Cangelosi et al., 2009; Chapman, 2013; Duphiliy, 2011; Parslow, 2008). Parslow (2008) and Weidman (2013) found that although some of their participants were recruited by nurse educators observing them in clinical, all had the desire to teach. Some novice faculty stated that they found
joy and satisfaction in patient teaching or precepting students and wanted to try
teaching as a career (Evans, 2013; Parslow, 2008); others stated they had become
experts in their field and wanted a chance for others to do the same (Cangelosi et al.,
2009). Gazza and Shellenbarger (2010) in a study of the lived experiences of part-
time faculty found that their part-time position was a way of fulfilling an aspiration to
get to a full-time position in the future. Evans (2013) and Chapman (2013) found that
nurse faculty role modeling, such as remembering an instructor who had a powerful
impact in nursing school, attracted some participants to nursing education.

The anticipation/preparation phase of transition is typically a positive time as
nurse educators enter academia with altruistic intentions of making a difference,
giving back, and shaping the next generation (Schoening, 2013). There is generally a
sense of excitement in many new nurse educators as they enter academic roles;
however, a dichotomy of emotions was also evident in studies by Anderson (2009),
who found participants related feelings of being excited and petrified at the same time,
and Cooley (2013), whose participants described the experience as exciting, yet
terrifying and overwhelming but intriguing. Expectations about student behavior,
workload, and skills involved in being a teacher and transitioning from a clinical
comfort zone as an expert to the unknown tempered some of the excitement
(Anderson, 2009; Cangelosi et al., 2009).

**Barriers to Transition**

Meleis (2010) stated that transition is the “passage from one fairly stable state
to another fairly stable state . . . a process triggered by a change” (p. 11). For many
novice educators this transition from one stable state to another may be fraught with
obstacles that may hinder the transition process, the development of competence in the role, and/or socialization to the role.

**Lack of preparation.** The role of nurse educator is complex and multifaceted. Preparation as expert clinician does not necessarily ensure an effective educator (Starnes-Ott & Kremer, 2007). Infante (1986) stated “becoming a nurse educator is not an additive process; that is, it not a matter of adding the role of educator to that of the nurse” (p. 94). Although clinical expertise is a critical component to the success of the nurse educator, knowledge of teaching and learning, curriculum design and evaluation, assessment, scholarship, and functioning within the educational environment are essential competencies necessary to develop proficiency in the faculty role (NLN, 2005). Some novice nurse educators self-identified as clinical experts (Bailey, 2012; Cangelosi et al., 2009; Parslow, 2008) or experienced nurses (McDonald, 2004) in their previous roles, yet were unprepared for the realities of the educator role, even if they had been an adjunct educator at the same institution (Gwin, 2012).

An overarching theme noted throughout the transition literature was a lack of knowledge about and preparation for the faculty role (Anderson, 2009; Anibas et al., 2009; Bailey, 2012; Chapman, 2013; Cooley, 2013; Dempsey, 2007; Dunham-Taylor et al., 2008; Dumphly, 2011; Gwin, 2012; Mann, 2013; McDonald, 2004; McDonald, 2010; Parslow, 2008; Paul, 2015; Rich & Nugent, 2010; Sawatzky & Enns, 2009; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013; Wilson et al., 2010; Young & Diekelmann, 2002). Novice nurse educators cited a number of areas of deficient knowledge or lack of preparation for the faculty role, including organizational
expectations such as setting up a class, creating a syllabus, evaluating students, and developing strategies to deal with challenging students or issues such as cheating.

Some novice educators were placed into clinical facilities where they had no prior experience to work with students and reported having to learn the unit, the staff, and charting systems along with their students (Parslow, 2008). Others who were able to teach clinical in familiar units found the transition easier and reported that their experience gave them credibility in the students’ eyes even though they lacked preparation in teaching (McDonald, 2004; Parslow, 2008; Testut, 2013).

One of the most difficult challenges novice nurse educators faced was the discrepancy between their expectations of the role and the actual experience, or role ambiguity (Anderson, 2009; Chapman, 2013; Cooley, 2013; Duphily, 2011; Mann, 2013; Parslow, 2008; Poronsky et al., 2012; Schriner, 2007). The term role ambiguity originates from the theoretical framework of occupational role stress by Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964). Role ambiguity is one of six role stressors and is defined as “uncertainty about behavioral requirements serving to satisfactorily define a role” (p. 61). The review of literature on occupational role stress across a variety of disciplines shows that role stress leads to decreased job satisfaction, decreased organizational commitment (Chang & Hancock, 2003; Culbreth, Scarborough, Banks-Johnson, & Soloman, 2005; Kemery, 2006; Touliatos, Bedeian, Mossholder, & Barkman, 1984), depression, health-related problems, thoughts of quitting, decreased connectedness (Kemery, 2006), teacher burnout, and high turnover (Culbreth et al., 2005). Chang and Hancock (2003) found the psychological consequences of role stress in new graduate nurses included inadequacy, self-doubt, lowered self-esteem, irritability, depression, somatic disturbance, sleep disorders, and burnout.
Additionally, Chang and Hancock found that the quality of patient care may be compromised as well as reduced patient satisfaction. Lambert and Lambert (2001) in a comprehensive review of the literature from 17 countries on role stress/strain among nurses found the same issues as Chang and Hancock, as well as substance abuse and turnover intention.

Novice educators with unrealistic expectations or no expectations at all found the transition into the faculty role to be much harder than anticipated (Mann, 2013). Even those novice educators who had formal graduate preparation in nursing education found the transition to be challenging and not what they expected (Cooley, 2013; Mann, 2013; McDonald, 2004) or had a difficult time applying theoretical content to classroom instruction and the administrative roles of teaching, such as grading (Dempsey, 2007). The consequences of role ambiguity were stress, frustration, discomfort, anxiety, and lack of confidence (Chapman, 2013; Cooley, 2013). Davidson (2011) and McDonald (2004) reported that some novice faculty experienced feelings of “walking in two worlds,” thinking of themselves as practicing nurses first and educators second, which hindered their ability to fully integrate the educator role identity. Isolation and feelings of being disconnected were also verbalized (McDonald, 2004; Siler & Kleiner, 2001). Perceived support from colleagues and administrators varied greatly across the breadth of transition literature from the extreme of no support to excellent support, with the majority of novice faculty fitting somewhere in the middle.

**Workload.** Many faculty new to academia reported that they were not prepared for the workload expectations and were surprised that the workload did not meet their expectations of the role (Bittner & O’Connor, 2012; Duphily, 2011; Gwin, 2012; Hrabowski & Sasser, 2011).
2012; Siler & Kleiner, 2001). In many cases, unrealistic expectations of workload hindered the novice faculty member’s transition (Bailey, 2012; Dempsey, 2007; Duphily, 2011; Kaufman, 2007a). Anderson (2009) reported that lighter workloads were assigned to some new faculty in her study as a strategy to moderate unrealistic expectations. While lighter workloads were mentioned in other studies as a desired strategy to facilitate the transition for new nurse educators, this was not a common strategy. Reports of faculty being granted release time for engaging in scholarship (including research), service activities, maintaining advanced practice competency and certification, or completing doctoral studies were scarce in the literature. National accreditation requirements and state regulatory bodies “discourage nursing programs from developing stable employment opportunities for experienced clinicians who might welcome the opportunity to divide their time between practice and teaching” (Robert Wood Johnson Foundation, 2007, p. 2).

Work/life balance is a barrier for many nurses moving to new positions in academia. As mentioned in the previous section on workload, many nursing faculty members report that there is never enough time and too much to do (Anderson, 2009; Bailey, 2012; Cooley, 2013; Dempsey, 2007; Duphily, 2011; Gazza, 2009; Poronsky et al., 2012). New faculty with young children found it especially difficult to navigate work/life balance with competing demands of scholarly production, preparation for classes, and time with family (Gazza, 2009; Poronsky et al., 2012). Some tenure-track faculty in their first two years of teaching spoke of the “push-pull” of balancing family responsibilities with work responsibilities and questioned “how do you measure how much time is adequate when it comes to your family” (Poronsky et al., 2012, p. 257)?
Lack of orientation programs. “Faculty development begins with orientation. The orientation of new faculty to the university or college . . . is fundamental to program effectiveness” (Billings & Halstead, 2012, p. 526). Orientation is one of the primary ways that novice faculty are prepared for and socialized to the roles and responsibilities of an academic appointment; however, the research findings about orientation programs revealed significant shortfalls. Several studies cited inadequate or abbreviated orientation programs (Bailey, 2012; Dempsey, 2007; Mann, 2013; Parslow, 2008; Schoening, 2013) or no orientation (formal and/or informal) program at all (Parslow, 2008).

McDonald (2004) studied the experiences of nurses moving from practice to academic appointments (one full-time and eight part-time) in Canada and found that all eight participants had some type of formal pre-service orientation to the institution where they worked. One full-time educator participated in a five-day regional college educator development program, but most learning for participants took place through informal connections made through the first semester of teaching. Although all eight participants experienced some level of orientation, all felt inadequately prepared, which caused stress and anxiety. Davidson (2011) reported that some new faculty learned by observing others and piecing together the duties, because most of the actual teaching occurred behind closed doors where seasoned faculty in action cannot be seen.

The lack of orientation was particularly evident in those studies looking at the transition of part-time or adjunct faculty to academia. Parslow (2008) reported on the experiences of nine clinical adjunct faculty members and found that all nine had little to no orientation to the adjunct role. Testut (2013), in a similar study, stated that none
of the participants \((n = 9)\) were offered an orientation prior to beginning the part-time educator role. The experiences of these part-time nursing faculty are not unlike the experiences reported by part-time faculty across campuses in higher education who are called the invisible faculty (Moorehead, Russell, & Pula, 2015), particularly the integration and socialization of part-time faculty into the culture and life of nursing programs. Eagan (2007), writing about the national picture of part-time community college faculty, stated,

> Part-time faculty in higher education are poorly integrated into the cultures within the department and across campus and campus . . . lack of offices, support staff, and inclusion in departmental and campus meetings may prevent part-time faculty from becoming fully integrated into the life of the institution. (p. 13)

The American Association of University Professors (n.d.) confirmed Eagan’s (2007) findings and stated that part-time or contingent faculty have been hampered in their performance and duties by lack of support and professional treatment by other faculty and administrators and poor access to basic necessities, such as office space and computer support. The American Association of University Professors stated that part-time faculty are “often hired on the spur of the moment with little evaluation” (para. 9). Testut (2013) found that there was a lack of professional development offered to part-time nursing faculty because of time conflicts and financial reasons; however, participants found support and guidance from the clinical coordinator at that institution. Parslow (2008) reported that part-time faculty felt disconnected from the department and university. Six out of nine participants stated that they lacked clear expectations of the role. Seven out of nine never received any feedback or a performance evaluation.
**Mentoring.** Mentoring, or lack of mentoring, was one of the primary factors that either facilitated or hindered the transition process for clinicians moving from practice to academia. Mentorship of any type was valued by the majority of new faculty moving from practice to academia; however, many lacked support, guidance, and information from experienced faculty and administrative leadership about the roles and responsibilities of the position (Bailey, 2012; Cangelosi et al., 2009; Cooley, 2013; Dempsey, 2007; Duphily, 2011; Gwin, 2012; Mann, 2013; Siler & Kleiner, 2001).

Mentoring activities were evident in several studies on transition from practice to academia, with results showing that the quality of and type of mentoring activities varied greatly. For those who received mentoring, it helped the process of settling in (Mann, 2013; McDonald, 2004), learning how to teach (Bailey, 2012), and was pivotal for successful entry into the academic community (Poronsky et al., 2012; Weidman, 2013; Young, 1999). Parslow (2008) reported that those who received mentoring stated that it was invaluable; however, one participant pointed out that being assigned a mentor does not guarantee mentoring, a finding echoed by Young (1999). In the absence of a formal mentoring program, or inadequate mentoring, many new novice faculty members sought out help from colleagues or a “go to” person on their own for answers (Schoening, 2013; Siler & Kleiner, 2001).

Faculty transitioning from practice to academia often “don’t know what they don’t know,” so they cannot even ask the right questions. It is clear from the research that preparation for the role is vital; however, many do not investigate or prepare for the role (Weidman, 2013) which can lead to feelings of anxiety and frustration and
possible intent to leave the profession. Cangelosi et al. (2009) eloquently summarized
the importance of mentoring this way:

Teaching is not a natural byproduct of clinical expertise, but requires a skill set
of its own. The anxiety, fear, and tension these novice educators experienced
and their perceived lack of mentoring speaks to the need for nurses to prepare
them for the roles and responsibilities of teaching. (p. 371)

It is essential that all faculty, but especially novice faculty, build the
confidence and skills needed to fulfill the expectations of teaching, practice,
scholarship, and service within the institution (Jacobson & Sherrod, 2012). Mentoring
is a vital component of a comprehensive professional development model that will
help develop these necessary skills (Dunham-Taylor et al., 2008; NLN, 2006). The
NLN (2006) and AACN (2005) advocated for the use of mentoring as a primary
strategy to facilitate and enhance career development for novice faculty, with the NLN
(2006) advocating for mentoring at all stages of a faculty member’s career. The 2013
Standards and Criteria from the Accreditation Commission for Education in Nursing
(2013) called for full- and part-time faculty in all levels of nursing education to be
“oriented and mentored in their areas of responsibility” (p. 2). Additionally, the NLN
(2004) Hallmarks of Excellence in Nursing Education included the following indicator
for faculty role preparation and mentoring: “all faculty have structured preparation for
the faculty role, as well as competence in their area(s) of teaching responsibility” (p. 1).

The concept of mentoring in nursing was pioneered by Vance (2002), who
described mentoring as a “professional obligation and a privilege for each of us” (p.
4). Vance went on to posit that mentoring is an educational necessity and makes good
business sense because it could aid in recruitment and retention, especially in light of a
nursing shortage. Mentoring has been utilized primarily in the context of career advancement or the professional development of a protégé and has many different domains, purposes, and goals depending on the type of relationship and setting. Traditional conceptualizations of mentoring often carried a hierarchical notion of power, rank, and clear role differentials; however, a more contemporary perspective, on mentoring in nursing considers the concept from a collaborative perspective, including both peer and co-mentoring (NLN, 2006; Thorpe & Kalischuk, 2003).

Peer and co-mentoring are defined in the NLN Board of Governors (2006) Position Statement: Mentoring of Nurse Faculty:

Peer mentoring occurs when the new faculty members themselves pool their information and expertise and support each other. Co-mentoring is characterized by reciprocity and involves listening and being listened to, teaching as well as learning, and offering and obtaining information and support through recurrent dialogue. (p. 1)

At its best, mentorship is both a personal and professional interaction based on mutual respect, trust, understanding, and empathy. A rich mentoring relationship is beneficial to both the protégés and mentor, but may also positively affect the program and institution (Farrell, Digiola, Broderick, & Coates, 2004).

The benefits of mentoring in nursing education have been studied and reported in a number of studies and articles. Mentoring improves faculty socialization (McDonald, 2010; Siler & Kleiner, 2001), is an effective way to assist faculty to move from novice to expert educator (Danna et al., 2010; Duphily, 2011; Wilson et al., 2010), improves faculty retention (Dunham-Taylor et al., 2008; Gazza, 2009; Gwyn, 2011; Sawatzky & Enns, 2009; Vance, 2002), increases job satisfaction (Dunham-Taylor et al., 2008), and helps in guiding and developing a research career for novice faculty (Records & Emerson, 2003).
There are few large scale studies that examined the outcomes of mentoring on nursing faculty. Chung and Kowalski (2012) explored mentoring relationships among 959 nursing faculty nationwide and its influence on job stress, psychological empowerment, and whether the variables ultimately affected job satisfaction. Results showed that the presence of a mentoring relationship significantly influenced job satisfaction. This study, although large, drew from full-time faculty of Commission on Collegiate Nursing Education accredited programs and not from the NLN Accreditation Commission (now Accreditation Commission for Education in Nursing) accredited programs which include all associate degree programs. The authors pointed out that another large scale study of the NLN Accreditation Commission accredited programs would be appropriate. In a related discipline, Falzarano and Zipp (2012) examined the occurrence, nature, and perception of mentoring of 818 full-time occupational therapy faculty in the United States. Over one-half of the participants in the study reported that mentoring had a positive influence on their academic success and academic socialization.

There is a paucity of research on mentorship models for nurse educators, and I could find no studies that tested mentorship models or related outcomes. Smith, Hecker-Fernandes, Zorn, and Duffy (2012) explored perceptions of mentoring and precepting at different phases of participant nursing education careers as well as organizational support of faculty mentoring and precepting needs and found three major themes: the needs for precepting and mentoring of faculty changed over the course of their careers, a lack of organizational precepting and mentoring philosophy, and a feeling of together but separateness. A model of precepting and mentoring emerged from this study which differentiated the activities and supportive actions of
precepting and mentoring with the ultimate goals of both being a healthier environment, meaningful support, sense of belonging, integrated personal and professional development, and a successful trajectory of growth and contribution to the institution (Smith et al., 2012)

Jacobson and Sherrod (2012) presented the transformational-transcendence mentorship model which is “built on the premise that the mentorship process is a transformational and transcending process” (p. 281). The authors stated the key components of the model are career development in the areas of teaching, scholarship, and practice. In this model, the mentor acts as a guide, problem-solver, and visionary and is in congruence with the mentee when the mentee demonstrates the roles of learner, integrator, and decision maker. The mentor knows when to give and when to sit back, and the mentee practices the attributes of openness to receive, readiness to take initiative, and demonstrates growth through performance (Jacobson & Sherrod, 2012). The authors stated the need for the testing of mentorship models; however, there was no empirical evidence of testing of this particular model.

Thorpe and Kalischuk (2003) offered “A Collegial Mentoring Model for Nurse Educators” in which mentoring is defined as “a friendship-based collegial relationship affording honest and open communication occurring over an extended period and resulting in a positive outcome for both individuals” (p. 7). This model presents a macro realm which encompasses the “historical, social, political, cultural, and economic facets of the larger educational, health, and social services systems” (p. 8) and a micro realm which involves making time for togetherness, creating ambience, and promoting “beingness” with the outcomes of developing personally and professionally (Thorpe & Kalischuk, 2003). A major limitation of this model is that it


evolved in relation to both authors’ experiences in nursing education and was not tested with other faculty members or in other settings.

Despite the call to mentor novice nursing faculty and the benefits previously mentioned, obstacles to mentoring success are evident. Efforts to sustain mentoring over time are difficult (Rogers, Monteiro, & Nora, 2008), and heavy faculty workloads leave faculty little time to mentor (Chung & Kowalski, 2012; Foley et al., 2003; Gerolamo & Roemer, 2011) especially in institutions where there are faculty vacancies and faculty are assigned increased workloads due to the nursing faculty shortage. Smith et al. (2012) related additional challenges of mentoring relationships that are spontaneous; irregular, short-lived, and unpredictable; that feel forced or artificial; and lack of rewards for mentoring. Limited resources and budget constraints facing many colleges and universities may also have a negative impact on mentoring. As noted by Foley et al. (2003), administrative support and faculty ownership of any professional development model including mentoring is critical to the success of the endeavor; without them, development of mentorship programs could be challenging.

Despite an overwhelming desire of many to teach, it was clear that with a lack of preparation for the faculty role and a lack of mentorship in many studies, learning to teach was a challenge for many novice educators. Learning the teaching role was described by some as being thrown into the water and having to “sink or swim” (Anderson, 2009; Bailey, 2012; Schoening, 2013), or “in over my head.” Others described learning how to teach by “trial and error” or “just winging it” (Parslow, 2008). A participant in the Cangelosi et al. (2009) study described learning how to teach like this: “not knowing what I should know about clinical education was a bit like playing pin the tail on the donkey. I realize I didn’t know enough to ask
meaningful questions” (p. 370). A large number of novice faculty reported wanting and needing feedback about their teaching but not receiving it (Anderson, 2009; McDonald, 2004; Parslow, 2008; Siler & Kleiner, 2001).

**Salary inequities.** Salary inequities between practice and clinical have been cited in a number of national studies as one of the key factors influencing the nursing faculty shortage as mentioned previously. Mann (2013) and Goodrich (2014) noted salary was an issue that hindered or challenged the transition process, and Duphily (2011) found that salary impacted the way participants perceived their new role as educator. Interestingly, all of the participants in the Duphily study and eight of nine participants in the Mann study were associate degree educators. It has been well documented that community college salaries tend to be lower than university salaries (Kaufman, 2007b), but it is unknown if this was an influencing factor. Overall, issues about salary inequities or low salaries in academia were not noted to be a major factor influencing the transition process or outcomes of transition as this researcher had anticipated in the transition literature.

**Support Strategies for Transition**

Support strategies for transition were identified facilitators to the development of competence in the academic role of a novice nurse educator. In Meleis’ (1975) work on the concept of transition, she described how the process of role supplementation aids the transition experience. Role supplementation is defined as,

> Any deliberative process whereby role insufficiency or potential role insufficiency is identified by the role incumbent or significant others, and the conditions and strategies of role clarification and role taking are used to develop a preventive or therapeutic intervention to decrease, ameliorate, or prevent role insufficiency. (p. 267)
Role supplementation or facilitators to the transition from practice to academia include preparation for the role, internal motivators, orientation, mentoring and peer support, observation of experienced teachers, and faculty development opportunities.

**Preparation for the role.** As previously mentioned, a lack of preparation for the faculty role is one of the primary factors hindering the transition from practice to academia. Chapman (2013), in a qualitative study of nurses transitioning to the clinical faculty role, summarized the importance of preparation for the role this way: “the stress and role strain experienced during the transition from expert to novice could have been ameliorated by preparing the novices for the expectations and responsibilities of the educator role” (p. 62). Novice faculty who had some formal preparation for nursing education said that it was helpful (Cooley, 2013; Dempsey, 2007; Mann, 2013), but all spoke of not being prepared for the complexities of the role and had different expectations than was presented in reality. Looking back, some novice educators wished they had prepared for the role (Bailey, 2012). Others realized that there was no way to know everything and had to learn to accept it, be patient with themselves, and look things up and/or ask questions (Mann, 2013).

In the absence of orientation programs and mentoring in their new roles, novice faculty found self-directed information seeking and participation in professional development activities, such as in-services and online classes, helpful during their early transition (Anderson, 2009; Bailey, 2012; Chapman, 2013; Mann, 2013).

Being paired with an experienced educator was one way to prepare for the teaching role (Anderson, 2009; Mann, 2013). Anderson (2009) found that participants who had the opportunity to be paired with a seasoned educator and were given lighter
workloads reported a “honeymoon sensation of less anxiety and serenity” (p. 205). Other novice educators, although not paired with a seasoned educator, suggested that it would be a good idea to better prepare for the role (Chapman, 2013; Culleiton & Shellenbarger, 2007; Dempsey, 2007; Gwin, 2012). A period of student teaching is expected of all new educators teaching in elementary and secondary schools. This is not a common experience in higher education or nursing programs; however, a graduate level practice experience is an expectation of core curriculum for master and doctoral preparation in nursing education (AACN, 2006, 2011). There is a gap in the research examining the outcome of graduate student teaching experiences and the perception of preparedness for the teaching role and whether a student teaching experience or observing a seasoned educator helps to decrease anxiety and role strain.

**Mentoring and support.** Although lack of mentoring was one of the primary barriers to the development of the novice nurse educator because of perceived inadequacies in mentorship programs and activities, mentoring was also cited as a facilitator of the transition to the nurse educator role as well (Bailey, 2012; Dempsey, 2007; Duphily, 2011; Mann, 2013; McDonald, 2004; Parslow, 2008; Weidman, 2013; Young, 1999). The overwhelming need for mentoring as a facilitator to faculty development in this transition literature matches previous literature on mentoring and national best practices calling for mentoring as a primary strategy to facilitate and enhance career development for novice faculty (AACN, 2005; NLN, 2006). There is a great need for more research on determining the effectiveness and outcomes of mentoring programs, both short-term and longitudinal; identifying the beneficial characteristics of mentorship models; exploring the mentor/mentee relationship and
how it affects transition; and ascertaining the association between mentoring, job satisfaction, and intent to stay in academia.

Cooley (2013) spoke of transformative learning experiences for nurse educators originating out of situations in which there was a strong relationship with another person. Desire and need for support in the form of relationship (formal and informal) with another person or persons was mentioned as frequently as mentoring (Anderson, 2009; Dempsey, 2007; Duphily, 2011; Gazza, 2009; Gazza & Shellenbarger, 2010; Goodrich, 2014; Gwin, 2012; McDonald, 2004; McDonald, 2010; Paul, 2015; Poronsky et al., 2012; Siler & Kleiner, 2001; Testut, 2013; Weidman, 2013). The individuals supporting novice educators varied in roles, relationships, and the amount of support they provided. In some cases, support was obtained from peers, deans, or family members. The type of support provided included information, guidance, perspective, and encouragement. Some educators had consistent guidance and support, whereas others had to seek it out.

**Internal motivators.** In spite of challenges associated with the transition to the role of educator, internal motivators such as personal characteristics to do well and strength of character helped facilitate the process of transition for some (Anderson, 2009; Cooley, 2013). Mann (2013) described some participants experiencing an “ah-ha” moment with students that resulted in a change or influenced their development as a clinical instructor. Chapman (2013) found that critical thinking skills that were developed as a nurse were helpful during the transition process. McDonald (2004) discovered that skills in organization, confidence, and independent decision-making were personal characteristics that aided in the development of the teaching role. Anderson (2009) found that reaching milestones, experience, and expert clinical skills
were factors that positively influenced the work-role transition. In a descriptive, correlational study of resources and barriers experienced during transition, Goodrich (2014) found that novice nurse educators had high overall confidence scores, high personal control scores, and moderately high self-esteem scores. Overall, nurse educators making the transition from practice to academia in this study assessed themselves as positive in psychological variables that support nursing transitions.

**Outcomes of transition.** Schumacher and Meleis (1994) contended that the outcomes of a successful or healthy transition are three-fold: subjective well-being, role mastery, and well-being of relationships. “When a successful transition is occurring feelings of distress give way to a sense of well-being” (Schumacher & Meleis, 1994, p. 124). Role mastery includes “competence, knowledge or cognitive skills, and self-confidence” (Schumacher & Meleis, 1994, p. 124). Well-being in relationships indicates that a successful transition is occurring (Schumacher & Meleis, 1994). There was evidence in the literature to suggest that, with time, novice nurse educators may develop an understanding of the expectations of the faculty role and begin to form their identity in that faculty. This also supports Benner’s (1984) supposition that experience is a requisite in the development of expertise in a role.

Despite challenges and barriers associated with the transition, it was clear that many novice faculty had a desire to return because of a sense of accomplishment or a desire to improve (Gwin, 2012), feelings of reinvigoration and personal growth (Parslow, 2008; Testut, 2013), or having a memorable experience (good or bad) that prompted them to reflect on the meaning of being a teacher (Siler & Kleiner, 2001).

Duphily (2011) looked at the experience of six novice faculty members in an associate degree nursing program and found that despite complex challenges with the
role, all participants desired to continue because they loved teaching. Dempsey (2007) in a qualitative study of the transition of Irish nurses from clinician to lecturer found that despite early stress and anxiety, when participants looked at the transition from an overall perspective it had been positive. Goodrich (2014) examined the resources and barriers in the transition of nurse to nurse educator and found that there were significant challenges in work/life balance, salary, and workload; however, all of the nurses surveyed planned to stay in the role.

Davidson (2011) concluded that those who can “transcend the ambiguity and duality of their transition tend to remain in the academic setting” (pp. 174–175). This finding was echoed by Schoening (2013) who found that those who identified themselves as making a successful transition were able to establish boundaries with students and achieved comfort with the inherent ambiguity of the academic setting. Anderson (2009) found that the timeline for successful transition was variable and called this transition “from survive to thrive” (p. 138) with characteristics that included identifying and initiating change, reaching out, recognizing rewards, developing a vision, finding balance, and regaining comfort and confidence. Paul (2015) found that connections, relationships, and ongoing support provided supplementation for transition and increased job satisfaction.

**Summary of Transition Literature**

In summary, an in-depth exploration of the recent scholarly literature revealed that the transition process for novice faculty moving from practice to academia can be challenging and stressful when they are unprepared and have unrealistic expectations for the role. Barriers to the transition included limited opportunities for orientation and mentoring and lack of supportive relationships. These barriers, along with
internal motivation, become supportive strategies that help to facilitate transition when they are in place.

The majority of the literature consists of unpublished qualitative dissertations and published qualitative studies exploring the role transition of clinical nurses transitioning to part-time and full-time roles in academia. Only one descriptive, correlational study was found that described the transition to the role of nurse educator and the relationships among levels of readiness, confidence, and personal control (Goodrich, 2014). Further study examining preparedness, perceived level of role stress/role strain, effectiveness of mentoring, job satisfaction, and intent to stay are areas that are ripe for empiric research.

Although the transition of the expert clinical nurse to the role of novice educator is not a new phenomenon, there is a scarcity in the literature that documents this experience in the community college setting. The majority of published studies and unpublished dissertations focused on the transition from practice to baccalaureate and graduate programs. Three qualitative studies explored the transition of nurses from practice to adjunct clinical positions: one in the community college setting only (Chapman, 2013) and two studies in multiple settings including the community college (Mann, 2013; Parslow, 2008). One qualitative study of the experiences of full-time faculty in the community college was found (Duphily, 2011). This study did not focus on the transition experience from practice to academia, but rather the experience of educators in their first two years in the role. Paul (2015), in a comparative qualitative study, explored the perceptions of novice adjunct educators who were transitioning to full-time roles in a community college. Weidman (2013) included two
community college faculty in her qualitative study \((n = 8)\) of the lived experience of the transition of the clinical nurse expert to the novice nurse educator.

There are significant differences between community college and four-year university nursing programs: (a) a higher percentage of master-prepared faculty members teach in the community college setting where a terminal degree is not often a requirement for teaching; (b) because of severe shortages in some areas, bachelor-prepared nurses pursuing master’s degrees are also hired to fill vacancies, particularly for clinical; and (c) in the community college, there is a missional emphasis on the scholarship of teaching, not research (Zambroski & Freeman, 2004), which may not attract doctorally-prepared faculty. There is a gap in the literature looking at the lived experience of the transition of the expert clinical nurse to novice nurse educators in the community college setting, particularly full-time appointments which carry more teaching responsibility in the classroom and clinical settings.

**Conclusion**

Chapter II has provided an in-depth review of the scholarly literature related to the study problem, the nursing faculty shortage, and the transition of nurses from practice to academia. A discussion of the middle-range theory, experiencing transitions, by Meleis et al. (2000) provided the theoretical framework to guide the study, and an exploration of Benner’s (1984) seminal work, *From Novice to Expert*, provided the context for defining the concepts of novice and expert. The literature supporting the use of this theory in education has been presented and discussed. Chapter III will introduce the chosen methodology, phenomenology, for the study.
CHAPTER III

METHODOLOGY

Introduction

The nursing faculty shortage has reached a critical point and is expected to worsen as the current professoriate reach retirement age. Recruiting bachelor- and master-prepared clinical experts into academia may be a human resources solution to the nursing faculty shortage; however, many expert clinicians lack formal preparation or orientation to the role. Nursing programs have a responsibility to assure that novice faculty are competent to teach and to help them progress in their roles as educators. The focus of this study was to explore and describe the lived experience of clinical nurse experts transitioning to the role of novice educators. Describing the transition experience of expert nurse to novice educator is imperative to the development of strategies which may help those who are making the transition. A successful and healthy transition experience from clinical practice to academia will facilitate the progression of the nurse educator from a novice to an expert. In turn, this will improve the recruitment and retention of qualified faculty and eventually help ease the nursing faculty shortage.

The purpose of this chapter is to discuss the study approach and method of inquiry to answer the research question:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?
It begins with a review of the purpose of the study and research question followed by a discussion of the chosen methodology, hermeneutic phenomenology and its philosophical underpinnings. Participant setting and selection is described, followed by a discussion of data collection and analysis. Finally, this chapter presents methodological limitations and strategies for enhancing trustworthiness and credibility as well as protection of human subjects.

**Purpose of Study and Research Question**

This study sought to gain insight into the real-life experiences of novice nurse educators and understand their perceptions and meaning of their transition experience. The paradigm of hermeneutic phenomenology addressed the central research question:

Q1  What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

Sub-questions included:

Q1a  Why did the practicing nurse choose a career in academia?

Q1b  What factors helped or hindered the transition process?

Q1c  What knowledge, skills, and attitudes do practicing nurses bring from a clinical setting that helped in the transition to academia?

Q1d  How does a novice nurse educator learn the teaching role during the first three years?

The goal of this study was to present a rich, composite description of the experience which is important for understanding of the meaning of role transition through the shared experiences of expert clinical nurses who had transitioned to the role of nurse educators.
Research Design

The chosen methodology for the study was a qualitative phenomenological approach. Qualitative researchers seek a holistic understanding of social phenomenon in the real world from the viewpoint of the individual being studied. “Phenomenology aims to bring these experiential realities to language” (van Manen, 2014, p. 69) through the creation of descriptive and interpretive text (van Manen, 2014). The focus of qualitative research is on what the participant’s story and what he or she wants to convey (emic), not the researcher’s point of view (etic) (De Chesnay, 2015).

Philosophical Framework of Research Design

In qualitative research, the researcher brings beliefs and philosophical assumptions to the research process which, in turn, informs the choice of theory that guides the research (Creswell, 2007). Creswell (2007) stressed the importance of understanding the beliefs and assumptions that inform research and to include them in the writing of the study. The philosophical assumptions with implications for the research process include ontology (the nature of reality and its characteristics), epistemological (how reality is known), axiological (asks what is the role of values), and methodological (what is the process of research) (Creswell, 2007). Next, these philosophical assumptions and underpinnings of the chosen methodology, phenomenology, is discussed.

Phenomenology is not only a methodology but is a philosophy with epistemological and ontological aspects (Mackey, 2005). Two main phenomenological approaches (descriptive and interpretive) are rooted in the philosophies of Husserl and Heidegger and examine the lived experience of
individuals and the meaning of that experience (Polit & Beck, 2012). Each approach has unique philosophical underpinnings which differ in relation to their philosophical values, how findings are generated, and how those findings are utilized to build nursing knowledge (Lopez & Willis, 2004).

Researchers using descriptive or Husserl-inspired phenomenology seek to reveal the meaning of the intentional relationship between the subject in philosophy (the experiencer) and the object in philosophy (the something that is experienced) (Vagel, 2014). Descriptive phenomenologists are primarily interested in answering the question: “What do we know as persons” (Polit & Beck, 2012, p. 495) through rich descriptions of the phenomenon as it is experienced by the individual? Descriptive phenomenologists seek to describe everyday conscious experiences in their pure form through a process of bracketing or setting aside all presuppositions or preconceived opinions (Reiners, 2012).

Heidegger stressed understanding and interpreting meanings found in experiences, not just describing phenomenon as they are found in the world. Heidegger rejected the theory of knowledge or epistemology and adopted ontology, the science of being. The central question of interpretive phenomenology is: What is being? Heidegger believed that “being was revealed by studying beings” (De Chesnay, 2015, p. 5) with the intent to enter another individual’s world in order to interpret and describe human experience (Converse, 2012; Lopez & Willis, 2004; Polit & Beck, 2012; Reiners, 2012; Vagel, 2014). Heidegger believed it was impossible to negate one’s own experiences and prior understanding of the phenomenon under study; therefore, hermeneutics allows the researcher to describe and interpret the
participant’s experience with the phenomenon without bracketing one’s own biases and prior knowledge (De Chesnay, 2015; Reiners, 2012).

Phenomenology is constantly evolving, and there are many options for nurse researchers which align with one or more of the historical phenomenologists but deviate in terms of procedures and/or techniques (van Manen, 1990). The modified hermeneutic approach of van Manen (1990) informed this study of the lived experiences of expert clinicians transitioning to the role of novice nurse educator. Van Manen’s hermeneutic phenomenology combines both descriptive and interpretive approaches. It is descriptive because “it wants to be attentive to how things appear, it wants to let things speak for themselves; it is interpretive because it claims that there are no such things as uninterpreted phenomena” (van Manen, 1990, p. 180).

Van Manen (1990) stated that phenomenology is the study of “the lifeworld . . . as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it” (p. 9). Van Manen (1990) maintained that consciousness is the only access that human beings have to the world around them and that anything that presents itself to our consciousness makes us aware of some aspect of the world. Phenomenological researchers are interested in the world of the human being. The term human science research is used interchangeably with phenomenology and hermeneutics to study “persons or beings that have consciousness and that act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world” (van Manen, 1990, p. 4). Human science researchers study the essence or nature of an experience and ask the question, what is it that makes “some-thing what it is” (van Manen, 1990, p. 10), in other words, the essence of some-thing that could not exist without it. Human science attempts to
describe and interpret the meanings of our everyday existence or lifeworld lived experience with depth and richness through language (van Manen, 1990).

Van Manen (1990) did not approach phenomenology with rigid rules, procedures, or a pre-scripted method, but instead stated that the aim of phenomenological research is to be presuppositionless. Instead of a preset approach, van Manen (1990) offered six themes which serve as practical guidelines for conducting human science.

1. Turn to a phenomenon which seriously interests us and commits us to the world.
2. Investigate experience as we live it rather than as we conceptualize it.
3. Reflect on essential themes which characterize the phenomenon.
4. Describe the phenomenon through the art of writing and rewriting.
5. Maintain a strong and oriented pedagogical relation to the phenomenon.
6. Balance the research context by considering parts and the whole. (pp. 30–31)

Rationale for Qualitative Design

Van Manen (1990) maintained that “lived experience is the starting point and end point of phenomenological research” (p. 36). He went on to say that “an appropriate topic for phenomenological inquiry is determined by the questioning of the essential nature of a lived experience: a certain way of being in the world” (van Manen, 1990, p. 39). Phenomenology allows individuals to describe their experiences in an effort to seek understanding of the world in which they work and live (Creswell, 2007). A phenomenological method was an appropriate choice for this study because it afforded this researcher an opportunity to explore the lived experience of novice nurse educators in order to create a deeper understanding of meaning of the transition experience.
Setting

The setting for this study was community and technical college nursing programs. The rationale for choosing to focus on the community and technical college setting was that although this problem is not new, there is a paucity of literature documenting the lived experience of the transition of the expert clinical nurse to novice nurse educator in the community college. Schools were limited to Washington State for practical reasons and accessibility to the researcher. Names of schools and contact information were obtained from the Council of Nursing Education in Washington State listserve and member roster of which the researcher is a member. The Council of Nursing Education in Washington State is an organization of deans and directors of all nursing programs in Washington State. A total of 31 community and technical colleges with associate degree nursing programs are located within the State of Washington.

Sampling Strategy

Prior to data collection, appropriate Institutional Review Board approval was sought and secured (see Appendix A). A purposeful sampling strategy targeting novice faculty in a community or technical college setting was employed. Purposeful sampling is a type of non-probability sampling in which the researcher consciously selects participants because they share characteristics relevant to the study. Richards and Morse (2013) suggested that “good participants are those who know the information required, are willing to reflect on the phenomena of interest, have the time, and are willing to participate” (p. 221). One key aspect of sampling in a qualitative study is that all participants must have experienced that same phenomena and are able to articulate the experience (Polit & Beck, 2012). Snowball sampling
may also be utilized if more participants are needed. Snowball sampling is a variant of convenience sampling (Polit & Beck, 2012). Snowball sampling is also a non-probability technique, where early study participants refer future participants who meet eligibility criteria (Polit & Beck, 2012).

Participants were recruited who met the following inclusion criteria:

1. Educational preparation at the bachelor- or master-level in nursing. Currently in the State of Washington bachelor-prepared nurses may be allowed to teach as long as they are currently enrolled in a graduate level nursing program and have been approved by the Nursing Care Quality Assurance Commission.

2. No previous formal academic teaching experience before current position.

3. No previous experience as a clinical instructor before current position.

4. Five years or more experience as a registered nurse (RN) in the clinical setting.

5. Self-identified or peer-identified as expert clinician.

6. Three years or less of teaching experience in current position, teaching both theory and clinical. The sample inclusion criteria of having taught theory in addition to clinical is to capture the added dimension of teaching that occurs when teaching theory which requires additional competencies in course and curriculum development, identification and presentation of didactic content, test development, and classroom management among others (National League for Nursing [NLN], 2002).

7. Full-time appointment as defined by the participant’s institution.
A novice as defined as Benner (1984) is an individual who lacks experience or knowledge in the situation they are expected to perform in. For the purpose of this study, a novice nurse educator included bachelor- and master-prepared nurses who had been in the academic setting less than three years (Cooley, 2013). Novices, in this study, had no formal academic preparation for the nurse educator role and had been in their academic roles. Benner (1984) described the expert in clinical practice as an individual with extensive experience who is able to intuitively comprehend a situation and make rapid decisions. Experts operate out of a deep and holistic understanding of a situation and no longer rely on rules or guidelines to connect that understanding to action. For the purpose of this study, an expert nurse had a requisite of five years of clinical experience (Anderson, 2009; Benner, 1984).

There is no set sample size for qualitative research studies; however, theoretical saturation has been the gold standard by which purposive sample sizes are determined in health science research (Guest, Bunce, & Johnson, 2006; Morse, 1995; O’Reilly & Parker, 2012). The concept of data saturation was developed in the approach of grounded theory (Guest et al., 2006), and variations have evolved for different qualitative methods; however, data saturation is generally taken to mean sampling continues until nothing new is generated (O’Reilly & Parker, 2012). There is debate in the literature regarding data saturation as a criterion by which to justify the adequacy of a sample (Guest et al., 2006; Morse, 1995; O’Reilly & Parker, 2012). Morse (1995) contended that “in qualitative research, there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation equivalent to those formulas used in quantitative research” (p. 147). While conducting a review of the literature for a study on data saturation and variability,
Guest et al. (2006) reviewed 24 research methods books and seven databases and came to the same conclusion as Morse, “very little headway has been made in this regard” (p. 60). O’Reilly and Parker (2012) offered three arguments against the uniform acceptance of using saturation as a quality marker: (a) saturation has multiple meanings, (b) there is a lack of practical guidance to help researchers recognize when saturation has been reached, and (c) there has historically been a lack of transparency by researchers in reporting the details of how saturation is determined.

Marshall (1996) offered this advice when determining the sample size of a qualitative study: “An appropriate sample size . . . is one that adequately answers the research question” (p. 523) using a flexible and pragmatic approach. O’Reilly and Parker (2012) stated that sampling in qualitative research should be concerned with richness of information, and Morse and Field (1995) stated that sampling is based on adequacy and appropriateness. It is difficult to predetermine the sample size needed to achieve these goals and information rich sources. For the purpose of this study, I intended to recruit six to eight participants to start. I planned to use a transparent and flexible approach with input from my peer reviewers as to whether the sample size was adequate and appropriate or if I should continue to recruit and interview participants.

**Data Collection**

The researcher is the primary instrument of data collection in qualitative studies. Face-to-face interviews were the primary strategy that was utilized to capture the meaning of the experience of transition in the participants’ own words. A demographic questionnaire was also used to obtain data about gender, ethnicity, length of time in the profession of nursing, and highest degree earned. The demographic
questions were asked in an effort to find out certain attributes which may be helpful for explaining what may underlie a participant’s perceptions, as well as similarities and differences in perceptions among the participants. Field notes and a journal with impressions, observations, and memos made by the researcher were also sources of data.

To obtain a purposive sample of novice nurse educators who met the inclusion criteria, the deans and directors of the 31 associate degree nursing programs in Washington State were contacted via e-mail with a letter of introduction to the study (see Appendix B) and asked to share a letter of invitation to any of the nursing faculty who met the inclusion criteria for the study (see Appendix C). Willing participants were asked to contact the researcher by e-mail with contact information. Interested faculty were contacted by the researcher by phone to talk through the inclusion criteria and to schedule a face-to-face interview. Interviews were arranged and conducted in private at a time convenient for the nurse faculty member that did not interfere with instructional time.

A 90-minute block of time was reserved for face-to-face interviews. Interviews took place in private settings chosen by the study participants. Seven of the interviews took place in the participant’s private office at their place of employment, one interview took place in a restaurant at a private table, and one interview was conducted via Skype. An amendment to the data collection method (Appendix D) to include Skype was submitted half way through the data collection process in order to facilitate an interview for a participant who had to be in a different state for a family emergency. This amendment was approved by the Institutional Review Board (see Appendix E). All interviews lasted between 30 and 60 minutes. An interview guide
created by the researcher was used as a guide for the interviews (see Appendix F). Before the interviews began, the researcher obtained written consent (see Appendix G) from the participants, and I went over the details of the consent as well as the overall purpose of the study.

At the beginning of each interview, participants were asked to complete a demographic survey (see Appendix H). All of the demographic form data were compiled into Table 1. Nine participants, representing two states and six community and technical colleges in the Pacific Northwest region of the United States, were interviewed. Participants in the study came from diverse educational and nursing backgrounds, as well as experience levels. All of the participants’ names were changed, and pseudonyms were used to protect their identity.

Eight participants held master’s degrees: one as a family nurse practitioner, one as a clinical nurse specialist, one in occupational health and environmental nursing, three in nursing education, and two held dual master’s degrees in nursing education and nursing leadership and nursing education and administration. One participant was hired into a full-time position with an associate degree in nursing, completed her bachelor of science in nursing during her first two years of employment, and is now enrolled in a master’s in nursing education program. Years of experience as a nurse ranged from 8 to 40 years.
<table>
<thead>
<tr>
<th>Name</th>
<th>Race</th>
<th>Teaching qtrs/yrs</th>
<th>Student teaching level 1\textsuperscript{st}/2\textsuperscript{nd} yr</th>
<th>Tenure Track?</th>
<th>Education</th>
<th>Workload breakdown\textsuperscript{a}</th>
<th>Other responsibilities</th>
<th>Currently practicing hrs/wk</th>
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<td>Melanie</td>
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<td>50/25/25</td>
<td>A, NC, IC</td>
<td>Yes, per diem</td>
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<td>Jennifer</td>
<td>Cauc.</td>
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<td>Yes</td>
<td>MN-Ed</td>
<td>50/50</td>
<td>A, IC</td>
<td>No</td>
</tr>
<tr>
<td>Laura</td>
<td>Cauc.</td>
<td>5\textsuperscript{th} qtr</td>
<td>2\textsuperscript{nd}</td>
<td>No</td>
<td>MN-CNS</td>
<td>50/50</td>
<td>A, IC</td>
<td>No</td>
</tr>
<tr>
<td>Jackie</td>
<td>Cauc.</td>
<td>2\textsuperscript{nd} qtr</td>
<td>1\textsuperscript{st}</td>
<td>Yes</td>
<td>MN-ARNP</td>
<td>50/35/10 5 sim &amp; other</td>
<td>A, NC, IC</td>
<td>No</td>
</tr>
<tr>
<td>Jill</td>
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<td>8\textsuperscript{th} qtr</td>
<td>Both</td>
<td>Yes</td>
<td>MN-Ed, Nursing Leadership</td>
<td>50/50</td>
<td>A, NC, IC</td>
<td>Yes, 8 hrs on call/wk</td>
</tr>
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<td>Sue</td>
<td>Cauc.</td>
<td>2\textsuperscript{nd} qtr</td>
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<td>40/60</td>
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<td>No</td>
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<td>2 yrs</td>
<td>Both</td>
<td>Yes</td>
<td>MSN, Administration &amp; Ed</td>
<td>50/50 clin &amp; sim</td>
<td>A, NC, IC</td>
<td>No</td>
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<td>3 yrs</td>
<td>Both</td>
<td>Yes</td>
<td>BSN, enrolled in MN-Ed</td>
<td>10/50/30/10 clin &amp; sim</td>
<td>A</td>
<td>Yes, 12 hrs/wk</td>
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<td>1\textsuperscript{st}</td>
<td>Yes</td>
<td>MN-Occupational health &amp; environmental nursing</td>
<td>50/50</td>
<td>A, student club advisor</td>
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</tr>
</tbody>
</table>

\textit{Note.} A = advising, NC = nursing committees, IC = institutional committees; MN = master of nursing degree, CNS = clinical nurse specialist, ARNP = advance registered nurse practitioner.  
\textsuperscript{a}didactic/clinical/laboratory/simulation and other.
All participants were hired into full-time positions (defined by their institutions) with six of the nine in a tenure-track role. Four participants were in their second quarter of teaching, three were in their second year, and two were in their third year of teaching. Three participants held part-time roles in practice: one per diem, one eight hours per week and on call, and one 12 hours per week. The workload of each participant included both didactic and clinical hours each week, and four participants also included hours for laboratory and/or simulation.

A semi-structured interview format was utilized. Semi-structured interviews are a more flexible approach than a structured interview and include questions where the interviewer may use a mix of open-ended and less structured questions (Merriam & Tisdell, 2016). The participants were asked to share their experiences in transitioning from practice to academia by using an open-ended prompt with as little interruption as possible. Follow-up questions were used for clarification of details or to elicit more information. A list of follow-up questions or probes may be found in Appendix F. Field notes were taken, and the interviews were audio taped per consent of the participant. At the conclusion of the interview, the participants were asked if there was anything they would like to add and/or clarify, and participants were thanked for their participation. Participation was voluntary with no monetary remuneration.

Van Manen (1990) also mentioned other types of data that may be collected, such as journals and accounts from drama, film, poetry, art, and novels. Sources of data for this study included transcripts of interviews, the researcher’s own field notes,
and the demographic survey. This was done for practical reasons to be able to manage the scope of this study.

**Data Analysis**

The narratives from the participants served as the means by which the experience of transitioning from expert clinician to novice educator was accessed. Phenomenological analysis allows themes and information about the meaning of this experience to emerge. The process of data analysis relied on van Manen’s (1990) method. According to van Manen (1990), gaining “insight into the essence of a phenomenon involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of the meaning of lived experience” (p. 77). The process of data analysis involves identifying the structures of meaning or themes that are embodied in the lived experience (van Manen, 1990). Van Manen (1990) was clear to distinguish that the idea of a theme is more than counting or coding terms in a text or breaking down of content but is best understood by looking at the methodological and philosophical character of a theme. Van Manen (1990) outlined four characteristics of a theme:

1. Theme is the experience of focus, of meaning, of point;
2. Theme formulation is at best a simplification;
3. Themes are not objects one encounters at certain points or moments in a text;
4. And theme is the form of capturing the phenomenon one tries to understand. (p. 87)

Van Manen (1990) outlined three approaches that may be utilized to uncover the thematic aspects of the lived experiences:
1. Holistic or sententious approach—attention is paid to the text as a whole and asks the question, “What sententious phrase may capture the fundamental meaning or main significance of the text as a whole” (p. 93)?

2. Selective or highlighting approach—listen to or read the text several times and asks the question, “What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described” (p. 93)? Essential statements are circled, highlighted, or underlined.

3. Detailed or line-by-line approach—read every sentence or sentence cluster carefully and ask the question, “What does this sentence or sentence cluster reveal about the phenomenon or experience being described” (p. 93)?

The data analysis phase of this study involved a prolonged, intensive engagement with the data. All interviews were transcribed verbatim and analyzed in their entirety. Each transcript was read multiple times for the purpose of understanding the participants’ experiences. Manual coding using a color-coding system was used by the researcher to uncover significant statements and phrases which seemed to be revealing of the meaning of the experience.

After transcript themes had been identified, these themes became objects of reflection, and the researcher returned to the participants where they collaborated to interpret the significance of the preliminary themes in light of the original research question (van Manen, 1990). Both the researcher and the participant weighed “the appropriateness of each theme by asking: is this what the experience is really like” (van Manen, 1990, p. 99)? A follow-up interview was offered to each participant to
collaborate and validate the significance of the preliminary themes. Van Manen (1990) posited that the “collaborative quality of the conversation lends itself especially to the task of reflecting on the themes of the phenomenon under study” (p. 98). The goal of hermeneutic interview is to keep the question open and allow participants to reflect on the text of previous interviews in order for them to gain as much interpretive insight as possible (van Manen, 1990). It was foreseeable that some, if not all, participants would decline a second interview. Six of the nine participants agreed to participate in a second interview. This may have impacted the results of the interpretive process, as some of the depth of meaning could be lost that may have been gained through this collaborative process. There are several phenomenological methods that do not include follow-up interviews (or member checks), and the end product is still rich in description and meaning. The process of peer review in this study helped increase the credibility of findings when no second interviews were scheduled.

After the follow-up interviews, the researcher attempted to differentiate between essential and incidental themes through a process of writing and reflection. Essential themes were determined by asking the questions, “Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning” (van Manen, 1990, p. 107)? If the answer to these questions was yes, then the theme was essential to the meaning of the phenomenon. Once the essential themes were uncovered, the researcher returned to writing. Van Manen (1990) stated that “the research process itself is practically inseparable from the writing process” (p. 167). Writing, reflection,
and re-writing are woven throughout the research process with the aim of creating a
phenomenological text that elucidates the essence and meaning of the lived experience
(van Manen, 1990).

Limitations, Delimitations, and Assumptions of Research Design

Assumptions. To address the main purpose of this study, the researcher
utilized a qualitative phenomenological method. Assumptions acknowledged in this study included:

1. Participants are truthful and able to recall the events of their transition experiences with accuracy.
2. The researcher also assumes that the utilization of a qualitative method is the appropriate choice to produce rich, comprehensive findings to fill in existing gaps in the existing body of knowledge in nursing education.
3. Role transitions take place for all expert clinical nurses assuming positions as novice nurse educators.
4. A fundamental set of competencies and skills is required to be an effective, expert nurse educator.

Limitations. The following limitations are noted as inherent in the research design:
1. The main data collection technique is interview, which may lead to misinterpretation of data by the researcher.

2. A small convenience sample of nurse educators does not allow findings to be transferable to the larger population of nurse educators.

**Delimitations.** The scope of this study was narrowed to focus on full-time nursing faculty members teaching pre-licensure students and who had been teaching less than three years. The study did not include part-time or adjunct faculty employed by academic institutions.

**Ethical Issues**

All research is guided by three major ethical principles that protect the rights of humans: respect for persons (or respect for human dignity), beneficence, and justice. Respect for persons or respect for human dignity includes the right to self-determination and the right to full disclosure. Self-determination means that individuals should be treated as autonomous agents with the right to decide whether or not to participate in a research study (Holloway & Wheeler, 1995). Full disclosure entails that the researcher fully describes the nature and purpose of the intended study as well as the participant’s right to refuse participation, the likely risks and benefits, and the right to withdraw participation at any time. Beneficence levies a duty on the researcher to minimize harm and maximize benefits to the participant. This principle includes the right to freedom from harm (nonmaleficence) and freedom from exploitation. The principle of justice includes the right to fair treatment before, during, and after the study and the right to privacy as virtually all research involves some type of intrusion into an individual’s personal life (Holloway & Wheeler, 1995).
These principles do not ensure ethical research but do contribute to a greater understanding of the ethical responsibility in research that involves human subjects.

The following safeguards were implemented to protect the rights of the participants of this study. This study was implemented following Institutional Review Board approval from the University of Northern Colorado. Participants recruited for this study were provided a written informed consent form that disclosed the procedures and ensured confidentiality, protection from harm, and the right to withdraw from the study at any time without repercussions. The informed consent contained the qualitative procedures utilized, permission to record the interview, and an explanation of how this researcher would maintain confidentiality and privacy of information shared. Participants were given ample time to read the consent form in its entirety and given a chance to ask any questions they had about the study. A copy of the informed consent was given to each participant, and the signed original was placed in a sealed envelope that was stored in a locked drawer in the researcher’s home office. Participants were given a full explanation of the nature of the research and the format of the interview.

To protect the identity of participants, a pseudonym was assigned which was used on all audio recordings, written field notes, and written research findings. All data contained no identifiable features of either the participant or institution where she was employed. All digital audio recordings were kept under password protection on the researcher’s personal recording device and computer and were shared with the professional transcriptionist hired to transcribe the interviews and the peer reviewers.
All written data were securely stored in the researcher’s home in a locked file drawer for a minimum of three years.

Risks to participants in the study were minimal. There was a negligible risk that self-reflection and sharing experiences would result in the participant feeling psychological discomfort such as stress, anxiety, or frustration. If the interviewee became distressed during the interview, consent was confirmed, and the participant was asked if she wished to continue. A benefit of participating in this study could be the opportunity to reflect on their experience as novice educators and their transition to academia. Participants may gain insight into their transition experience; however, the study was not designed to facilitate their transition as a nurse educator. All participation was voluntary, and no monetary remuneration was provided to participants.

**Trustworthiness and Enhancing Credibility of Qualitative Data**

In qualitative research, there is an inherent level of trust from the participants that the researcher will be forthcoming about the purpose of the study, not use coercive methods to gather data, and not exploit information shared for the purpose of the study. Confidentiality of participants is paramount. Lincoln and Guba, 1985 (as cited in Holloway & Wheeler, 2010), stated the rigor in qualitative research focuses on trustworthiness which is measured by four key concepts: credibility, transferability, confirmability, and dependability. To ensure the trustworthiness of the interpretations made during the process of data analysis and to ensure sound and credible findings, strategies such as member checks and peer-review were used (Creswell, 2007) as well
as making every effort to ensure that the experiences relayed by the participants truly reflected their actual experiences.

Credibility or truth value refers to the confidence in the truth of the findings of a particular inquiry for participants and the context of the inquiry (De Chesnay, 2015). Member checking, though debated in the literature, is one way to establish the credibility of qualitative data. In a member check, the researcher goes back to the participant either in writing or in a face-to-face discussion to provide feedback to participants about emerging themes, interpretations, and to gain feedback about whether meanings were understood and obtain participants’ reactions (Holloway & Wheeler, 2010; Merriam & Tisdell, 2016). Phenomenologists, such as van Kaam and Colaizzi, advocated the benefits of this strategy; while others, such as Giorgi, saw it as inappropriate because it puts the participant into the role of evaluator rather than a describer of lived experience (De Chesnay, 2015). In this study, a follow-up interview was offered to each participant to collaborate and validate the significance of the preliminary themes, a strategy endorsed by van Manen (1990).

Peer review was used as an external check of the research process. Lincoln and Guba, 1985 (as cited in Creswell, 2007), defined the role of peer reviewer as,

a devil’s advocate, an individual who keeps the researcher honest; asks hard questions about methods, meanings, and interpretations; and provides the researcher with the opportunity for catharsis by sympathetically listening to the researcher’s feelings. (p. 208)

Transcripts and data analysis were reviewed by the primary researcher’s advisor, Faye Hummel, throughout the entire process of the study. A second doctorally-prepared nurse researcher with extensive qualitative research experience also reviewed the data and analysis through the process. This nurse researcher lived in the researcher’s local
area, which helped the logistics of collaboration. Using peer reviewers helped strengthen the credibility of this study.

An audit trail was maintained during this study as a means to document the research process as suggested by Creswell (2007). Audit trails in qualitative research are used to outline the research process, research activities, interviews, transcription, initial coding, evolution of categories, themes, and how decisions were made (Creswell, 2007). The researcher kept a binder and journal documenting each step of the research process. Field notes, self-reflections, analysis, and communication with research advisors were logged into the audit trail binder.

In hermeneutic phenomenology the researcher is both the instrument for and interpreter of the research data, making it difficult to separate one’s culture and history from the lens of researcher (Creswell, 2007). Heidegger (as cited in Reiners, 2012) believed it was impossible to negate one’s own experiences and prior understanding of the phenomenon under study; therefore, hermeneutics allows the researcher to describe and interpret the participant’s experience with the phenomenon without bracketing one’s own biases and prior knowledge.

Reflexivity is defined as the “process by which researchers recognize they are an integral part of the research and vice versa” (Munhall, 2012, p. 321). As a nurse educator myself, I brought certain assumptions and biases to the study which could have potentially interfered with data collection and analysis. The first of these was my own experience as a clinical nurse and then nurse educator. I had five years of clinical experience in the acute care setting before I started a master’s degree in nursing with an emphasis as an acute care nurse practitioner and simultaneously began teaching in a
community college nursing program. I did not have a formal orientation to teaching, and my background in my graduate program was primarily clinical in nature, so I started teaching with virtually no formal preparation in education. I was fortunate to have a very supportive faculty to work with, but my transition was very difficult at times as I felt as if I was learning as I went along and staying one day ahead of my students. During the process of data collection, I consciously made myself aware of these biases before each scheduled interview and made every effort to ensure that my questions and probes were not introduced to the participant. After each interview I practiced self-reflection by way of journaling to re-clarify my biases and search for additional assumptions or biases throughout the research process.

**Summary**

Chapter III provided a review of the purpose of the study and research question followed by a discussion of the chosen methodology and hermeneutic phenomenology and its philosophical underpinnings. Van Manen’s (1990) methodology was an appropriate choice for investigating the research question:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

This method allowed the researcher to explore the meaning of the transition from expert clinician to novice educator through the shared descriptions of those who had experienced it. Methods of data collection and analysis were explicated, and strategies to ensure trustworthiness and strengthen credibility were also discussed. Ethical issues of research involving human subjects were outlined as well as safeguards implemented to protect participants.
CHAPTER IV

RESULTS AND DISCUSSION

Introduction

The purpose of this study was to explore and describe the lived experience of clinical nurse experts transitioning into the role of novice educator. This study sought to gain insight into the real-life experiences of novice nurse educators and understand their perceptions and meaning of their transition experience. The paradigm of hermeneutic phenomenology addressed the central research question:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

Nine nurse educators were interviewed and asked to describe their transition experience from an expert role in clinical practice to a novice role in nursing education. Through the process of data analysis, five themes emerged representing the collective essence of the transition experience.

Results and Findings

The central research question for this study was:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

In this qualitative study, nine participants were interviewed, and each shared a unique experience transitioning from a clinical practice setting to a novice educator role in a community or technical college. Despite differences in age, years of experience as a
nurse, preparation for transition, and other characterizing factors, common themes representing different aspects of the transition experience emerged through the process of data analysis.

The texts of the interviews provided the primary data for analysis. A process of manual coding was used to determine significant statements, meanings, and subsequent patterns and categories of data which represented the lived experience of the nine participants. Coding generated 31 categories which were clustered into six preliminary themes. These categories and themes were shared with each of the participants along with an invitation for a follow-up interview to collaborate and validate the significance of the preliminary themes.

Six participants agreed to participate in a follow-up interview. Each follow-up interview was conducted via Skype or phone and lasted between 35 to 90 minutes. During the follow-up interview, the researcher and the participant collaborated to interpret the significance of the preliminary themes, taking into account the original research question. Using van Manen’s (1990) data analysis method, both the researcher and the participant weighed the appropriateness and significance of each theme in light of the original research question. Each participant was excited for the opportunity to collaborate in the iterative process of theme development and was eager to see the collective experience that was beginning to unfold. After each follow-up interview, the researcher went back to the data and further reflected on and refined the themes and sub-themes. Preliminary categories, themes, and sub-themes were shared with both the research advisor and local peer mentor who provided feedback about how to further collapse and refine the themes and sub-themes.
The data analysis process yielded five final themes and 15 sub-themes that represented the collective essence of the experience of the transition from expert clinical roles to novice roles in academia (see Table 2). These themes are presented in the subsequent sections.

Table 2

*Themes and Sub-Themes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
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<tbody>
<tr>
<td>1: Anticipating the transition</td>
<td>Having the desire to teach</td>
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<tr>
<td></td>
<td>Being recruited to teach</td>
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<td></td>
<td>Being dissatisfied with practice role</td>
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<tr>
<td>2: Starting out</td>
<td>Inadequate orientation and mentoring</td>
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<td></td>
<td>Lack of preparedness</td>
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<td></td>
<td>Need for knowledge and information</td>
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<td>3: Learning to teach</td>
<td>Jumping in with both feet</td>
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<td></td>
<td>Early experiences</td>
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<td></td>
<td>Wanting and receiving feedback</td>
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<tr>
<td>4: Influencing factors</td>
<td>Facilitating factors</td>
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<td></td>
<td>Hindering factors</td>
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<tr>
<td></td>
<td>Knowledge, skills, and attitudes of new faculty</td>
</tr>
<tr>
<td>5: Getting there</td>
<td>Identifying growth and initiating change</td>
</tr>
<tr>
<td></td>
<td>Finding rewards and satisfaction in the role</td>
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<td></td>
<td>Choosing to continue</td>
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</table>
Theme 1: Anticipating the Transition

For all of the participants there was a period of time varying in length from weeks to years leading up to the transition from practice to academia. During this time period several different underlying factors led the participants to choose to transition to nursing education. Three sub-themes were identified as reflective of the time leading up to the decision to transition to academia: (a) having the desire to teach, (b) being recruited to teach, and (c) being dissatisfied with practice role. Among the three sub-themes, there was also overlap, as most participants’ decision to pursue academia was often a result of more than one factor.

Having the desire to teach. Participants reflected on their interest in nursing education and teaching years prior to their transition. Jennifer shared specifically that she knew her perfect fit was teaching brand new nurses after orienting new hires in her clinical unit. Jennifer was strategic in completing her master’s degree but did not seek a position in academia right away because she wanted to wait until she had enough experience behind her to offer in the classroom. When she felt like she was ready to apply, a position opened up at the college where she wanted to teach.

At some point in their clinical careers, participants had precepted or oriented a new hire and found the experience enjoyable. Melanie expressed,

I just always enjoyed having a student with me. I enjoyed seeing them learn and seeing the “oh, I get it.” This is just fun. I just really enjoyed seeing that excitement . . . it was just my favorite part of the day when you get a student that would really want to learn, and so I liked to teach.

Jackie shared about how she always thought about being a teacher since high school, but it was not until well over 30 years into her career that she precepted a nurse
practitioner student and found that it was a wonderful experience and she “wished she had a student all the time.”

Jill’s interest in education stemmed from a love of doing patient teaching in her clinical practice in the emergency room. Jill expressed, “I loved being able to teach even if it was for only a few minutes and so that’s kind of what got me the education bug.” Jill went back to school for her master’s degree and said that “the biggest thing I wrote about was about when nurses eat their young.” Jill shared that what really drove her to education was her desire to start or help the upcoming nurses fix this unhealthy culture. Jill felt that she was giving back by “helping grow nurses that I would want to see and I would want to be taken care of and who I want to represent the field of nursing.”

Heather always had an interest in teaching and expressed how she felt very blessed by her long career in military nursing and wanted to give back to her community.

I felt the military was really good to me. And I felt that ahm . . . we need people really vested in making good quality nurses. And, because that is our future. And I was seeing that if we don’t just take care of our future what’s going to happen to our profession. So that was kind of the underlining motivation that I’d been blessed with in this field. I’d been blessed with my experience. I met so many great nurses who mentored me, that I think you have to share what you’ve learned with others. Ahm, it’s a travesty if you don’t. And unfortunately I do see people that don’t do that.

**Being recruited to teach.** Recruitment by program administrators or other faculty was a strategy utilized to fill faculty vacancies. One participant, Jill, had a desire to teach as mentioned previously and was also recruited by the nurse administrator. She shared that the nurse administrator came to her graduate school graduation ceremony and asked her to consider applying for an opening.
Participants who were recruited to academia may not have considered a career in teaching before being asked, but were at a point in their career where they were ready for a change. Laura knew the program director and another faculty member who she would run into occasionally in the community. Both of them encouraged her to try teaching. Kay was very good friends with a program director for years, who encouraged her to consider teaching if she wanted to make a change.

Sophie was working on an associate degree-prepared nurse in the local rural hospital when she was approached by the college looking for nursing instructors. Sophie shared that the college was very short staffed and would allow her to teach with the requirement that she would work on her bachelor’s degree.

Well, I didn’t really have an intention to working on my BSN [bachelor of science in nursing] so that kind of pushed me to work on it quicker. So ahm, then I wasn’t really happy with my current job as a supervisor just because the current roles just seemed a little stressful.

**Being dissatisfied with practice role.** Participants voiced dissatisfaction in their practice roles a number of ways: frustrations with systems, 12-hour shifts getting harder, tired of the commute to work, feelings of burn out, and being ready for a change physically and emotionally. Feelings of dissatisfaction often overlapped with other factors in deciding to make the transition from practice to academia.

Melanie found that as she was getting older, 12-hours shifts were getting harder, and she was starting to feel a little burned out on some of it. She felt like she was not able to take care of patients the way she wanted because of charting, the demands, and an accumulation of things. Underneath it all there was still a desire to teach, and so she found an open position and applied. Jackie expressed some of her frustrations with her role as an advanced practice nurse, particularly with learning the
electronic health record system, difficult patients, and other system issues. After precepting a nurse practitioner student and enjoying the experience, she decided that she was ready for a change and applied for a position at the college. Sophie was working as a nursing supervisor in acute care and found the role to be stressful and was not really happy, and when the college came to her looking for instructors she decided to apply for the position. Jill enjoyed patient teaching and was recruited by the nursing director; however, she also voiced that after seven years in the emergency department and cath lab, she was starting to feel a little burned out.

Laura was ready for a change in her career and expressed:

I worked for a local hospital here for 22 years in various roles. At the very end, I was a nurse team leader in a cardiovascular unit. But, I just felt like I was ready for a change. Just, it was just emotionally, physically, I needed a break from it.

When an opportunity became available, she decided, “why not” and applied.

Kay was looking to make a change and recalled:

The lady that hired me was the director of the program at the time. And she was a really good friend of mine. She said, “we’d like to have you come on board if you’d like to.” And I said, “you know after almost 15 years, I’m really tired of commuting from [city] to [city].” Once a week and back. Back and forth, back and forth. And I would stay over there when I was working. And I would love to just be able to stay home. And I said, “sure, that’s fine.”

**Theme 2: Starting Out**

After choosing to transition to academia, participants described a time of entering into an environment and role that were very different than what they were used to. Heather summarized entry into academia well when she said, “it's a whole paradigm shift.” Initial feelings ranged from being excited for something new to being scared to death because they had no idea what they were getting themselves into. The second theme, starting out, describes the common aspects of entry into the
new role of nurse educator. The theme is characterized by three sub-themes: (a) inadequate orientation and mentoring, (b) lack of preparedness, and (c) need for knowledge and information.

**Inadequate orientation and mentoring.** Orientation and mentoring are two key components in the socialization of a new faculty member to the knowledge, skills, behaviors, and culture of a novice faculty role. Orientation to the role and mentoring occurred simultaneously for some participants, where others experienced one or the other or none.

A common thread was the lack of a formal orientation or shortened orientation to the nursing program and inadequate socialization to the faculty role. A shared feeling of having to “figure things out on my own” resonated with those participants who believed they received an inadequate orientation. Consequently, some felt that they were learning by “trial and error,” “by making mistakes,” or “just doing the best that they could.”

Often, participants were hired and started their roles with very little preparation time, in most cases a week or two before the students were in class. There was pressure to figure out what content they were going to teach, how they were going to teach it, as well as learn other aspects of their roles and orient to the college. Some had the added pressure of having to attend required all-faculty meetings before the students came back and felt a tension about where to spend their time, participate and learn important information about the college or spend the time preparing for class. Sue explained:

> We had faculty week, is what they called it. That was kind of helpful. Where they had a luncheon out west of town by the lake . . . we spent the day in
different classes and talking to teachers all over the campus. And then there were more classes during that week that we went to, and eventually by Wednesday the other new teacher and I were kind of like, we have a lot of stuff to do before we get going for the class. So we went and bowed out of some of the stuff.

Melanie recalled:

We came back a week before students were on campus. There’s a lot of campus meetings during that time where it’s difficult to spend some of your time [preparing and orientating] because of the other college requirements that they’re wanting you to do.

Descriptions of orientation processes varied significantly, even for two participants employed in the same institution. The quality and quantity of the orientation experience was influenced by factors such as faculty shortages or vacancies within programs, especially seasoned faculty to orient new faculty and leadership turnover, communication breakdowns, colleagues who were too busy or had other competing priorities, or lack of a structured program or process in place to orient new faculty.

On one end of the spectrum, Laura described a structured orientation process which included coming in over the summer to faculty meetings to meet faculty and learn the lingo and participating in two formal education courses designed to orient new faculty to the campus her first two quarters. On the other end of the spectrum, lengthy, structured orientation programs were not an established practice.

Jill explained that she had an orientation to the nursing department and college and received a big binder with policies and procedures for the nursing program. Heather, who worked at the same institution as Jill, said she also received an orientation to the college and the same big binder, but felt that she did not really have
orientation to the nursing program. Heather shared, “I felt like I was given the textbooks and then said, ‘here’s the syllabus and go off.’”

Sue and Kay were hired to fill vacancies in a program that had just experienced a large faculty turnover, including the nursing director. Both started a week or two before the students started and had a two-day intensive computer training on instructional resources and that was the extent of their orientation. Both shared that everyone was new and so busy that there really was no time to orient. During their second quarter, another dean started to meet with them once a week to orient them to resources on campus. Sue voiced, “it’s the kind of thing that you usually do on the first day, but we didn’t.” Kay shared that she relied heavily on second-year students for information.

Well, there’s so many new people that there’s not really anybody to go to and say, “okay, how did you do this in the past?” I’ve been relying on the second-year students. I’ve been sending them e-mails and saying, “well, how did they do this in the past?” And they’ve been great about giving me information on how clinical paperwork was done in the past. And some of the assignments that were actually done in the past, and how they graded . . . and it’s like nobody else has time. We’re all kind of in the same little boat. We don’t know what we’re doing and everybody is just kind of overwhelmed.

Jennifer shared that her program was experiencing a faculty shortage, the director had stepped down into a faculty role, and three faculty members were trying to pick up those administrative responsibilities. Jennifer recalled that she really was not oriented to the program. She said, “it worked out for me, I’m the kind of person I don’t like to have somebody show me things anyways because I pick up stuff quickly . . . I guess having those things up front would have been more helpful.” She also recalled a breakdown in communication her first day which led her to miss a general college orientation.
So about the afternoon of my first day, I got access to my e-mail finally and found out that I was supposed to have been at a new faculty orientation at 8:00 in the morning where they covered all of our benefits and pay and things like that as well as things like how to get your e-mail and your login to Canvas which is our learning platform. And so I missed all of that. So a lot of stuff I just never learned. Just little things like my phone—I had to reset the password, so I could get messages. And how to figure out who to talk to to get test banks downloaded onto my computer. Just all these little details that I’ve had to really go hunt for.

Sophie shared that her program also was experiencing a severe faculty shortage and felt that her orientation at the beginning was inadequate because everyone was so busy and they were so short staffed. She received a copy of the student handbook and a department handbook and went through those but still did not have a clear idea of what her role was in the beginning.

I think with our rural area and not enough instructors, I feel it was a disadvantage. I think the orientation was kind of scrambled together real quick, because I don’t think they had one. I know that when they hired another instructor, she didn’t get any orientation. She was slammed with several courses and told, “here you go.” At least they were able to develop a binder for us and talk about policies and outcomes of the curriculum itself.

Melanie started her position in September right before the students. She was given an orientation to the college, but her orientation to the classroom was minimal, and she did not have an orientation to clinical. Melanie stated that before her first lecture class, she was given keys, shown the classroom, how to turn on the projector and work the equipment, and how to turn on her PowerPoint presentation. She stated that was the extent of the classroom orientation and she was told, “good luck!” She went on to say that “everybody else at the beginning of the quarter is really busy, the staff wanted to help me, but they were also trying to get their beginning of the quarter stuff done as well.” As the first quarter went on, Melanie found that other faculty members were also supportive and helpful in stepping in to do small things when they
could, such as loading things on the computer. Melanie recalled that “there were a lot of things that kind of helped me relieve some of the stress, when people just kind of came in and helped out and stuff.”

Jackie did not go through a structured orientation process when she was hired but was oriented and mentored by her team teacher throughout her first two years. Jackie did get the opportunity to attend a state-wide New Faculty Boot Camp Part I the summer after her first year and expressed, “I needed that on day one, I got it a year after.” Heather said she would also be attending New Faculty Boot Camp Part II this coming summer and was excited about that.

Some type of mentoring or mentoring relationship existed both formally and informally for participants; however, the nature, quantity, and quality of mentoring varied greatly. Any type of mentoring from colleagues and the nurse administrator provided a vital form of support for the transition experience.

Those who were assigned a formal mentor upon hire shared experiences that ranged from feeling supported to disappointed and frustrated. Jill shared that she felt comfortable going to her mentor for questions and advice. She said, “it’s more e-mail and then if they’re here . . . stop in” to ask questions and solicit advice about situations or issues. Jill felt free to go to any faculty member, not just her mentor, for questions and to get advice. Jill said there is another new instructor who started the quarter after her who she has a mentoring type of relationship with also because they shared a common bond of both being new in the transition. She said, “I feel like I have support in both of those ways.”
Heather’s formal mentor was helpful in answering questions about general things but taught in the licensed practical nurse program and not in the associate degree program, and so she was not able to answer some of the “technical questions.” Heather also shared that her other faculty colleagues tried to be helpful, but Heather was disappointed because many times they were busy, unavailable, or there was miscommunication. Heather shared her frustration saying,

the mentorship for the new faculty . . . that went out the window. I really feel. I talked to one of them [another faculty member] and I said, “you know there’s a lot of miscommunication around here.” I said, “I don’t understand your grading scale, but you were on sabbatical, you’re doing your doctorate, you’re teaching, you’re in overload.” And she said, “well, maybe we didn’t do such a good job at that.” And I said to her, “of course there’s going to be miscommunication, because you’re not even here to ask questions.” So I have to figure it out on my own. So, you know what I did. I had to do work around it, and I did the best that I could.

Sophie shared similar frustration and disappointment in her mentoring experience as she explained,

I did have a mentor but is wasn’t like . . . oh, this is what you’re going to do, and this is how you’re going to teach. It was like, oh, here’s the old PowerPoints, go ahead and follow up. Those types of things. And just research as much as you can and go off of your practice. Well, I was kind of like, how does that work? So it was a lot of fumbling the first year and trying to figure it out.

Informal mentoring relationships developed in the absence of an assigned mentor and existed in a variety of forms, most notably support and guidance from colleagues and, in some instances, the dean or director as well. Participants reflected on stories about being able to seek out help for questions, advice or concerns or instances when a colleague did something that helped out like load a document for them or help them fix a syllabus or write tests.
Melanie was told by her director that she was “welcome to come to anybody that I wanted to go to” and that she had an open door policy as well for any concerns or advice. Melanie described that “it is just a matter of whoever looks like they were least busy and say, ‘tell me what you think.’”

Jennifer expressed that she did not ask for much help when she started because the program was small, the director had stepped back into a faculty role, and other faculty were picking up additional responsibilities. She recalled, “I did not get much guidance . . . and I just kind of had to wing it” but went on to say, “it worked well because I learn things on my own best anyways.” Despite the lack or formal guidance, Jennifer shared that when she needed it, her colleagues, including the former director, were “really great . . . really eager to help me . . . and they’re always willing to answer questions” and it had “worked out.”

Laura described a similar camaraderie with the faculty and director at her institution and also developed an informal, mutually supportive mentoring relationship with her office mate and team teacher her first two quarters.

So I kind of felt like she was my mentor . . . It worked out really well for us to both be working together, and I could bounce things off of her. And she hadn’t been in the clinical setting a long time, so she said, “well, I am depending on you to let us know what’s the current thing and how does this really work and what are the hospital policies these days.” So, I felt like I was contributing.

Jackie also experienced support from the faculty and director, saying, “there is great camaraderie here at this college with all these awesome teachers and these beautiful students. . . . I would lay down my life for these people, they are so good, so kind.” Jackie also developed a tight knit relationship with her team teacher who she said guided and mentored her “literally, through everything.”
Sue found that she was able to get some informal mentoring from the director and two faculty members who had previous teaching experience.

The director is very, very good with us, but she’s got her own load of work, too, so. We pop in there and ask her things and, my ahm, office mate here, she’s very good at helping us out as we go; I guess I consider them my mentors but it’s just kind of a “as you need it” type of . . . you know what I mean? Get help as I need it.

Kay voiced much more disappointment in the lack of mentoring she received, sharing that the previous director who hired her promised to ease her in with “one class and some clinicals” and mentor her into the position. When she started, she found out that everything had changed and was given a full workload without a formal mentor. The lack of mentoring, she shared, had left her feeling overwhelmed and “totally unsupported.”

**Lack of preparedness.** Participants entered full-time academia unprepared for the faculty role. As per the inclusion criteria for the study, all participants entered academia with no formal teaching experience and expressed at least some degree of uncertainty about what their new role entailed. Phrases such as, “I had no idea what I was getting into . . . I don’t know anything” (Jackie), “I didn’t know what my expectations were because I hadn’t processed the whole thing” (Jill), “I was so naïve to education” (Laura), “started out and didn’t have a clue . . . everything was new” (Sue), and “you’re learning a whole other thing” (Melanie) illustrated an overall sense of ambiguity.

Participants with master’s degrees in nursing education prior to their first teaching experience lacked preparation in key aspects of the role, particularly didactic
instruction. Participants cited similar struggles in how to create a curriculum, write tests, deliver a lecture, and manage a classroom.

When Jennifer was asked about her formal preparation in nursing education, she shared the following:

I feel like I learned the most from the practice setting. And I don’t know how a program. . . . I just I try to think of what could the program have done differently to prepare for the transition in here. And I, I mean I don’t know if there’s a better way. I mean I feel like the master’s program, even though the emphasis was on education, I think because every nursing program is set up a little differently, meaning it’s hard, I don’t know. But I didn’t really get any education about how to plan a curriculum or. . . . Also, I would have liked much more education about, like, learning and how students get and retain information and different learning styles. I would have liked more about that. But I just kind of researched that on my own. I feel like the bachelor’s and master’s, mostly I was just going to school to get the degree so that I could teach. And then as far as learning how to teach, I had to do that separate from school.

Formal teaching practicums were not a common part of nursing education curricula. Sue shared that she did her preceptorship/project all online because the place she had originally arranged for fell through. She recalled, “I tried, like, colleges and they didn’t really respond, so I didn’t get much support there, so I did it like as an online class and that didn’t give me much teaching experience there either.” Jill said that her master’s project was more clinically-focused rather than classroom-focused because at the time she was planning to do an education role in the hospital. Jennifer said that a teaching practicum would have been helpful depending on how it was set up and if the program was similar to the one she currently teaches in. Melanie did not have one and felt that would have been helpful. Heather did have a teaching practicum in her master’s program but “that was 20 years ago . . . I would have to say it did not help with today’s set up of the curriculum. There was no QSEN [quality and safety education for nurses] or student learning outcomes.”
Those with clinically-focused master’s degrees in nursing shared similar struggles as they lacked formal courses in education and deficiencies in pedagogy and educational “lingo.” Laura felt that she was “still catching up” on the education part and “how to be prepared when I came to the classroom. So, that is a lot of my preparation [for class], is I’m still trying to learn that part, too.” Laura felt that she was missing pieces in adult education theory and how to actively engage learners as well as educational “lingo.”

Jackie shared emphatically how she did not “know anything” when she started. Jackie found that the lingo associated with an academic role to be all new and a challenge. Jackie remembered a story about going to a union meeting with a co-worker to talk about workload.

We go over to a union meeting and even all of the lingo they talk about, I don’t understand a dang thing. I just can’t believe how this whole thing is, like, the weirdest thing, how I don’t understand what they’re saying. I have no idea. To this day, I still don’t understand how they figure out an FTE [full-time equivalent].

Kay shared, “I don’t have a teaching background . . . I don’t have the benefit of a master’s degree in education.” Kay felt very unprepared for the teaching aspect of her role as well as the other duties such as advising, committee work, and finding clinical placements for students.

Sophie started her position with an associate degree in nursing, working on a bachelor’s degree. Sophie had no idea what her role as an educator entailed because “the BSN [bachelor of science in nursing] doesn’t really educate you on how to be an educator.” Sophie said that in the beginning she had “zero experience . . . my confidence level was zero.” She went on to say, “in the beginning I kind of just kept quiet and assessed the situation . . . thinking, What’s my role? What am I supposed to
be doing?” She shared that “there was a lot of fumbling the first year trying to figure it out.”

Regardless of their formal preparation for the educator role, participants felt that their clinical expertise and experience prepared them to teach in the clinical setting, because clinical was “easier,” more of a “comfort zone,” and what they were used to. The ability to work with smaller groups or one-on-one with a student in real life situations was enjoyable. Although participants identified themselves as clinical experts, they were unprepared for some of the expectations of clinical instruction which presented challenges. These included unfamiliarity with evaluating students, particularly grading clinical paperwork; unfamiliarity with assigned clinical facilities or units; and developing relationships and maintaining rapport with staff.

**Need for knowledge and information.** There was an overall need for knowledge and information in a number of areas as participants were getting started in their new roles. Some were offered formal education classes and others found out information more informally through colleagues, students, and administrators. Novice educators needed knowledge and information about their institutions and basics such as benefits and pay, what the faculty role entailed, technology used in the classroom, educational lingo, and information about the curriculum and how to teach. A common feeling of being left to “figure it out on my own” was evident. Participants sought out information by doing research online and reading books and journal articles or attending workshops, conferences, or professional development opportunities on their own to fill in the gaps.
Participants cited a need for information about college basics, such as how to get e-mail and set up voicemail, benefits and pay, and resources on campus. Some were provided this information in the form of a notebook or at the faculty in-service week, whereas others had to figure it out on their own.

Participants found that they lacked information about what the faculty role entailed, including requirements other than teaching such as finding clinical placements, advising, and college committee work information. Kay recalled: “At the end of the first quarter, they said, ‘okay, well, now you’re going to do advising,’ and I looked at them and said, ‘what do I do in advising? I have no idea what that is.’” So we had a little brief class on that.” Initially, Sophie wanted information about what her role was, but had a difficult time finding the right questions to ask. “I don’t think they understood what I was asking. Because I don’t’ think I understood what I was really wanting. Because I didn’t know where I was . . . what I needed.” As time went on, she noted that additional duties were added to her workload that she didn’t know anything about.

Educational lingo was likened to learning a foreign language. Laura talked about coming in to a few faculty meetings in the summer before she started, and the faculty were talking about the learning management system, Canvas. She remembered thinking, “what is Canvas? I had no idea. That’s the learning program they use for all of the classrooms, and I was so naïve to education, it was like I didn’t know any of that lingo.” Heather said that for her, standing up and teaching was the easy part; the hard part was learning the lingo for accreditation. Jackie shared a similar story and gives her co-teacher credit for helping her learn the lingo.
I didn’t know what any of these terms meant... I mean I just had to, like, sit down with my team teacher and went over and over it. We’ve constructed tests together. And I learned all the lingo. Which I’m still only, you know, about 50% there.

Technology-related needs such as the learning management system, electronic instructional resources, teaching stations, and simulation technology were common knowledge needs as well. Jackie talked about her frustrations learning about the technology in the teaching stations.

We have this Panapto [lecture capture] thing and it doesn’t have a little thing to tell you whether it’s recording or not. Oh god, it’s still my nemesis. It took me all year long to figure out that teaching station; it is really complex. But through time and effort I learned.

Sue and Kay had two intense days of orientation to electronic instructional resources; however, Sue felt uncomfortable and said, “you don’t know it until you get into it, or at least that’s the way I am with computerized stuff.” Kay recalled, “two days is not enough to just be in there and learn it all and then step away for a week or two and then come back and be, like, “how did I do that? How did I get there?” Laura said one of the formal education classes she took at her institution when she started included information about technology, including the learning management system. She recalled the instructor was struggling with Canvas (the learning management system) and felt that she didn’t,

have a good grasp on it at the end and I was like, “I’m still not getting it.” She went on to say, I didn’t quite grasp how grade books were set up and how to set up the online course and move things around, which I feel like I’ve learned by trial and error, actually quite a bit.

The most pressing knowledge need was the need for information about teaching, particularly the curriculum and the way it was structured, what was supposed to be taught and when, how to teach it, and how to evaluate students. Participants
started with little to no knowledge about how to teach nursing and spoke of having to learn by “trial and error quite a bit” or by “making mistakes” and “figuring it out on my own” or learning as they went along. Jackie summarized it best this way, “oh my god, the learning curve.”

Melanie did not know what content teaching she would be teaching, just that she would be teaching second-year students when she started. She also had been told that the tests would need to be re-written, but she had no experience in writing tests.

Jennifer found out what content she would be teaching up front, but did not have access to previous curriculum until almost the end of the first quarter and was unsure about what she was supposed to include or what the students had already learned about a particular concept. Jennifer talked quite a bit about the different concepts she was teaching, but when asked if her curriculum was set up around concepts she replied,

I’m not really sure. Okay, so, like, I had a friend of mind who’s also new to teaching ask me if our curriculum was concept-based or something else. And I was, like, I don’t know. So, for instance, the first year we’re learning fundamentals. I taught homeostasis, ahm documentation, and something else . . . asepsis. So, I guess those are concepts.

Sue and Kay did not have any idea about how curriculum was structured when they started, and they also did not have access to old curriculum files until their third quarter. Both expressed how challenging it was to try to figure out what they were supposed to teach and how to teach it. Kay shared a story about trying to figure out what to do about readings for the students. She recalled,

There was something . . . I think it was in the student handbook or the catalog that said what they would be teaching that quarter. And so whatever was there I took that and put that into the readings because I really didn’t know what else to do . . . nobody came back and said this is totally wrong . . . but I just did what I could.
Jackie recalled asking her co-worker for simple things such as, “how do you put a PowerPoint together?” and “how do you file it so you can find it again?” to sitting down and learning to construct test items together. Heather decided to seek out information on her own while she was waiting to retire from the military and transition to the new role.

I came on my own. Like four months prior to going to the faculty institute, paid for out of my own pocket to come up. And just go through the general community college. I did Canvas training on line. I did rubric QM [quality matters] and I also did open educational resources on my own time prior to coming. Because I had no idea what a rubric was. I didn’t even know what they were talking about. Never used a learning management system, ever. So I tried to be proactive. Because my husband was up here and I was stuck down there. And I was living with a friend. So I tried to . . . I tried to prepare myself with what I felt I needed. And it really wasn’t ahm, really wasn’t directed to me. I had to be a self-starter. Thank God I am a self-starter because I would have failed miserably in that quarter if ahm, I didn’t seek out my own resources.

**Theme 3: Learning to Teach**

Learning to teach is the third theme which emerged from the data. Novice educators faced a variety of new situations and experiences which brought to light the complexities of the teaching aspect of the faculty role. Three sub-themes characterized this reality of the role for the participants: (a) jumping in with both feet, (b) early experiences, and (c) wanting and receiving feedback.

**Jumping in with both feet.** Starting out, faculty workload varied significantly for all participants. Per inclusion criteria for the study, participants were teaching in a full-time appointment which included both didactic and clinical instruction. Typically, full-time faculty in community college pre-licensure programs “wear a number of different hats” depending on the size of the program and the number of faculty. They may teach didactic, clinical, skills lab, simulation, and have other roles
such as committee membership or club advising, sometimes in the same term. All institutions calculated workload for faculty differently, and the factors that influenced workload were not examined in this study. Participants jumping in to full-time positions felt tired and overwhelmed from the amount of time spent preparing for classes and other duties. Phrases such as “so much work,” “time consuming,” “tiring,” “barely staying ahead of the students,” and “exhausting” were common. Some were not prepared for the time commitment and extra time they spent outside of the institution.

Jackie started teaching didactic and clinical courses and was 131% over full-time her first five quarters. She shared:

Yep, I worked all last year. I barely could take a Sunday off last year. Last quarter, I’m thinking okay, it’s going to be way easier. I’ve had it one year. Well, we changed the curriculum, we’ve changed to new books . . . that meant that we had to redo the whole syllabus and the whole, oh my god. So, oh my god, my tongue’s hanging out cause I’m so tired.

Jackie and her co-teacher went to the union to advocate for hiring adjuncts. Jackie remembered her co-teacher saying, “you know what, we’re overworked and underpaid and we are going to the union meeting.” They advocated for hiring an adjunct to help ease their workload, and Jackie shared that they were successful and two new adjunct faculty members were going to start the week after our interview. In my follow-up interview with Jackie, she said the adjunct instructors had made a huge difference in her workload.

Heather started mid-academic year (in January) and had two weeks to prepare for classes after retiring from the military. She found the initial transition to be “fast and furious” and “oh, by the way, they put me on overload my first quarter. I was 80 overload for the first year.” Heather went on to say:
The first few months I hardly ever saw, like, my colleagues to really talk to. You know what I’m saying?” Cause I was trying to tread water. I was trying not to sink and drown . . . after that, I was, like I don’t know if I really want to do this. Like after my winter quarter, I was like, this stinks. I don’t know. I’m not getting paid enough money for this. That is what I was really thinking.

Heather dropped the overload the quarter she was interviewed. She shared that she had some personal issues and decided, “I just need to step back. I don’t mind being a team player, but literally I had the whole second year all by myself.”

Melanie shared, “I would try to do stuff at home, but by the time I got home I was too tired . . . I’m at home now, I already put my time in.” Sue shared, “I try to stay positive, but sometimes it’s stressful to get all the work done and meet deadlines.”

Kay thought she would be “easing into her role” with one class and some clinical when she was hired, but that was not the case when she actually started. With the large turnover of faculty, Kay was given a full load. She said, “I had the responsibility for the whole first year by myself.” With minimal orientation and lack of formal preparation for the role, Kay felt completely overwhelmed and unsupported when she started.

I’ve got a lot of hours and I feel like a lot of responsibility. I’m doing not only the fundamentals. I’m doing nutrition and the clinical and then there’s nursing club and, you know, everything else. And, I just at times, I just feel like I’ve got an elephant sitting on my chest.

Kay went on to say, “If I could just walk into the classroom, prepare a lesson and walk out, or go to clinical—walk in and walk out. I would be just fine. But when you’ve got to do all the other stuff that goes with it, it’s just too much.”

Jill found that teaching full-time and trying to work per diem with a family was difficult to balance some weeks.

So there’s weeks where I feel like I’ve got this, and then there’s weeks where I’m like, “what am doing. This is too much.” Cause I also have three kids
and, you know, I’d love to just be a stay-at-home mom and now I’ve gone into . . . with my husband being sick, like the bread winner, and so I am lucky that in nursing you can do a bunch of things to kind of, ahm figure it out. But there . . . I guess that sometimes I do feel like it’s kind of this tipping and depending on the week I’m either in balance or I’m not. And so, just still trying to figure it out.

**Early teaching experiences.** The length of time each of the participants had been teaching at the time of the interviews varied greatly. Four were in their second quarter, and the others were either in the second or third year. Each shared common experiences related to teaching didactic and clinical courses in the first few quarters, which are the focus of this section.

**Teaching didactic courses.** Novice educators experienced many initial challenges and a wide range of emotions when they started teaching in the classroom. A common phenomenon of “learning to teach as you teach” was evident among the participants who felt unprepared in how to teach, were still trying to figure out what to teach, and were barely staying ahead of the students. A desire to “teach right” and a feeling of being “responsible for their learning” was common in early teaching experiences.

Sue found the transition to teaching to be “quite a learning experience” and went on to say:

I’m finding it very difficult to learn how to lecture and teach . . . it’s kind of hard when you don’t know what you’re doing. It’s hard to get it together. I had it a little bit easier for the second quarter, at least to know where to start and what we’re doing, because everything was new.

Melanie recalled feeling anxious her first quarter as she was, trying to learn how to give a lecture, learning the material, and trying to give a lecture plus learning all the other duties as assigned and then I’m giving a test and I’m not really familiar with. So I’m not really going over solidly what’s going to be on the test. And so there was a little bit of disconnect and so the
whole quarter we realized the tests needed to be re-done, so now I have this anxiety of I’ve never written tests before.

Whether participants had access to old curriculum files or had to start from scratch to develop the content they were going to teach, all spent hours prepping for classes, learning the content, and trying to make it their own. Those who did not have access to old curriculum files in the beginning found it difficult to figure out what to teach and what had already been taught. Kay and Sue felt completely overwhelmed trying to create a curriculum from scratch and learn how to deliver it at the same time. Jennifer did not have access to any old curriculum for the majority of the first quarter and shared that it was hard to know what had been taught.

Heather said the dean did share her binders with her, and another faculty member shared a disc with material on it when she started, but found “it’s really hard to use someone else’s notes if you’re not the one who made the notes.” She did find it was easier to start with something and said, “I would have sunk miserably [without it], and I got through the quarter, but I had a lot of hours of prepping and more prepping.” Laura recalled, “it took me awhile to catch on. Then I felt like I was just like learning, trying to learn so much and keep ahead of the students a little bit.” Sophie also had a difficult time keeping up with the students her first quarter. “I got three weeks done so they had their first three weeks reading and then during the first three weeks reading I’m trying to play catch up for the rest of the term.”

A wide range of emotions and physical reactions were common the first time participants stepped into a classroom. On one end of the spectrum, participants recalled feeling nervous, anxious, and physically ill and on the other end, others felt a
“rush” and excitement. Jill was anxious about public speaking initially, but quickly found that she loved talking about nursing and telling stories.

My initial first goal is not to go pass out. Like, in class. But I do love nursing, and I love talking about nursing, and I love telling stories, and so I just went with my comfort zone and I told a lot of stories. And the students have really appreciated the fact that yeah, this one time this happened and this is how we dealt with it.

Laura shared,

I was shaking, I was sweating, I could hardly talk. They kept telling me to talk louder because it’s a big room of 30 people, that they couldn’t hear me in the back. I was just almost physically ill, I was so nervous. I’m not . . . I’m not a real social out-there kind of person. And it was terrifying to me, but my co-teacher . . . she’s like “you’ve got this, you know this, remember you know more than they do,” which helped a little bit. But still it’s kind of a . . . kind of rough to be that first person out there. But I got through it and after the first time I didn’t die. It was like, “oh, that felt okay, I’ll do that again.”

Jennifer recalled that she was “really, really nervous” the first couple of times in the classroom, but when she was done it “felt like a rush” and was “really, really, fun.” Jennifer said the hardest part of teaching in the classroom was “to scale it down and figure out what the beginner nurse needed to know” and not teach to the level she had been practicing at. Kay enjoyed her first classroom experiences and said, “it was fun trying to develop learning games and having rewards for them, like a candy bar or something, you know, just some little thing.”

Heather felt comfortable and enjoyed being in the classroom. She felt that with her leadership background in the military, she had no problem walking into a classroom and engaging students, it seemed natural. The area Heather found challenging to start with was figuring out what she was supposed to teach. She shared, “in the beginning I thought I had to teach the entire textbook, every paragraph . . . literally. It was not explained to me that it wasn’t part of my job.” Kay had a similar
experience in preparing for a new unit on cardiac. She recalled looking at the 86 objectives for the unit and thinking, “how I am going to do this?” and I went in and talked to the director and found out I could “pare them down and teach what she thought would give the students the most bang for their buck.” Kay was relieved, but also frustrated that she did not know this sooner.

The desire to “teach right” and “feeling responsible for their learning” were expressed by the participants. Some expressed self-doubt or anxiety in their ability to deliver the content adequately or give the students what they needed to be successful in class and ultimately on their board exams. Melanie stated that she was not uncomfortable being in front of a group of people as she had done presentations for groups before, but “had anxiety about presenting the material adequately so that the students would be prepared to pass the test or later their board exam . . . things that I feel like I’m responsible for their learning.” Jennifer voiced a similar concern, “I stressed a lot about it a lot. Wanting to make sure that I was teaching everything that I should be teaching when we were talking about that concept.” Kay shared that she was overwhelmed by the responsibility she felt in her early teaching experiences.

I’m responsible for teaching these people correctly. And even though I know nursing, I’ve been doing it long enough that I had to stop and think about, okay how am I going to teach somebody who knows zero about nursing? How am I going to ahm, teach them, you know, how they need to start out and how they progress.

Many spent hours preparing and memorizing what they were going to say. Participants shared that it was important to be able to answer questions. Jennifer said that it was important to her that she knew “three times more than students did about the content.”
Some participants were assigned content to teach in their area of clinical expertise; however, it was common to also be assigned to teach content outside their specialty areas. Jennifer shared that she was teaching content for first-year students and pediatrics for second-year students. She was comfortable doing either but found her greatest challenge was figuring out what the students had already been taught or if it was her responsibility to teach it. Jill was assigned to teach mental health and shared,

I am not a mental health nurse, but my background is ER [emergence room] so I have a lot of acute mental health. And, so I try to really explain to them that my experience, my mental health, is acute and you are in a chronic setting and so I’m going to tell you acute situations and you’re here to work with nurses and identify chronically what’s happening.

Sue voiced that she felt comfortable with the majority of the content she was assigned to teach except for pharmacology.

I got to the first pharmacology lecture, I just felt like I was reading, because I was reading it. I was okay with it but then trying to teach it was like, I can’t do this. So the director had told us, if we need experts in the field, just feel free to get them in here. And, so I got a pharmacist to go and kind of redo the lecture that I hadn’t done. And she came back a few weeks ago and helped with the neuro drugs, too, so she’s on board with it.

Laura shared that she taught second-year “really heavy med surg when she started” which she was really comfortable with and later added “softer” content such as management, policy, and budget. She expressed,

I don’t feel that strongly about [them] but I’m learning. Always open to learning, and I share that with the students, too. It’s like, “okay, I don’t, I’m not an expert on this but we’ll get it. We’ll get it.” Yeah, yeah, I really like the clinical part. Yes, I’ll teach ARDS [acute respiratory distress syndrome]. Yes, please, thank you. I’ll take that one.

Teaching clinical courses. Participants found that their clinical experience and expertise made being in a clinical setting “easier” and more “comfortable” than
the classroom. There were aspects of being in a clinical instruction, however, that they felt unprepared for and found challenging. Novice educators expressed self-doubt around their ability to evaluate students and grade clinical paperwork as this was not a part of their previous role as a practicing nurse. Early challenges included being assigned to new and unfamiliar clinical units, shortened orientations and lack of training, and developing rapport with the staff on the units.

Melanie was assigned to teach on a floor that she was not used to but relied on her past experiences as a preceptor and quickly found that,

Nursing is nursing in as far as patient assessments, and so it’s just a matter of helping them do an assessment, helping them prioritize, helping them with their med passes. Those are things I have already done as a preceptor, and so it was something I had already done, it was just a matter of learning how to complete the paper[work].

Sue also started teaching clinical in a facility that was new to her and said, “even though it’s a new environment there, I’m a lot more comfortable.” She felt that clinical was more of a “comfort zone” compared to the classroom. Jill said clinical was “easier because I felt like I had it [the patients] in front of me so I had what I was talking about versus when I’m in class.” Sophie found that teaching clinical was better than teaching in the classroom and compared it to orienting new hires in the practice setting. “In the beginning it was easy because I was molding them as if they were little employees. But on a lower level . . . patient safety first, the standards, the basics. And, so I felt that part was easy.”

Jennifer found that her clinical background allowed her to move easily to new units, but she also had difficulty with staff and trying to figure out how much to supervise students. Jennifer felt comfortable in the clinical setting but shared that teaching clinical was actually “more awkward” then teaching in the classroom. She
was teaching outside her specialty unit in long-term care and a medical surgical unit. Jennifer talked about not knowing the flow of the floor such as when vital signs were taken and generally “felt disconnected from the staff.” She also talked about not knowing how much to “follow the students around and watch them [do skills], “how much workload to expect from the students,” and was surprised at “how slowly they do everything first quarter.”

Heather found teaching clinical was easy because of her experience and expertise, but had a more difficult time with the transition from a military to civilian hospital, staff relationships, and lack of orientation and training in the facilities. Heather expressed, “I’ve been at the bedside for a long, long time. That is easy . . . the clinical part is really easy. It’s the interpersonal part of dealing with the nurses that don’t want students.” Heather transitioned from a high ranking military position in a veteran’s hospital to academia and was surprised about the differences in the clinical environment. Heather felt a similar disconnect to the staff on the clinical units.

So I thought that it would be more mentorship and then ahm, I was kind of disappointed with, like, our facilities. Ahm, as a nursing faculty member ahm, you know sometimes you go to the facilities and you’re ignored. And I don’t see the collegialship [yes, this word] and I’ve seen a little bit more now because I have some graduates out there, but the incivility and dissatisfaction that I see in the community with nurses working on the floor makes it really hard because I don’t work for that facility. And ahm, I think that’s the biggest part is that they want us to function like a staff nurse, but we’re not part of that facility. So sometimes, “what is my role, actually at that hospital?”

Sophie said that her program had adopted a statewide curriculum with 10 core competencies, and she was unsure of how to assess the student’s achievement toward the competencies using the grading tool.

It was unclear of how I was supposed to objectively assess them to that tool. I didn’t know how to use that tool. So I would just put anecdotal notes
throughout the day. I was like okay, and then somehow try to blend those together. So the process of mentoring in the clinical, I just, I had . . . I was on my own. Like nobody told me how to govern these students.

Sophie also felt very uncomfortable grading papers because she did not feel like her “paper writing skills at the time were great.” She said she would frequently ask other faculty, “do you want to check my grading here? Is this what you guys are doing? And they were like, ‘oh, you’re doing fine,’ and I don’t know if they checked or not.”

Kay found that “the clinical part wasn’t bad, ahm, it’s kind of fun” because she felt that she could help the first-year students when they were really nervous starting out and help grow their confidence. Kay was challenged when it came time to grade clinical paperwork. She said, “I had no idea” and found herself asking second-year students what was done in the past.

I just think that that’s a really crummy way to do things. Ahm, because it it just to me, I want my instructor to be sure of what they’re doing and how they’re doing it and to give me the confidence that I need to succeed in the class. And instead, I’m trying to draw confidence from them, ahm, you know, “Am I doing this right? Is it, you know, is everybody understanding this?” And ahm, I don’t actually say that. But I just feel like I’m trying to get my confidence from an outside source. Ahm, cause I don’t have any confidence at this point. So . . . does that shock you?

**Wanting and receiving feedback.** Novice nurse educators desired feedback and sometimes actively sought out feedback for support and guidance and also to help them grow and improve in their role. Primary sources of feedback were colleagues, administrators, and students. In reflecting on their roles in practice, some were surprised how frequently they were evaluated in their new roles, often quarterly on a tenure track, and some wished they were evaluated more often to provide them with feedback on how to improve. Feedback on evaluations from students ranged from
very positive to critical and sometimes hurtful which affected how the participant utilized the feedback.

Jill shared how she had appreciated the quarterly feedback she received from students and faculty during her tenure process.

So one thing that I’ve appreciated being a teacher more than being a nurse is that you get more of that . . . you get student input and you get other faculty input quarterly. Whereas, when you’re a nurse, you get it once a year. And you don’t kinda know how you’re doing unless someone tells you something. So having those quarterly, like “this is what you’re doing.” “This is how you can adjust.” “This is how you’re improving.” Ahm, I think really helps kind of guides which direction I want to go.

Sophie said the feedback from her student evaluations had improved over time, and she was also using it to improve as an educator.

I took their feedback and I tried to mold my courses to that feedback. So, if they were saying ahm, “there wasn’t enough lab time,” I’d make more lab time the next course. Or if they’re saying, “the readings were too big,” I would narrow the reading down based on the reading guide. Or ahm . . . but not like every piece of feedback didn’t need to be addressed because, of course, they’re going to be like, well the course didn’t teach us everything. We had to teach ourselves. It’s like, well yeah, you’re gonna have to at some point, so we’re not going to teach you everything. So I took some of the feedback and tried to mold it to it.

Positive feedback from students helped affirm that novice teachers were on the right track and pushed them to improve more. Jennifer “felt good” and “wanted to work harder to be better at teaching because I get a lot of feedback.” Heather felt that teaching in the classroom was “easy” for her, and the positive feedback helped her affirm that she was doing well in the classroom. Jill thought that the positive evaluations in the beginning must be because “she was a natural at teaching.” Over time, she began to question whether they were high because she was “a great teacher, or was it high because they just liked me or because I was easy” when she had students who she passed in clinical fail the National Council Licensure Examination.
Jill said she was making changes now to be a better teacher, one that challenges and pushes the students and was not “just likeable.”

Not all feedback was positive, and sometimes new educators received negative feedback, particularly from students. Jackie recalled her first student evaluations. “Okay, the student evaluation of me, you know, they tear you apart. So you read those when you’re in a really good mood. ‘Jackie is so disorganized it isn’t even funny. . . . I cannot tell where she’s going and what she’s doing.’” Jackie said, “through time and effort, I learned” and her co-teacher has also provided feedback and encouragement and reminded her that “the students are okay, just keep trying.”

Melanie shared that one of her major frustrations the first quarter was that the students were not very understanding of her and were “very critical that she wasn’t spoon-feeding them.” Melanie said that the dean received a lot of feedback and complaints from the students her first quarter, and this was frustrating because they did not come directly to her.

I would tell them, you know, I’m new; I’m trying to fix the tests. I’m doing the best that I can. The best suggestion that I have for you is to make sure that you read the book. And so they . . . I guess felt that they needed more than that. And, so that was not a forgiving thing for them. And, so there were a lot of complaints, you know, from the students. So here I’m thinking, wow, I’m working really hard trying to do what’s good for you, and from my perspective and I’m telling you my perspective . . . but it’s like we know, and we’re not gracious. And so that was difficult. Um, trying, something that I couldn’t anticipate dealing with.

Laura found that many faculty members at her institution do not read their student evaluations. She questioned this practice at first saying, “why don’t you want to know?” When she opened up her first evaluation she understood a little better. She recalled reading through and finding,
satisfactory, satisfactory, not satisfactory [emphasis added]. I just zeroed in on that one. The not satisfactory. So ahm, so I wanted to believe the less favorable ones and I didn’t want to believe the favorable ones. Cause I’m like I can’t be a good teacher cause I’m new. I must be ahhhh . . . That’s just sounds weird. But that’s what I really thought.

Laura found that some of the negative comments “hurt . . . they just really hurt,” and it was much different than the clinical setting where you get an employee evaluation once a year, “this is in every course, and it is like wow.”

Feedback from colleagues was a critically important form of support and encouragement for novice educators. Laura appreciated when faculty members would sit down and debrief with her after a test that a student may not have done well on. She recalled they were really good about saying, “you know that happens a lot . . . take from it when you can, but then you’ve got to just let it go . . . see what you can learn from it. Is what they’re saying valid? If it is, yeah, let’s fix it.” Melanie found support and encouragement through that difficult time from the other faculty and the dean.

They have told me . . . just hang in there, it gets better. It gets easier the more you do it. You know, I would be feeling overwhelmed and stressed and the faculty would say it just gets easier, I promise. You know you’ll be a pro at it by the end of the year. Just have confidence that you can do it, that you’re doing it right. Don’t let maybe one bad incident paint how the whole time is going to be.

**Theme 4: Influencing Factors**

A fourth theme, factors influencing the transition, were broken down into three sub-themes: (a) facilitating factors which contributed positively to, or helped, the transition experience, (b) hindering factors which may have negatively affected the transition experience, and (c) the knowledge, skills, and attitudes possessed by the participants that influenced the transition.
Facilitating factors. A number of factors were identified that facilitated or eased the transition in some way. These included clinical expertise and background, orientation and mentoring, formal preparation and education, professional development, support, teaching clinical and lab only to start, observation of others, co-teaching, repetition, and time.

Participants believed that their clinical expertise and experience helped their transition process, particularly in the clinical setting where they felt more “comfortable.” The novice educator was also able to use knowledge and expertise to teach theory and make connections to clinical. Heather shared, “my class, my clinical, is congruent and what they learn in class they directly apply in clinical. And that’s what I take pride in.” Jill shared her students appreciated the connections she made through her stories from practice. “Students have really appreciated the fact that yeah, this one time this happened and this is how we dealt with it.”

Orientation and mentoring were both facilitating factors and hindering factors depending on the amount and quality of the experience. Any amount of orientation and mentoring, whether formal or informal, was a facilitating factor. Novice educators needed information about all aspects of the role, particularly teaching, and found any information they received was helpful. Participants developed informal mentoring relationships with colleagues in the absence of a formal mentor and found the support and guidance was helpful and appreciated.

Formal graduate education in nursing was both a facilitator and hindering factor. Participants with master’s degrees in nursing education prior to transitioning to academia commented about how it prepared them for certain aspects of the role which
was helpful; however, they felt deficient in key aspects of the role which are discussed in hindering factors. Participants with clinically-focused master’s degrees were less prepared, did not have education classes, and were less prepared for the role which was a hindering factor. Sophie was currently enrolled in a master in nursing education program at the time of the interview. She shared that the program had been very helpful to her transition, because “I can apply what I am learning into work which I don’t know if everybody who’s in the program is able to do, which I feel is a benefit on my part.”

Professional development offerings were helpful. Laura took two education courses at her institution her first two quarters and found courses were helpful and “doable” with her teaching workload. Jackie went to a Boot Camp for New Educators during the summer after her first year. Although she would have liked to have had the information on day one, she found the camp to be very helpful and was scheduled to attend Boot Camp for New Educators Part II during the coming summer. Some of the participants attended all-faculty workshops or meetings prior to the start of the academic year. Most found the information helpful but also felt a tension to use that time to get ready to teach the following week. Heather sought out professional development on her own prior to starting her position. Heather went to a faculty development institute and took online courses in quality matters, the online learning management system Canvas, and open educational resources. In retrospect, she said she was glad she was “proactive” and a “self-starter” because “I would have failed miserably in that quarter [first quarter] if I didn’t seek out my own resources.”
Supportive relationships with colleagues and administrators were a critical facilitator to the transition experience. Laura felt that faculty support had been especially helpful when she felt like the students were wearing her down. Jennifer spoke highly of all of the faculty and the previous director in giving them credit for helping to ease her transition.

The thing that has made it [the transition] work has been that my colleagues are so, so wonderful and supportive and encouraging to me; and if I didn’t have that, I don’t know how . . . I mean this first year would have gone very differently if they were not like 100% supportive. Because I’m really insecure, because I don’t know what I’m doing, and I worry a lot, and that I’m not teaching the right stuff or I’m not teaching well. And so every time basically that I ask them anything they’re just so reassuring to me. That has made it a good experience . . . I can’t imagine going into an area if I was to go into a department where the other instructors weren’t like really, really personable and helpful. It would be really, really difficult.

Jackie has found support in her mentor and the entire nursing faculty, stating, “there is great camaraderie here at this college . . . awesome teachers.”

Observing seasoned faculty in the classroom was helpful in learning how to teach. Melanie felt like she was able to gain some “little pearls” from what she observed and went back and made sure her slides “were updated, kind of matching what she did.” Jackie found it helpful to observe other faculty and emulate what they did. “I watched other teachers. I’ve watched [co-workers]. I did it for two weeks before I ever taught a class. So, I tried to do it just like her.” Sophie felt that there were areas where she “was lacking” when she started and decided that observing others would help her learn the teaching role. She felt that it was helpful and suggested that it should be a requirement of new faculty.

I sat in on ahm, a lot of the other instructors courses and just tried to see how they’re teaching methods were, because I was kind of feeling like maybe I was lacking somewhere. And so, I mentored myself that way cause I thought oh, what’s a better way than observing how they’re teaching . . . and so then I kind
of meshed what they were doing. Which I thought, maybe there should have been a requirement that we should have to sit in on other people’s lectures or something.

Co-teaching or team teaching was a way for the novice faculty member to observe and learn from seasoned faculty and have support in the classroom. Laura found her co-teacher to be encouraging to her. She would say, ‘‘you’ve got this, you know this, remember you know more than they do’’ which helped a little bit.’’ Sophie’s team taught her first didactic course and found that it was helpful. ‘‘So we kind of blended our thinking together and made it kind of equal, so things were congruent so it was good.’’

Repetition and time were the final facilitating factors, particularly in teaching didactic courses. Melanie taught the same content each quarter to different cohorts of students and was starting to see some growth her second time through. ‘‘That’ll be my second time and at the point my third time teaching . . . I’ll be able to keep . . . just repetition, repetition, will help me become better at it . . . so, it really should get better by the end of the year.’’ Jackie found that teaching strategies she was uncomfortable with the first year of teaching were comfortable her second year. Sophie shared, ‘‘I am still learning, but it’s definitely different from first year to now.’’

**Hindering factors.** Hindering factors were those circumstances or phenomena which made the transition more difficult or challenging. Novice educators cited a number of factors which hindered their transition to the role: lack of preparation for and key information about the role, inadequate orientation and mentoring, having to figure things out on their own, and workload.

The most prevalent hindering factor identified by participants was the lack of preparation for the role and need for knowledge. Novice educators were unprepared
for key aspects of the role, particularly curriculum development, test writing, how to teach, and classroom management. Formal graduate courses in nursing education prepared some of the novice educators with some theory about the role; however, there was a general lack of practical application, particularly teaching practicums or time spent in a classroom with a seasoned teacher. All participants repeatedly mentioned that this would have been helpful to the transition. Novice educators learned how to teach as they taught, by researching pedagogy on their own, by “trial and error,” and by “making mistakes.” A lack of confidence and comfort in teaching early on was related to the participant’s lack of preparation for the role and knowledge deficits.

The quality and quantity of orientation that participants received varied greatly, and structured orientation programs were not routine. Participants expected more orientation and were challenged to find information themselves. Sophie summed up the common experience saying, “I thought there was going to be a different orientation to the role. There was kind of like, “oh, you got the job, you need to fill in the role and roll with it.”

The lack of mentoring was also cited as a hindering factor. Some programs were experiencing a lack of seasoned faculty to orient and mentor faculty or to fill key roles in the program. Jackie explained that her program had lost, one very experienced nursing educator last spring quarter . . . a huge loss to our nursing program without [her]. Oh my god. This is such a wonderful nursing school, but so fragile; this place would fall apart if we lose any more experienced faculty. When [she] left us, it was a big crisis here. Oh my god. It was bad. So we have [another nursing instructor] who has been selected to replace her. . . . It’s going to take years to learn. And so, I mean we’re doing the best we can. I mean I, you know, I’m doing the best I can.
Kay said that lack of seasoned faculty in her program made mentoring difficult and she felt unsupported. Heather found that the more experienced faculty members in her program were busy, on sabbatical, or in graduate school, and mentoring new faculty suffered. Even those who were assigned a formal mentor expressed an overall dissatisfaction with their mentoring experience.

All participants started with little preparation and a full workload or overload. Feelings of being tired, overwhelmed, not being able to take time off on weekends, and barely staying ahead of the students was common. Heather felt like a “puppy treading water . . . trying not to drown” her first quarter. She said she asked the faculty “if they were trying to initiate me, because it felt a bit like that.” Sophie remembered a conversation she had with the faculty when she was hired which really illustrated the collective experience of the first year.

They said you know the first year’s going to kind of just go really quick and it’s going to be really overwhelming. Ahm, as the process goes, you’re going to have all these questions. And things are going to start making more sense after the first year of fumbling. So it was like, “well that’s not really good on us.” I feel like it’s a little overwhelming. And the first year was overwhelming. For sure.

**Knowledge, skills, and attitudes of new faculty.** Knowledge, skills, and attitudes (personal characteristics) of novice faculty emerged as factors influencing the transition from practice to academia. All participants self-identified themselves as clinical experts and agreed that this knowledge and experience helped them in different aspects of their transition, particularly the clinical setting. Novice educators relied on their ability to problem-solve and figure things out on their own to survive early challenges such as lack of information and inadequate orientations. Novice educators demonstrated personal characteristics of perseverance, being proactive,
striving for excellence, wanting to succeed, wanting students to succeed, and being passionate about teaching which positively affected their transition to academia.

Despite many early challenges, participants demonstrated perseverance in figuring things out on their own and finding ways to make things work. All had an overwhelming desire to succeed in their role and help their students succeed. Heather shared, “I’m very perseverant, and I don’t . . . don’t tell me something that I’m going to figure out a way to make it successful.” Participants were proactive in seeking out information and researching about how to teach, have active learning strategies, or obtain other information necessary for their role. Jennifer explained:

I would just Google something like “innovative strategies in the classroom” or, ahm like ways to teach students who have learning problems. Or, you know, just and then keep looking and keep looking until I find a site that has just what I feel like is a lot of useful information or, ahm, or until I find the name of somebody who has maybe done some research in that area, and then I’ll go and learn as much about that as I can. Things like that.

Participants exhibited passion for nursing and nursing education, wanting to share their knowledge with the next generation of nurses and give back to nursing. Jill explained:

And I do feel that I . . . I am giving back a lot to nursing by creating and helping grow nurses, ahm, that I would want to see and I would want to be taken care of and who I want to represent the field of nursing, and being the teacher is you’re the leader and you’re leading by example and so I want to see a bunch of nurses who care as much as I care and who worry as much as I worry about their patients.

**Theme 5: Getting There**

The fifth theme, getting there, marked a passage from surviving and just getting through it to a place of being able to (a) identify growth and initiate change and (b) find rewards and satisfaction in the role. A third sub-theme, choosing to
continue, is presented representing the factors influencing the decision to continue in the role.

**Identifying growth and initiating change.** As participants gained more experience in and knowledge of their role, they started to identify areas of positive change and also initiate changes, particularly in the teaching aspect of their role. Growth and change were attributed to experience and practice, making mistakes, learning through trial and error, support and mentoring from colleagues, and figuring things out on their own. The most frequently cited changes included increased comfort and confidence in the role, using new teaching methodologies in the classroom, improved ability to manage the classroom and establish clear boundaries with students, better understanding of the college and program, better overall understanding of the curriculum, and improved life/work balance.

Melanie had just finished teaching a unit for the second time and felt that repetition of the content had helped. She expressed,

> I know what the material is. I was able to lecture over it, so the first exam is next Monday and we’ll see . . . how well I was able to translate that material onto the test . . . It really should get better by the end of the year, cause in March I’ll have another new group.

Melanie was also excited about having the autonomy to initiate change in the physical assessment class she was teaching. She said, “so that’s exciting that I can take it and change it and modify it and make it mine . . . you know, create something that wasn’t so great before and I can build it up and then have it really good.” Melanie was also finding better balance her second quarter and was more willing to work on things at home to make the weekdays less stressful.
Jennifer reported that she was less anxious than she was her first day in the classroom, but reported that she grew the most as a clinical instructor the first quarter.

I felt like I grew a lot as a teacher. . . . I know in the future if I get the opportunity to do the very first-quarter students again, I’ll be much better able to, like, plan out over the whole quarter of ways to help develop them. . . . I learned that a lot of my role was just to help build their confidence.

Laura, who was in her fifth quarter of teaching, shared that learning how to teach had been a “struggle” but she feels like she “is getting better at it.” Laura was starting to see her identity as a novice change, “I don’t feel like I’m a novice any more. I may be just approaching proficiency if we’re thinking about Benner.” Laura felt that she was giving better lectures and feeling more comfortable in the classroom.

So I think I’m getting there. . . . The director gave me the chance to teach a class on my own this quarter and I was, I said “you know, I don’t think I’m ready to manage a 20-person classroom all on my own,” so I am co-teaching again. So, I guess she thought I was ready.

Laura also said she had a better understanding of the framework of the concept-based curriculum and different learning styles. She was moving around the room more and modifying her presentations to make them more clear and meaningful.

Heather, who was also in her second year of teaching, shared that she felt more comfortable with the material she was teaching and was at a place where she could start making changes to the curriculum, instead of just “surviving it.” Heather said she was now able to say, “What can I do to make it better?” and started incorporating more active learning strategies in her classroom.

So how I’ve evolved is that I’m looking at getting Vsim [computer simulation] now in maternity. So, we have case studies weekly in my course. Ahm, I’ve incorporated more case studies, more group work. I felt when I was up there, I had to lecture the whole time. And that really wasn’t quite explained, and I thought I had to cover everything that was listed in that syllabus. Okay, but I think that just being a novice instructor. Now I’ll incorporate . . . well. . . . My ahm, first group, I had a little bit almost a mutiny, because I was doing that and
it was too long. It was four hours. So they said “this is just too much.” So I took their suggestion, and I started adding video clips and more discussion. But that wasn’t really clearly communicated to me that it wasn’t my responsibility to teach everything in that textbook. So how I’ve evolved . . . I realized that I can’t do that. And I’m going to focus on the important topics, get them involved in more group work so they can get more clinical reasoning and thinking, show some videos, kind of divide . . . and now I’m going to add much more simulation into the class. So, I think I’ve felt more comfortable with the material. I think I’m able to evolve to where I can do a lot of different modalities to get my point across. So I think that’s been the biggest change. I’m incorporating a lot more class work, videos, ahm, case studies.

Jackie, who was in her fifth quarter of teaching said, “I learned to give better lectures, how to involve the students by using think/pair/share techniques. I learned how to group them in teams of two to four and give short assignments during class to reinforce their learning.” Jackie credited her team teacher for helping her learn the teaching role but also said she learned through “time and effort.” Jill, who was in her eight quarter of teaching, said her comfort had increased and she felt confident enough to suggest some changes she would like to implement in the program, but has learned that there is a lengthy approval process and that has been difficult for her.

So that is one I’m having to get used to is this . . . like you can’t just do something. There’s all these committees and then it has to go through another higher up committee and then a higher up committee. Which is really difficult for me because I just want to do something and then do it. And so, it has been difficult to learn as a teacher, versus I feel nursing . . . like you find a problem, you go to your manager, it gets worked out and fixed.

Sophie, in her third year, shared “I feel like I’m growing as an instructor . . . more confident.” When Sophie started, she “did not know what she didn’t know.” In reflecting back to her first year, she believed she had a much better idea about what her role entailed because she was able to ask better questions.

I am able to ask them [colleagues] more questions that pertain to what I’m doing. Because I know . . . I’m starting to know what I’m supposed to be doing. So I have a better understanding of the questions I should be asking. Rather than just waiting for them to tell me.
Sophie also felt more comfortable in clinical, especially grading clinical paperwork. “It definitely has evolved around our evaluating students based on those 10 competencies. I think we’re all on the same page now, rather than where we were, or where I was. Sophie also shared that her “knowledge base” had changed as well; she is incorporating new teaching strategies she is learning in her master’s program, and her comfort level with the students in the classroom has increased.

I’ve been going over the material more often and updating things to evidence-based practice. Things that were outdated. Ahm, teaching strategies as I’m learning through my master’s program. That’s been different . . . my communication with the students has changed most definitely in the classroom. I’m more comfortable speaking in front of them rather than trying to just get through the presentation and, you know, the anxiety of it. And fearful of questions, I’m more open to them asking questions and I want them to engage and I’m moving around the room more than hiding behind the podium.

**Finding rewards and satisfaction in the role.** Recognizing rewards and satisfaction in the role brought feelings of success and a sense that the participants were impacting the next generation of nurses. Seeing students learn and having fun in the role was rewarding. Laura felt like she was contributing and making a difference for the students which made her feel good. “I think, I think I’m getting it. I think I’m helping. I think I’ve taught, maybe taught some people some stuff. So that feels good.” Laura went on to say, “seeing them graduate is pretty awesome. Hearing that they’re passing their boards, that’s awesome.”

Jill found that she really liked the role and said,

I feel really happy. I’m not, like, when you work in the hospital, you know, you come home and you’re just physically exhausted. You’re emotionally exhausted. And here it’s like you still have you, have that with anything like with anything you would do. But I really like feeling that I impacted somebody and, ahm, in nursing and maybe like one of them will go off to make, you know, some great discovery or something. But, I feel like I get, sometimes I get more out of it than I did in nursing.
Heather talked about how rewarding it was to see graduates out in the community who would come up to her and say that she made a difference for them or e-mails from graduates thanking her for the impact she made on them. She shared:

Sometimes you don’t realize what you’re doing will make a difference in someone's life. So just seeing people through. . . . Maybe your single parents are trying to support themselves and now they’re at a community and they’re doing so well and they’re thriving. That’s what keeps me going.

Jennifer said that teaching was “exactly what I thought it would be” when she started and had found great satisfaction in the role. She shared, “I really, really love being in the classroom and I absolutely love clinical.” Jennifer mentioned multiple times how much fun she is having and, “in fact, I’ve told, you know, everybody who asks how I like teaching; I’m like, I can’t even describe how much I like it.”

Although there were many frustrating and stressful times through the first two quarters, Melanie shared that she has had fun, too, and enjoyed seeing the students learn.

I still have just fun with the students. Again, when I would see them, like oh, I understand; oh, I get it; oh, okay, that makes sense. You know when you start seeing again the fun of learning . . . and just getting to know different people. I always enjoy getting to know people and seeing their background. But that was fun still to see them getting learning, despite my inadequacies. That they still were able to learn and that was fun.

**Choosing to continue.** Participants were asked whether they planned to continue in their role. Each shared that they planned to continue in the role and reflected on a number of different factors which influenced their decision including a desire to succeed and have their students succeed, feelings of making a difference, feeling appreciated, passion, and not wanting to change jobs or go back to practice. Commonly, more than one factor influenced their decision to stay.
For Sue, the desire to succeed in the role and see her students succeed was an important factor in deciding to continue in the role. Despite numerous challenges in getting started and learning to teach, Sue shared what kept her going was,

the fact I want to succeed. I want to keep doing this. I kind of think that as many years as I spent working in the hospital, I kind of don’t want to go back there. I mean, it’s the truth. And so, I don’t know what else I’d do if this doesn’t work out. . . . If it’s just not working, well then I’ll just have to go with plan B. I want my students to succeed.

Melanie planned to continue in her role. She related that some of her stress with the transition has been self-imposed because of her personality; she is a perfectionist and wants to exceed and excel. She compared starting this new position to starting as a new intensive care unit director with no experience. She worried about the things she does not know that she should know, but through her previous experiences has come to realize that she will learn them when she needs to. The self-imposed stress comes from wanting to get the learning curve “over with.”

I want to get it all perfect now so I can build other things that I want to work on. But first I have to go through the novice part and so being, just like two years ago, had gone through the whole learning curve with being a new director and now I get to start all over again as an educator. I like it.

Jill planned to continue in nursing education but shared the most difficult transition to teaching so far had been financial. Jill, who did not practice nursing outside of academia during her first two years, decided to start working part-time this year to augment her salary and also to keep up her skills. As a mother to three small children and the sole breadwinner, Jill had to pick up shifts “to make up” some of the difference in salary from what she was making previously in practice. She expressed that a,

very difficult part [of the transition] is knowing the students I’m graduating at the ADN [associate degree in nursing] level will probably be making more
than I am with 10 years of experience and a master’s degree in education. That has been difficult. But it’s definitely something that if you are passionate, you have to be passionate about it. I guess that’s one way . . . no one goes into it for the money. But definitely what’s left behind are people who are passionate about it and want to give back to nursing. And, I do feel that I am giving back a lot to nursing by creating and helping grow nurses that I would want to see and I would want to be taken care of and who I want to represent the field of nursing.

Jill pointed out that she felt that it was important for educators to also keep current in the field and that was another reason she started working part-time. “I’m doing it financially, but I’m also doing it so when I say this is what’s happening, this is what’s happening to keep me relevant.” Jill plans to continue and expressed that like with anything in nursing, there is, 

physical and emotional exhaustion; however, in education it feels like you’re getting somewhere and the sacrifices that you have made, you are impacting somebody. And so, I do like that aspect of education. You know, to keep you going and burn out less.

Financially, Heather was in a similar situation to Jill and also added that nurse educators were not valued as much as staff nurses.

The only reason why I do this job is I have my retirement [from the military]. If I didn’t, I could not even do this job. There’d be no way cause my husband doesn’t work. So you’re losing good people cause you’re not giving them a wage that they can make in the hospital. So this problem is not going away. Yeah, I mean because we’re not valued like the hospital staff nurse. And oh, by the way, they don’t give you recognition for having your master’s, right? You get no extra money for having certification in your field as an expert. Right?

Heather shared that her family would like her to continue because they like the hours better in academia. She said she is taking it “one tour at a time” just like when she was in the military and felt like she could walk away if she chose to.” For Heather, it was really “not about the pay” as much as “making a difference in nurses.” She chose to continue right now because she is enjoying it and is passionate about teaching.
Laura shared a similar motivation to continue teaching, saying she could make more in practice but was happy with what she was paid. “I’m not here for the money. Well, I’m not going to do it for free. I can make a lot more money other places, but it’s my turn to give back.” Laura felt as though she was making a difference and said “I’m getting it, I think I’m helping. I think I’ve taught, maybe taught some people some stuff. So that feels good.” Laura’s position was grant funded, and she did have some worry that she would not get funded the following year.

Jill and Jackie both agreed that receiving positive affirmation was helpful, but not the only factor motivating them to continue in their roles. Jill said,

The field I was in where, you know, people aren’t happy when they’re in the emergency room. And so, you get a lot of that. This care sucks. You guys are horrible. Whereas in teaching, you get a lot more of the, “You’re great” and “I’ll always remember what you said.” And so, that makes you like . . . we don’t do it because we want people to tell us we do good. But it does help. And it does feel like you’re getting somewhere, and the sacrifices that you have made you are impacting somebody. And so I do, I do like that aspect of education. You know to keep you going and burn out less.

Jackie said, “the workload has been really, really heavy, but I can do anything when I am appreciated.” Jackie planned to continue in her position stating, “I have three-and a-half years to retire. I am not changing jobs again. Heaven forbid. So yep, anyway that’s my plan. We’ll see. I wouldn’t mind being one of these adjuncts over here. To do this part-time wouldn’t hurt my feelings.” Jackie would also like to be able to continue practicing as a nurse practitioner, but stated, “I am really tired.” She recently renewed her family practice certification so that she has the option; however, she was having a difficult time finding the time to get her practice hours done. Heather was in a similar situation, trying to find time to practice. She had renewed her certification as
an operating room nurse and had applied for a few per diem positions, but they did not work with her teaching schedule.

Despite some early challenges with orientation and not having access to curriculum, Jennifer found that teaching was exactly what she was hoping for and planned to continue in her role. She said, “this is what I want to do for long term.” Sophie said her transition had been an “overwhelming” experience, but she also planned to continue and shared that she “might even continue on with schooling” when she is done with her master’s degree.

Kay shared, “I really want this to work; I just wished there was more support . . . it would be nice to have more support. I just feel unsupported.” Kay shared that she talked to her spouse about it and said,

I don’t mind working. I love working with nursing students. They’re an awesome group of people. But I think I’m going to have to cut back to part-time because this is just way too much. I just feel overwhelmed and unsupported.

Kay shared that the two things that helped her get through the first two quarters were her faith and the students.

Summary

Chapter IV presented the findings of this study, which revealed the transition experience from expert clinician to novice educator to be complex and challenging. Participants reported a lack of knowledge about how to teach and being ill-prepared for the role of nurse educator; shortened orientations and inadequate mentoring left novice educators trying to navigate academia on their own. Participants experienced a wide range of emotions and feelings in early teaching experiences and reported having to “learn to teach as they taught.” However, informal mentoring and support by co-
workers was found to play a critical role in facilitating the transition. Novice educators also reported that their nursing expertise and experience was helpful in increasing their comfort level in the clinical setting.

Despite many challenges, participants exhibited perseverance and started to identify growth, recognize rewards, and find satisfaction in their role. When asked if they wished to continue in their role, participants cited a number of factors which influenced their decision to continue, most notably a desire to teach well and see their students succeed, feelings of making a difference, passion, and not wanting to change jobs or go back to practice.
CHAPTER V

DISCUSSION, RECOMMENDATIONS,
AND CONCLUSION

This study sought to gain insight into the real-life experiences of nine novice nurse educators and understand their perceptions and meaning of their transition experience. The paradigm of hermeneutic phenomenology was utilized to address the central research question:

Q1 What is the lived experience of clinical nurse experts transitioning to the role of novice educators?

Additionally the study sought to identify:

Q1a Why did the practicing nurse choose a career in academia?

Q1b What factors helped or hindered the transition process?

Q1c What knowledge, skills, and attitudes do practicing nurses bring from a clinical setting that helped in the transition to academia?

Q1d How does a novice nurse educator learn the teaching role during the first three years?

The study’s methodology involved conducting eight face-to-face interviews and one Skype interview which were audio recorded and transcribed verbatim. All transcripts were sent to participants to review for accuracy and completeness. The narratives from the participants served as the means by which the experience of transitioning from expert clinician to novice educator is accessed. Van Manen’s (1990) method of data analysis was utilized which involved prolonged engagement
with the data. A second interview was offered to each participant after preliminary themes began to emerge. Six of the nine participants agreed to a second interview where the researcher and participant collaborated and validated the significance of the preliminary themes. After the follow-up interviews, the researcher returned to reflection and refinement of the preliminary themes. Once essential themes were uncovered, the researcher returned to writing. Five themes and 15 sub-themes emerged from the collective experience of the participants in this study which provided insight into the central research question.

Chapter V will open with a discussion of the major findings of this study relative to the research questions and the related nursing literature and their application to the theory of experiencing transitions (Meleis et al., 2000). Limitations, recommendations for nursing education, and recommendations for further research will also be presented.

Discussion of Findings Related to the Nursing Literature

An in-depth exploration of the literature was completed prior to recruiting participants for this study. The areas reviewed focused on the factors influencing the nursing faculty shortage and literature on transitioning from practice to academia. Although the transition of the expert clinical nurse to the role of novice educator is not a new phenomenon, there is a scarcity in the literature that documents this experience in the community college setting. There was a gap in the literature looking at the lived experience of the transition of the expert clinical nurse to novice nurse educators in the community college setting, particularly full-time appointments which carry more teaching responsibility in the classroom and clinical settings. This study was
conducted as a means to help fill the research gap identified from the literature review. The findings of this study are presented by theme and sub-themes with a discussion of the related literature.

**Theme 1: Anticipating the Transition**

Research Question Q1a of this study sought to find out why the practicing nurse chose a career in academia. The desire to teach, being recruited to teach, and being dissatisfied with the practice role were the three main factors (sub-themes) in the participants’ decision to transition from the expert clinical role to the novice educator role. For most, the decision was the result of one or more factor. The desire to teach is cited in the literature as one of the primary reasons that nurses seek careers in academia (Bailey, 2012; Cangelosi et al., 2009; Chapman, 2013; Duphily, 2011; Parslow, 2008). Participants in this study felt a desire to give back to the profession, shape the upcoming culture of nursing, or had previous experiences with students in clinical as a preceptor that were positive and wanted to teach. These altruistic motivations were also evident in the participants in studies by Cangelosi et al. (2009), Evans (2013), Gazza (2009), Parslow (2008), and Shoening (2013).

Some participants in this study were recruited to fill open positions and had not considered teaching, but were ready for a change. This is a different finding than the studies by Parslow (2008) and Weidman (2013) who discovered that the educators recruited in their studies also had the desire to teach.

The desire for a change and feeling dissatisfied with the current practice role was a factor leading to the decision to pursue academia. Participants in this study voiced frustrations with systems, 12-hour shifts becoming harder, tired of the
commute to work, feelings of burn out, and being ready for a change physically and emotionally. For the participants in this study, dissatisfaction alone was not the primary motivating factor to transition but overlapped with other factors. Dissatisfaction was not found to be an influencing factor in the literature. One study by Schoening (2013) found that some participants desired a more predictable lifestyle and schedule, but were not necessarily dissatisfied with their previous practice role when deciding to transition. The literature also cited the positive influence of previous nurse educators in nursing school (Chapman, 2013; Evans, 2013) and the desire to influence the nursing profession through research and policy (Poronsky et al., 2012) as motivators to pursue careers in nursing education; however, these findings were not evident in this study.

**Theme 2: Starting Out**

As the participants in this study transitioned into their new roles, they found they were entering an unfamiliar environment, one they were not prepared for, and lacked information about. Three sub-themes characterized this theme: inadequate orientation and mentoring, lack of preparedness, and need for knowledge and information. These findings mirrored the nursing literature which revealed the transition process was challenging, because novice educators lacked preparation for the role, had unrealistic expectations of the role, and faced barriers such as limited opportunities for orientation and mentoring.

Billings and Halstead (2012) posited that orientation is a foundational part of the faculty development process at the time of hire and is critical to program effectiveness. As participants entered their new roles, they cited a lack of formal
orientation or shortened orientation and inadequate socialization to the faculty role. This was a common finding in the nursing literature as well. Several studies cited inadequate or abbreviated orientation programs (Bailey, 2012; Dempsey, 2007; Mann, 2013; Parslow, 2008; Schoening, 2013) or no orientation (formal and/or informal) program at all (Parslow, 2008). McDonald (2004) found that all participants in her study of nurses moving from practice to academic appointments had some type of pre-service orientation to the institution. Although all experienced this orientation, they still felt inadequately prepared, stressed, and anxious. Attendance at faculty workshops and in-services prior to the start of the academic year was a common practice for the participants in this study. Participants found the information helpful, but still felt unprepared, because they were torn about where to spend their time: prepping for class or getting information about the college and teaching.

Inadequate orientation left novice educators to “figure things out on their own,” learn by “trial and error,” “making mistakes,” or “just doing the best that they could.” Davidson (2011) echoed similar findings saying that some new faculty learned by observing others and piecing together the duties. There was a discrepancy of expectations with what faculty felt they needed in an orientation, assistance, and guidance and what they actually received. These same findings were validated in the literature in studies by Anderson (2009), Schriner (2007), and Siler and Kleiner (2001).

The literature strongly emphasized the importance of mentoring as a primary strategy to facilitate and enhance the career development of all nursing faculty, particularly novice faculty (Dunham-Taylor et al., 2008; Jacobson & Sherrod, 2012;
National League for Nursing [NLN], 2004, 2006). Some type of mentoring relationship existed both formally and informally for participants in this study. The quantity and quality of the mentoring varied greatly from feeling supported to feeling disappointed and frustrated. Mentoring fell short in programs where there were faculty vacancies or where faculty were busy with competing priorities. The literature paints a similar picture. Chung and Kowalski (2012), Foley et al. (2003), and Gerolamo and Roemer (2011) found heavy faculty workloads leave faculty little time to mentor, especially in institutions where there are faculty vacancies and faculty are assigned increased workloads due to the nursing faculty shortage.

Participants in this study valued any type of mentorship which provided a critical source of support for their transition. In the absence of formal mentoring, many sought out advice and guidance from whoever was available at the time, whether colleague or dean or director. Participants found informal mentoring was helpful practically and also provided a source of support and a network. Perceived support from colleagues and administrators varied greatly across the breadth of literature from excellent support to no support with the majority of novice faculty fitting somewhere in the middle. Schoening (2013) and Siler and Kleiner (2001) found that in the absence of formal mentoring, novice faculty sought help from colleagues or a “go to” person for questions, a form of peer mentoring. The NLN (2006) stated that “peer mentorship occurs when the new faculty members pool themselves, pool their information and expertise and support each other” (p. 1).

Participants in this study entered their academic appointments with no prior teaching experience, felt unprepared, and expressed at least some degree of
uncertainty about what their new role entailed. Kahn et al. (1964) defined role ambiguity as “uncertainty about behavioral requirements serving to satisfactorily define a role” (p. 61). Role ambiguity was one of the most difficult challenges novice nurse educators cited in the transition literature which left them feeling stressed, frustrated, uncomfortable, anxious, and lacking confidence (Anderson, 2009; Chapman, 2013; Cooley, 2013; Duphily, 2011; Mann, 2013; Parslow, 2008; Poronsky et al., 2012; Schriner, 2007).

An overarching theme noted throughout the transition literature was a lack of knowledge about and preparation for the faculty role (Anderson, 2009; Anibas et al., 2009; Bailey, 2012; Chapman, 2013; Cooley, 2013; Dempsey, 2007; Dunham-Taylor et al., 2008; Duphily, 2011; Gwin, 2012; Mann, 2013; McDonald, 2004; McDonald, 2010; Parslow, 2008; Paul, 2015; Rich & Nugent, 2010; Sawatzky & Enns, 2009; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013; Wilson et al., 2010; Young & Diekelmann, 2002). Participants with formal preparation in master’s programs with an education focus lacked preparation in key aspects of the role, particularly didactic instruction and a teaching practicum. This is similar to the findings by Cooley (2013), Mann (2013), and McDonald (2004) who reported that even those educators with formal graduate preparation said that the transition was challenging and not what they expected. Dempsey (2007) found that novice educators had a difficult time applying theoretical content to classroom instruction and the administrative roles of teaching, such as grading. Participants with clinically-focused master’s degrees shared similar struggles citing deficiencies in pedagogy and educational “lingo.” Anderson (2009),
in a study of advanced practice nurses, reported on similar struggles with curriculum, how to teach, and academic language.

Regardless of their formal preparation for the educator role, participants felt that their clinical expertise and experience prepared them to teach in the clinical setting, because clinical was “easier” or more of a “comfort zone.” Although participants identified themselves as clinical experts, they were unprepared for some of the expectations of clinical instruction which presented challenges. Starnes-Ott and Kremer (2007) posited that preparation as an expert clinician does not necessarily ensure an effective educator. Novice educators lacked preparation in evaluating students and grading clinical paperwork, found it challenging to be assigned to an unfamiliar clinical unit, and often received short or no orientation to the clinical facility (Schriner, 2007). Developing rapport with the staff on the unit was also a challenge, particularly if the instructor did not have experience on that unit as a staff nurse or if staff did not want to work with students.

Some of these same challenges were reported in the transition literature as well. Parslow (2008) found that novice educators who were assigned to clinical facilities where they had no experience reported having to learn the unit, the staff, and charting systems along with the students. Others who were able to teach clinical in familiar units found the transition easier and reported that their experience gave them credibility in the students’ eyes even though they lacked preparation in teaching (McDonald, 2004; Parslow, 2008; Testut, 2013).

Participants cited a need for knowledge and information in many aspects of the role including the “nuts and bolts” about their institutions, basics such as benefits and
pay, what the faculty role entailed, technology used in the classroom, educational lingo, and information about the curriculum and how to teach. Some were offered professional development when they started their roles which they found helpful. More commonly novice educators were left to figure it out on their own. Participants found information by asking colleagues, administrators, or students or by doing research online, reading books, or taking classes on their own which helped them learn the role. Similar strategies were evident in the nursing literature where in the absence of orientation programs and mentoring in their new roles, novice faculty found self-directed information seeking and participation in professional development activities, such as in-services and online classes, helpful during their early transition (Anderson, 2009; Bailey, 2012; Chapman, 2013; Mann, 2013).

**Theme 3: Learning to Teach**

Learning to teach was the third theme which emerged from the data characterized by three sub-themes: jumping in with both feet, early teaching experiences, and wanting and receiving feedback. In learning to teach, novice educators faced a variety of new situations and challenges that brought to light the complexities of the role. The major emphasis of the faculty role in the community college setting is teaching, and there is typically less emphasis on scholarship and service. The majority of the participants’ workload was comprised of teaching both in the classroom and clinical settings. The length of time each of the participants had been teaching varied greatly; however, all shared common experiences related to their first few quarters.
All participants started teaching in full-time appointments per this study’s eligibility criteria, with some on overload their first quarter. Anderson (2009) found that participants who were paired with a seasoned educator and given lighter workloads reported a “honeymoon sensation of less anxiety and serenity” (p. 205). This was not a common finding in the literature or the case for the participants in this study who jumped into a full workload with both feet. Participants felt tired and overwhelmed from the amount of time spent prepping for classes and other duties. Some were not prepared for the time commitment and extra time spent at home above and beyond their work week. This discrepancy in workload expectations was found in the transition literature as well (Bittner & O’Connor, 2012; Duphily, 2011; Gwin, 2012; Siler & Kleiner, 2001). Others found they were barely staying ahead of their students in prepping for class. This was commonly reported in the transition literature by novice faculty who said there is never enough time and too much to do (Anderson, 2009; Bailey, 2012; Cooley, 2013; Dempsey, 2007; Duphily, 2011; Gazza, 2009; Poronsky et al., 2012).

Workload has been cited as one issue that is associated with job dissatisfaction and possible intent to leave academia (American Association of Colleges of Nursing [AACN], 2005; Bittner & O’Connor, 2012; Durham et al., 2007; Kaufman, 2007c). Participants in this study voiced some dissatisfaction with their workload, especially their first few quarters. Faculty who were on overload felt like they were “trying to tread water . . . not sink and drown;” others felt stressed or overwhelmed by the amount of work and prepping for classes. The analogy to “drowning” and “sink or swim” used by participants early on was also found in studies by Anderson (2009) and
Schoening (2013). Participants were not prepared for additional responsibilities such as advising and finding clinical placements which added to their workload and stress. Siler and Kleiner (2001) reported faculty found their workload “much more than they expected” when committee work and special projects were added to their primary responsibility of teaching and managing courses their first year. Participants in this study shared that they intended to stay in their roles despite these early challenges.

Novice educators experienced a wide range of emotions and initial challenges when they started teaching in the classroom. “Learning to teach as you teach” was a common experience among participants who felt unprepared and were still trying to figure out the curriculum and how to teach. Many lacked confidence as they were trying to figure out how to teach as they went along. Similar findings were reported in the literature where novice educators described early teaching experiences as “flying by the seat of my pants” (Cooley, 2013; Schoening, 2013), “winging it” (Schoening, 2013), or relying on “teaching as they had been taught” (Parslow, 2008).

A dichotomy of emotions and feelings were evident in the participants in the first time they taught in the classroom. Participants described feelings of nervousness, anxiety, and being physically ill on one end of the spectrum to a rush and excitement on the other end. Cooley (2013) and Schoening (2013) reported similar feelings such as anxiety and discomfort; however, feeling a rush or excitement was not evident in the literature. Participants’ clinical expertise and experience made teaching in the clinical setting more comfortable and easier than the classroom; however, there were aspects of clinical instruction that they were unprepared for and found challenging. This was discussed previously in Theme 2, starting out. The findings of this study
clearly delineate a difference between early teaching experiences in didactic versus clinical courses. Participants in this study were assigned to teach in both areas as well as having the responsibility to teach simulation or in the laboratory. A unique aspect of the population of nurse educators in the community college setting is that they tend to have multiple teaching responsibilities and lack preparation in didactic and clinical teaching. There is a dearth of existing literature separating the experiences of educators who are teaching in both areas simultaneously.

Participants desired to teach “right” and felt responsible for the students’ learning. Some expressed self-doubt or anxiety in their ability to deliver the content adequately or give the students what they needed to be successful in class or ultimately on their board exam. Siler and Kleiner (2001) found that novice faculty were most concerned about their performance as teachers and prioritized how well they were teaching above scholarship and service their first year. Anderson (2009) reported that a common concern of participants was that they were always afraid of not knowing something, because they wanted to establish credibility with students and clinical agencies.

Novice educators desired and actively sought out feedback for support and guidance to help them grow in their role. A number of studies reported that novice faculty who wanted and needed feedback about their teaching did not receive it (Anderson, 2009; McDonald, 2004; Parslow, 2008; Siler & Kleiner, 2001). The primary sources of feedback for the novice educators in this study were colleagues, administrators, and students. Feedback from student evaluations was the most common form of feedback and ranged from very positive to critical which affected
how participants utilized the feedback. Participants who received positive feedback were more apt to accept the feedback and use it to help them improve in their teaching role and felt affirmed that they were doing well; whereas, those who received negative feedback felt frustrated and hurt. Anderson (2009) found that negative student evaluations had “a profound effect on most participants, but positive feedback also was acknowledged as helping participants identify with the role of an educator” (p. 207). Feedback from colleagues was a critically important form of support to novice educators. Participants in this study found encouragement when colleagues would give guidance or advice during difficult times. Cooley (2013) spoke of transformative learning experiences originating out of situations in which there was a strong relationship with another person. The desire and need for support in the form of a relationship with another person or persons was mentioned as frequently in the literature as mentoring (Anderson, 2009; Dempsey, 2007; Duphily, 2011; Gazza, 2009; Gazza & Shellenbarger, 2010; Goodrich, 2014; Gwin, 2012; McDonald, 2004; McDonald, 2010; Paul, 2015; Poronsky et al., 2012; Siler & Kleiner, 2001; Testut, 2013; Weidman, 2013).

**Theme 4: Influencing Factors**

Research Question Q1b of this study sought to identify factors that helped or hindered the transition experience. Facilitating factors contributed positively to or helped the transition process; while hindering factors may have made the transition more difficult or challenging. Research Question Q1c asked what knowledge, skills, and attitudes possessed by the participants influenced their transition. This was found to be one of the three sub-themes that characterized the theme of influencing factors.
Some facilitating factors were also found to be hindering factors, and those factors are discussed together in this next section.

Several key facilitators were identified by participants as having helped or eased their transition process in some way. Participants believed that their clinical expertise and experience helped their transition process, particularly in the clinical setting where they felt more comfortable. Anderson (2009) found that participants “had a secure environment in which they operated as expert clinicians . . . you did things easily in your previous clinical profession . . . there were challenges. . . But you had a way of figuring out how to do it” (p. 205). Testut (2013) and Parslow (2008) reported that novice educators felt comfortable in the clinical setting because of their expertise which also gave them credibility. Participants in this study found that clinical expertise enabled them to bridge the theory–clinical gap and make connections for students to the real world. A position statement from the NLN Board of Governors (2005) supported that clinical expertise is a critical component to the success of the nurse educator; however, advocates for the essential competencies of knowledge of teaching and learning, curriculum design and evaluation, assessment, scholarship, and the ability to function in the educational environment to develop proficiency in the faculty role.

Formal graduate education in nursing was both a facilitating factor and a hindering factor. Participants who earned master’s degrees in nursing education prior to transitioning to academia commented about how it prepared them for certain aspects of the role which was helpful; however, they felt deficient in other aspects of the role, particularly curriculum development, test writing, how to teach, and
classroom management. Cooley (2013), Dempsey (2007), and Mann (2013) also found that novice faculty who had some formal preparation for nursing education said that it was helpful, however, were unprepared for the complexities of the role and had different expectations than reality.

Participants in this study lacked practical application of theoretical knowledge to the classroom in the form of a teaching practicum which was a hindering factor. A graduate level practice experience is an expectation of the core curriculum for master and doctoral level preparation in nursing education (AACN, 2006, 2011); however, the novice educators in this study did not have a teaching experience in school or had completed one too long ago to be relevant. Without preparation, participants in this study learned the teaching role as they taught, by researching and “figuring things out on their own,” “trial and error,” or by “making mistakes.” There is ample evidence in the literature connecting role ambiguity and lack of preparation to role stress. The consequences of role stress leads to decreased job satisfaction, decreased organizational commitment (Chang & Hancock, 2003; Culbreth et al., 2005; Kemery, 2006; Touliatos et al., 1984), depression, health-related problems, thoughts of quitting, decreased connectedness (Kemery, 2006), teacher burnout, and high turnover (Culbreth et al., 2005). Participants felt challenged by the steep learning curve and experienced many negative feelings including disconnectedness and frustration; however, the other consequences noted in the literature were not evident in this study.

Orientation and mentoring were both facilitating and hindering factors depending on the amount and quality of the experience. This same finding was evident throughout the transition literature. Although lack of mentoring was one of
the primary barriers to the development of the novice nurse educator because of perceived inadequacies in mentorship programs and activities, mentoring was also cited as a facilitator of the transition to the nurse educator role as well (Bailey, 2012; Dempsey, 2007; Duphily, 2011; Mann, 2013; McDonald, 2004; Parslow, 2008; Weidman, 2013; Young, 1999).

Participants developed mentoring relationships with colleagues in the absence of a formal mentor which was helpful. Participants found that informal mentoring and supportive relationships and camaraderie among faculty were the most influential facilitators of the transition experience. Gardner (2014) also found that “if formal mentoring was not available, informal mentoring and support were crucial” (p. 108). Gazza (2009) also found that all participants “needed support to perform in the faculty role. It simply was not possible for them to do the job alone” (p. 223). Paul (2015) acknowledged that connections, relationships, and ongoing support provide supplementation for the transition process and increased job satisfaction. The overwhelming need for mentoring as a facilitator to faculty development in the transition literature matches previous literature on mentoring and national best practices calling for mentoring as a primary strategy to facilitate and enhance career development for novice faculty (AACN, 2005; NLN, 2006).

In the absence of orientation programs and mentoring in their new roles, novice faculty found self-directed information seeking and participation in professional development activities, such as in-services and online classes, helpful during their early transition (Anderson, 2009; Bailey, 2012; Chapman, 2013; Mann, 2013). Participants in this study reported that taking classes, reading books, going to
conferences, or taking educational classes such as “boot camps” facilitated their transition to teaching, especially early on in the transition, rather than later.

Observing seasoned educators or co-teaching courses was found to be a facilitator for novice educators with no experience in the classroom. Being paired with an experienced educator was one way to prepare for the teaching role (Anderson, 2009; Mann, 2013). Other novice educators, although not paired with a seasoned educator, suggested that it would be a good idea to better prepare for the role (Chapman, 2013; Culleiton & Shellenbarger, 2007; Dempsey, 2007; Gwin, 2012).

Penn et al. (2008) posited that most of the early challenges in the transition diminish with time and experience. Repetition and time were the final facilitating factors for the participants in this study. Participants who had the opportunity to repeat content or who were in their second or third year began to see growth and feel more comfortable, particularly in teaching didactic courses. Anderson (2009) reported that “rehearsal and experience were the key elements to comfort and confidence” (p. 207).

Starting a new appointment with a full workload or on overload was a hindering factor for the participants in this study. This left the novice educators overwhelmed, tired, not being able to take time off on the weekends, and barely staying ahead of the students in prepping for classes. Teaching full-time left little time to practice and those who were trying to balance both found it difficult. Findings were similar to the nursing literature. Novice educators reported that they were not prepared for the workload expectations and were surprised that the workload did not meet their expectations of the role (Bittner & O’Connor, 2012; Duphily, 2011; Gwin, 2012).
2012; Siler & Kleiner, 2001). In many cases, unrealistic expectations of workload hindered the novice faculty member’s transition (Bailey, 2012; Dempsey, 2007; Duphily, 2011; Kaufman, 2007a). Anderson (2009) reported that lighter workloads were assigned to some new faculty in her study as a strategy to moderate unrealistic expectations. While lighter workloads were mentioned in other studies as a desired strategy to facilitate the transition for new nurse educators, this was not a common strategy. Reports of faculty being granted release time for engaging in scholarship (including research), service activities, maintaining advanced practice competency and certification, or completing doctoral studies were scarce in the literature.

Knowledge, skills, and attitudes of novice faculty emerged as factors that positively influenced the transition from practice to academia. Participants agreed that their knowledge of clinical expertise and clinical experience helped facilitate their transition in the clinical setting and, to some extent, in the classroom. Novice educators relied on their ability to problem-solve and figure things out on their own to survive the early challenges of limited orientation and lack of preparedness. This finding was also reported by McDonald (2004) who said skills such as organization and being an independent decision-maker were helpful in the transition. Novice educators demonstrated personal characteristics of perseverance, being proactive, striving for excellence, wanting to succeed, wanting students to succeed, and being passionate about nursing which all positively influenced their transition to academia. Anderson (2009) and Cooley (2013) found that personal characteristics of internal drive to do well, self-instruction, self-preparation, and strength of character were facilitators to the development of competence in the role.
Theme 5: Getting There

Getting there marked the passage from surviving and getting through the transition to being able to identify growth and initiate change. Over time, participants began to find rewards and satisfaction in the role of nurse educator. A number of factors influenced their decision to continue.

As participants in this study gained more experience in and knowledge about their role, they started to identify areas of growth and began to initiate changes, specifically in the teaching aspect of their role. Areas of growth cited by the participants included increased comfort and confidence, use of new teaching methodologies in the classroom, improved ability to manage the classroom, and establishment of clear boundaries with students. Participants also voiced having a clearer understanding of the college, program, and curriculum. They also cited improved life/work balance.

Similar findings were identified in the transition literature. Anderson (2009) reported that in early patterns of work-role transition, participants “were focused on self and survival . . . with no time to think, no space to be creative” (p. 206). Participants who moved out of these early patterns reported increased comfort, began to develop a vision, found rewards, and identified and initiated change. Schoening (2013) similarly found that “as participants gained confidence through experience, they began to focus less on themselves as teachers and more on their students as learners, empowering the participants to implement new teaching strategies” (p. 171). Siler and Kleiner (2001) found that as novice educators progressed through the first year, they gained a clearer understanding of what was expected of them and what they
could expect of themselves. Dempsey (2007) reported that initial negative feelings in the new role decreased as participants accepted the role change, gained experience in the new role, and became more familiar with their new environment.

As participants in this study began to gain comfort and confidence in their roles, they started to recognize rewards and satisfaction that brought feelings of success and a sense that they were impacting the next generation of nurses. Despite challenges in the transition, participants shared rewarding moments, such as having fun teaching, enjoying the “ah ha” moments where they could see learning happening and watch students graduate, receive their nursing pins, and pass the National Council Licensure Examination. Some spoke of seeing their graduates in the community who were thriving, which brought a great sense of satisfaction. Anderson (2009) found that recognition of rewards brought “intrinsic feelings of success, reaffirming for participants that their decision to become an educator was the correct action” (p. 206). Participants in the study by Duphily (2011) also reported finding rewards in the role “from making a positive change in one student’s life through a one-to-one interaction to guiding entire classes toward pinning and graduation” (p. 128). Others found the challenges of teaching, such as overload of hours, an investment in their professional future. Paul (2015) found that participants recognized the value of “time/experience being in the teaching role” (p. 7) as their teaching identity evolved. Siler and Kleiner (2001) described how “memorable experiences occurred during the first year that promoted novice faculty to reflect on the meaning of being a teacher” (p. 401). These experiences encouraged novice faculty.
Participants in this study were asked whether they planned to continue in their role. Each shared that they planned to continue and reflected on the factors which influenced their decision, including a desire to succeed and have their students succeed, feelings of making a difference, feeling appreciated, passion, and not wanting to change jobs or go back to practice. Commonly, more than one factor influenced their decision to stay. Similar findings were also found in the nursing transition literature where despite being unprepared for the role and challenges associated with different aspects of the transition, participants wanted to continue in their roles (Duphily, 2011; Goodrich, 2014; Siler & Kleiner, 2001). Garbee and Killacky (2008) studied factors influencing the nurse educators’ intent to stay in academia and found that none of the predictor variables (job satisfaction, mentoring, organizational commitment, and leadership behaviors) significantly correlated with intent to stay in the position. Respondents stated that “they love nursing and felt education allowed them to give back to the profession and make a difference” (p. 11).

The collective findings from the transition experience of the participants in this study add to the existing body of nursing transition literature and support and strengthen existing findings. The overall experience of new faculty entering academia often find the transition to be challenging with many feeling inadequately prepared and overwhelmed (Anderson, 2009; Anibas et al., 2009; Bailey, 2012; Chapman, 2013; Cooley, 2013; Dempsey, 2007; Dunham-Taylor et al., 2008; Duphily, 2011; Gwin, 2012; Mann, 2013; McDonald, 2004; McDonald, 2010; Parslow, 2008; Paul, 2015; Rich & Nugent, 2010; Sawatzky & Enns, 2009; Schriner, 2007; Siler & Kleiner, 2001; Weidman, 2013; Wilson et al., 2010; Young & Diekelmann, 2002). This begs
the question, What has changed? Siler and Kleiner (2001) asked the same question 15 years ago.

Are the struggles of the first year simply to be endured to pay one’s dues in academia? Is our history in nursing repeating itself, or is it possible that new educators may have a different experience? What needs to happen for novice faculty to have a different experience? (p. 402)

Recommendations for nursing education will be addressed later in this chapter.

**Application of Findings to the Theory of Experiencing Transitions**

In this discussion of the findings, the application of the experiencing transitions theory by Meleis et al. (2000) and how it relates to the transition from clinical nurse expert to novice nurse educator will be presented. This study advances knowledge and contributes to the ongoing development of the theory of experiencing transitions.

**Types of Transitions**

Meleis et al. (2000) supported four types of transitions that are central to nursing: developmental, situational, health–illness, and organizational. In this study, the transition the participants made was identified as situational. Chick and Meleis (1986) defined situational transitions as those that include movement in and/or through educational or professional roles. All participants in this study moved from a role as an expert clinician into a nurse educator.

**Structure of Transitions**

Transition is defined as the passage from “one life phase, condition, or status to another” (Chick & Meleis, 1986, p. 239). Transitions are complex, fluid, and have a universal structure including an entry phase, passage phase, and exit phase. The entry
phase begins when transitions are first anticipated, often years before the actual change occurs. Antecedents to the transition from nursing practice to education for this study’s participants included a desire to teach, being recruited to teach, and dissatisfaction with the current practice role. Among the antecedents, there was overlap as the decision to pursue academia was often the result of more than one. Participants reflected on the desire to teach for weeks to years prior to starting a position as a nurse educator. Some participants reported being recruited to teach to fill vacant nursing faculty positions. Participants also stated being dissatisfied with work conditions in their previous places of employment and were ready for a change.

The passage phase is exemplified by five common themes: process, disconnectedness, perceptions, awareness, and patterns of response (Meleis et al., 2000). For participants in this study, the process of transition was ongoing and characterized by continued professional growth and development in the educator role. No participants directly stated feeling a degree of disconnectedness to others, but made statements such as having to “figure things out on my own” and described having colleagues who were too busy or had competing priorities. Perceptions that participants ascribed early in the transition included the sense of lacking knowledge and needing information and lacking preparation for the role. After starting to teach, they described having to jump into the role with both feet—of “learning to teach as you teach” and needing feedback, but finding negative feedback discouraging. Participants were aware of the changes that were occurring in their new role and related feelings of discomfort and stress that typically accompany change.
Meleis et al. (2000) posited that a healthy transition is identified by patterns of response which are characterized by process and outcome indicators. Process indicators included feeling connected, interacting, location and being situated, developing confidence, and coping. Outcome indicators included the mastery of new skills to manage the transition and identification of a new sense of self. This study did not specifically address the outcomes of the transition from the role of clinical expert to novice educator, because the purpose was to describe the experience of the transition. However, indicators such as gaining comfort and confidence in the role, implementing new teaching strategies, finding rewards and satisfaction, and a desire to stay in the role of nurse educator were congruent with process indicators identified by Meleis et al. (2000).

The exit phase occurs after a period of stability is achieved in the new position and a new status is obtained (Chick & Meleis, 1986). Participants in the study were not asked specifically if they had reached a period of stability in their new positions.

**Properties of Transitions**

Meleis et al. (2000) contended that transitions are “complex and multidimensional” (p. 18) and include the following interrelated essential properties: awareness, engagement, change and difference, time span, and critical points and events. A person’s awareness of the changes of the transition is reflected in the congruence between what is known about the processes and responses and the expected responses and perceptions of an individual undergoing a similar transition. Although the participants in this study were highly aware of the changes occurring in
the transition from one role to another, none felt prepared for reality of the role and needed knowledge and information about various aspects of the role.

Meleis et al. (2000) provided examples of engagement, including seeking out information, using role models, actively preparing, and proactively modifying activities. Participants in this study were actively engaged in the process as they sought out needed knowledge and information on their own, found support and sought mentoring and feedback from colleagues, and observed others to learn the role.

Participants cited change and confronted difference in a number of areas through the transition process. Initially, participants cited a change in comfort level as they moved from roles in practice, where they were considered experts and were comfortable, to the new environment of the classroom, where participants cited a collective level of discomfort in knowing what to teach, how to teach, and learning to teach as they taught. The clinical setting was a more comfortable setting; however, participants found that the role of the practicing nurse differed from that of the clinical instructor where they lacked information about how to evaluate students, grade clinical paperwork, and navigate different relationships with staff. Participants found positive change as they gained comfort in their roles, began to try new thing as educators, and started to recognize rewards and satisfaction in the role.

**Conditions of Transitions**

Transition conditions “influence transitions and include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being” (Schumacher & Meleis, 1994, p. 121). Transition conditions either aid or hinder the transition process toward a healthy outcome.
Conditions in this study that negatively impacted the participants included environmental factors such as high and/or recent faculty turnover and the lack of seasoned faculty to orient and mentor novice faculty. Participants’ lack of knowledge and experience as educators also negatively impacted the transition experience, as did negative student feedback. On the other hand, being proactive in seeking out resources prior to starting the teaching process aided the transition, as did mentoring (formal and informal) and participating in orientation. Physical well-being as a transition condition was not specifically addressed by participants during interviews.

Role Supplementation

Role supplementation is an intentional process where role insufficiency is identified, and strategies and therapeutic interventions are developed to decrease, ameliorate, or prevent role insufficiency (Meleis, 1975). Mentoring relationships and support were critical types of role supplementation in this study. Participants found that any type of mentoring relationship, whether formal or informal, was helpful in the transition. Participants also reported that taking classes, reading books and journals, attending “boot camps,” or going to in-service learning sessions were helpful, although they could not always take advantage of these offerings as they felt that preparing for class was a more important task. Reducing workload, teaching familiar content, having observational opportunities, and having ready access to syllabi and curriculum used by previous faculty was also helpful in preparing to teach.

Limitations

One potential limitation of this study was a sample size of nine participants. Although appropriate for this qualitative inquiry, because redundancy in data was
reached, it may not be fully representative of the larger population of expert clinicians transitioning from practice to novice roles in academia. This multi-site study was limited to one geographic region in the United States, the Pacific Northwest. Other regions may differ in respect to institutional practices, academic culture, orientation processes, mentoring, and teaching practices.

The sample was exclusively Caucasian females. Although this is the dominant demographic in nursing and nursing education, as well as the United States and Pacific Northwest, this limits transferability to the male population and those from diverse backgrounds.

Per inclusion criteria, the sample was limited to associate degree faculty in the community college setting. The mission of the community college is fundamentally different than the university setting. The missional focus of the community college is teaching, where more emphasis is placed on the terminal degree, research, and securing funding in the university setting. This criterion inherently limits the application of the experience to novice faculty in baccalaureate and higher institutions.

One potential limitation may be the eligibility criteria of having no previous formal academic teaching experience before the current position and no previous experience as a clinical instructor before the current position. In recruiting potential participants, there was a great interest in participating in the study; however, many potential participants were excluded because they had previously taught as part-time or adjunct clinical faculty prior to assuming full-time appointments. In talking with many deans and directors in the region, this was a common occurrence at their
institutions. This may limit the transferability to new faculty with prior teaching experience.

As a nurse educator myself, I brought certain assumptions and biases to the study which could have potentially interfered with data collection and analysis. During the process of data collection, I consciously made myself aware of these biases before each scheduled interview and made every effort to ensure that my questions and probes were not introduced to the participant. After each interview I practiced self-reflection by way of journaling to re-clarify my biases and search for additional assumptions or biases throughout the research process.

**Recommendations for Nursing Education**

The findings in this study have significant implications for nursing education, including the preparation of nurses anticipating a transition to academia and novice nurse educators. Several recommendations for nurse educators and administrators in academia as well as practicing nurses considering a role change to academia may be drawn from the study.

**Identify Educators Earlier in Career**

The demographics of this study show that the mean age of educators was 49.8 years which is close the national average. There is a need to identify nurse educators early in their nursing career and support (time and financial) ways to start graduate education earlier in order to build a strong pipeline of nurse educators to teach and advance the body of knowledge and practice of nursing.
Minimum Education Level

The minimum level of formal preparation for the role of nurse educator should be the master’s degree in nursing. Seamless pathways need to be created to encourage practicing nurses to continue to their education. More registered nurse (RN) to bachelor of science in nursing, RN to master’s programs, and master’s in nursing with an education focus programs are crucial to facilitate the timely development of nurse educators.

Graduate Course Work in Education

The AACN (2011) Essentials of Master’s Education in Nursing delineated all the knowledge and skills that all master-prepared nurses must acquire, including competence in “applying teaching/learning principles in work with patients and/or students . . . preparation in curriculum design and development, teaching methodologies, educational needs assessment, and learner-centered theories and methods” (p. 6). Practical application of these essentials is lacking as participants in this study felt inadequately prepared in the areas of curriculum development, test item writing, evaluation of students, and a hands-on teaching practicum. Nursing education master’s curriculum must include a teaching practicum structured with a seasoned or master teacher, observation, and hands-on experience in a classroom. This could be structured similar to the model utilized in elementary and secondary education for student teachers. Structured feedback throughout the practicum is essential to help the novice educator grow in the role. Clinically-focused master and doctorate of nursing practice degrees should also include education electives for nurses who desire to pursue academia.
Preparation to Teach Clinical

Although novice educators in this study felt more comfortable in the clinical setting, they lacked necessary preparation to evaluate students, grade clinical paperwork, and negotiate new relationships with staff. Shadowing an experienced educator for multiple shifts in the facility and unit that the nurse will be assigned to would be helpful to increase familiarity with staff, unit layout, equipment, policies and procedures, and workflow of the unit. Formal mentoring with clinical faculty should include paperwork expectations, how to grade clinical work, how to use clinical evaluation tools, and expected amount of supervision of students. Mentoring with seasoned clinical faculty would help facilitate the novice educator in learning the teaching aspect of the clinical role.

Formal Orientation Programs

Formal orientation programs are necessary to socialize the novice faculty member to the college and the nursing program. Programs should include an introduction to the college mission, policies and procedures, and “nuts and bolts” of the college including student services available on campus, how students access those resources, e-mail, voicemail, and technology available on campus such as lecture capture systems, learning management system, teaching stations, and computer software applications. Novice educators should be oriented to the college-wide expectations of faculty such as workload requirements and how they are calculated, service obligations, and other expectations such as scholarship, research, or grant writing.
Orientation specific to the nursing program should include a faculty handbook, orientation to policies and procedures specific to the nursing program as these may differ from the college (e.g., immunization policies), an overview of the curriculum and how it is set up (e.g., is the curriculum concept-based?), available instructor resources for textbooks and other teaching tools, specific program expectations of the faculty such as work on accreditation efforts, advising, and tutoring. Having a novice faculty member complete a learning needs self-assessment would help identify priority needs for knowledge and information gaps, which would allow for a more tailored orientation to meet the novice educator’s needs. The Core Competencies for Nurse Educators (NLN, 2005) should be utilized to guide the development of a structured program to orient and mentor novice faculty toward proficiency in the role.

**Mentoring**

Role supplementation in the form of support for novice educators is critical. Developing formal and informal mentoring relationships early on is necessary to support the novice educator in navigating an unfamiliar environment. One hindering factor in this study was the lack of seasoned faculty to mentor and faculty who were too busy to mentor. Consider bringing on retired faculty to help mentor new faculty. Consider release time and stipends for faculty who commit to a mentoring relationship with a novice educator.

**Professional Development**

Novice educators need professional development early in their transition. Formal courses, conferences, and workshops focused on teaching and learning and “boot camps” for new faculty help facilitate the transition to the educator role.
Jumping into a new appointment with a full workload or overload was common experience for the participants in this study. Participants felt tired and overwhelmed and spent countless hours preparing for class and learning how to teach. Strategies should be developed to ease faculty into new appointments. Observing others and team teaching were cited as facilitators for those unfamiliar with didactic teaching. Teaching clinical only to start is an example of a strategy that could allow the novice time to observe and learn from seasoned faculty in the classroom. Policies for no overload during the first year could also be implemented to help new faculty adjust to and learn their roles.

**Competitive Salaries**

Strategies need to be developed at the local, state, and national level to make faculty salaries more competitive with the salaries in advanced practice and industry. Advocate for continued and increased funding under Title VIII of the Public Health Service Act and other publicly funded initiatives for nursing scholarships and grants, faculty fellowships, and program expansion grants in schools of nursing. Nurse educators need to continue to encourage national campaigns such as Johnson and Johnson’s Campaign for Nursing’s Future to attract nurses to nursing education as a financially viable practice option.

In looking forward to the future of nursing education, it is critical to examine strategies to recruit and retain the professoriate. The preceding recommendations will cost not only money but time, and these are already in short supply. The return on investment, however, could be invaluable if strategies are effective and the pipeline is strengthened.
Recommendations for Further Research

While this study contributes to the body of knowledge pertaining to the transition of the clinical expert to the novice educator role, the findings and limitations of this study support the need for further research in the following areas:

1. Replicate this study in associate degree programs in other regions of the United States.
2. Develop longitudinal studies to follow the role progression of novice nurse educators.
3. Develop quantitative research to examine the effectiveness and outcomes of structured orientation and mentoring programs, both short-term and longitudinal.
4. Utilize the data from this study and other qualitative studies to develop reliable and valid instruments to measure role ambiguity, role stress, and role satisfaction.
5. A mixed methods study could be developed from this study, adding quantitative components such as scales to measure preparedness, role ambiguity, role stress, and intent to stay.

Conclusion

The significance of this study is vital as the United States faces a national shortage of nurses and nursing faculty. Thousands of qualified applicants are turned away from nursing schools around the country each year, because there is simply not enough faculty to teach. In response to the national nursing faculty shortage, there are an increasing number of expert clinicians entering into part-time and full-time
academic faculty appointments. These novice faculty members have extensive clinical experience and skills, but are often lacking knowledge and preparation for the multifaceted role of the nurse educator. New faculty often voice a difficult transition into a new role and role stress which creates great concern regarding the educational preparation of new nurses.

Moving from the role of expert clinician to novice educator involves identity change, and transition to mastery of the role involves time and experience (Benner et al., 2009; Meleis et al., 2000). This study uniquely contributes to this body of knowledge by providing a rich description of the lived experience of clinical experts transitioning to the role of novice educators in the community college setting, particularly insights into preparation of novice faculty, early teaching experiences, and facilitating and hindering factors. The timing and relevance of this study was critical as there was a gap in the literature examining the experiences of full-time novice faculty in the community college. The missional emphasis on quality teaching in the community college places responsibility on nursing programs to assure that novice faculty members are competent to teach and help them grow in their roles as educators. Describing the transition experience of the expert nurse to novice educator is imperative to the development of strategies, which may help those who are making the transition which may, in turn, help improve the recruitment and retention of qualified faculty and eventually help ease the nursing faculty shortage. Recommendations for nursing education as well as recommendations for further research were drawn from the findings.
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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL
Verification of Research Subject or Participant Compliance
(To be filed with dissertation proposals, final dissertations, final theses, and final capstones)

Student Name: Kimberley Tucker
Last 4 numbers of Bear ID: 4973
Student’s UNC E-mail: tuck5291@bears.unco.edu
Degree Program: PhD Nursing Education
Department/School: School of Nursing
Date Submitted to Grad School: 11/24/15

All researchers planning to examine data from human participants or animal subjects for which IRB or IACUC approval is necessary, according to the procedures of these entities, are required by the University of Northern Colorado to obtain approval prior to the initiation of any data collection.

This form must be turned in to the Graduate School at the same time the documents for the Dissertation Proposal, Final Dissertation, Final Master’s Thesis, or Final Capstone are being submitted. It is understood that circumstances may arise in which the researcher may need to alter some aspect of the research plan necessitating filing of a Change in Protocol to IRB or IACUC. Failure to maintain the necessary records of research review and approval is a violation of Federal Law and could result in suspension of federal research funds to the University of Northern Colorado. Non-compliance with filing this form will significantly delay graduation for the student by disallowing the inclusion of any dissertation, thesis, or capstone data collected while out of compliance. In addition, non-compliance could result in scientific misconduct for the student’s advisor (see section on IRB Non-Compliance and Reported Irregularities during Research in the Procedures for Research Involving Human Participants).

Check one of the following:

☑ Institutional Review Board Approval (Please attach appropriate documentation)
   Expiration date: 11/24/19 Last date of data collection (if applicable): 

☐ IACUC Board Approval (Please attach appropriate documentation)
   Expiration date: 
   Last date of data collection (if applicable): 

☐ No Approval from either IRB or IACUC needed (Please provide an explanation, which will be reviewed by the Graduate School)

Student Researcher Signature*: 
Date: 11/24/15

Research Advisor Signature*: 
Date: 11/24/15

* Signatures may be submitted either by hand or digitally.
APPENDIX B

INTRODUCTION E-MAIL TO DEANS AND DIRECTORS OF NURSING PROGRAMS
Letter of Introduction to Deans and Directors of Nursing Programs in Washington State

Dear Dean or Director,

My name is Kim Tucker and I am a PhD student in Nursing at the University of Northern Colorado in Greeley, Colorado. I am in the process of completing my doctoral research study exploring the lived experience of expert clinicians transitioning to the role of novice educators. Since you have insight into those individuals who may qualify for this study, I would ask that you share the attached letter of invitation to any of your faculty who may be willing to become a participant for the qualitative study. This study has received approval from the University of Northern Colorado Institutional Review Board for solicitation of participants.

The specific criteria for being a participant in this study are: (a) in the first, second, or third year of teaching full-time in a pre-licensure Associate Degree in Nursing Program, (b) educational preparation at the Bachelor of Science in Nursing or Masters of Nursing level, (c) have no previous formal teaching experience, (d) have no previous experience as a clinical instructor, (e) have five years or more experience as a Registered Nurse in the clinical setting, and (f) have peer-identified or self-identified as a clinical expert.

With the shortage of nursing faculty, more expert clinicians are being recruited to faculty positions. Their perspective on the experience would provide valuable insight into an area that has been given minimal attention in nursing research, particularly in the community college. Thank you for your assistance in facilitating this aspect of my study.

Respectfully,

Kim Tucker, MN, RN, CNE
Doctoral Candidate
University of Northern Colorado
APPENDIX C

INTRODUCTION LETTER TO POTENTIAL PARTICIPANTS
Letter of Introduction to Potential Participants

My name is Kim Tucker and I am a PhD student in Nursing at the University of Northern Colorado in Greeley, Colorado. I am in the process of completing my doctoral research study exploring the lived experience of expert clinicians transitioning to the role of novice educators. The nursing administrator at your institution has identified you as a beginning educator with a background as an expert clinician and a minimum of 5 years as a Registered Nurse. I would like to extend an invitation to you to become a participant for this qualitative study. This study has received approval from the University of Northern Colorado Institutional Review Board for solicitation of participants.

With the nursing faculty shortage, more expert clinicians are being recruited to faculty positions. Your perspective on the experience would provide valuable insight into an area which has been given little attention in nursing research.

The specific criteria for being a participant in this study are: (a) in the first, second, or third year of teaching full-time in a pre-licensure Associate Degree in Nursing Program, (b) educational preparation at the Bachelor of Science in Nursing or Masters of Nursing level, (c) have no previous formal teaching experience, (d) have no previous experience as a clinical instructor, (e) have five years or more experience as a Registered Nurse in the clinical setting, and (f) have peer-identified or self-identified as a clinical expert.

I would be most appreciative if you would grant me time for a personal interview sharing your experiences of transitioning to the educator role. The face-to-face interview would last approximately one to one and a half hours. Completion of a brief demographic survey is also requested; it will take approximately 10 minutes. The interview will be audio taped with your permission and will be conducted at a mutually agreed upon site. The interview will be scheduled at a time that is convenient for you and does not interfere with your teaching schedule. During the analysis of the data I will contact you to offer a second interview as a way to verify the data. Any information obtained during this study which could identify you will be kept strictly confidential and your decision to participate if you choose to do so will not be shared with your employing institution.

No monetary compensation will be given for participation and participation is completely voluntary.

If you choose to participate in this study please reply via electronic mail with your name and contact information so that I may contact you by telephone to arrange a suitable time for an interview and a location of your convenience. Your assistance is greatly appreciated.

Respectfully,

Kim Tucker, MN, RN, CNE
Doctoral Candidate/University of Northern Colorado
APPENDIX D

MODIFICATION OF METHODS DOCUMENT TO INSTITUTIONAL REVIEW BOARD
Title: The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators

Kimberley Tucker, MN,RN,CNE

January 6, 2016

Dear IRB Committee,

I would like to make the following modification / amendment to the data collection procedures of my proposed study:

In addition to face-to-face interviews, include the use of Skype to interview participants who live at an extended distance or whose schedule precludes scheduling a face-to-face interview.

Please see changes in red below.

1. Data Collection Procedures

The researcher is the primary instrument of data collection in qualitative studies. Face-to-face interviews is the primary strategy that will be utilized to capture the meaning of the experience of transition in the participants own words. A demographic questionnaire will also be used to obtain data about gender, ethnicity, length of time in the profession of nursing, and highest degree earned. The demographic questions will be asked in an effort to find out certain attributes which may be helpful for explaining what may underlie a participant’s perceptions as well as similarities and differences in perceptions among the participants.

After making initial contact with potential participants by phone, a 90 minute block of time will be reserved for face-to-face or Skype / videoconference interviews at a time and place convenient to the participant. Before the interviews begin, the researcher will obtain written consent from the participants and go over the details of the consent as well as the overall purpose of the study. Participants who are participating via Skype will have an electronic copy of the consent form sent via email ahead of time. Participants recruited for this study will be provided a written informed consent form that discloses the procedures and ensures confidentiality, protection from harm, and the right to withdraw from the study at any time without repercussions. The informed consent will contain qualitative procedures to be utilized, permission to record the interview, and an explanation of how this researcher will maintain confidentiality and privacy of information shared. The participant will be given ample time to read the consent form in its entirety and given a chance to ask any questions they may have about the study. A copy of the informed consent will be given to the participant and the signed original will
be placed in a sealed envelope that will be stored in a locked drawer in the researcher’s home office. Skype participants will be given a self-addressed stamped envelope to mail the signed consent form back to the researcher. Participants will be given a full explanation of the nature of the research and the format for the interview.

To protect the identity of participants, a pseudonym will be assigned which will be used on all audio recordings, written field notes, and written research findings. All data will contain no identifiable features of either the participant or institution where they are employed. All digital audio recordings and will be kept under password protection on the researcher’s personal recording device and computer will be shared with the professional transcriptionist to be hired to transcribe the interviews and the peer reviewers. All written data will be securely stored in the researcher’s home in a locked file drawer for a minimum of three years.

The participant will be asked to complete a brief demographic survey and then a semi-structured interview format will be utilized. Skype participants will be sent an electronic copy of the demographic survey ahead of time and will mail it back to the researcher with the signed consent form in the self-addressed, stamped envelope. The participants will be asked to share their experiences in transitioning from practice to academia by using an open-ended prompt with as little interruption as possible. Follow-up questions may be for clarification of details or to elicit more information. Field notes will be taken and the interviews will be audio taped per consent of the participant. Skype interviews will be audio-recorded only with the same recording device as the face-to-face interviews. At the conclusion of the interview, the participant will be asked if there is anything they would like to add and / or clarify and the participant will be thanked for their participation.
APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL
FOR MODIFICATION OF METHODS
DATE: January 29, 2016

TO: Kimberley Tucker, MN
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [832470-2] The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS
DECISION DATE: January 27, 2016

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Thank you for clear descriptions of the modifications and amendments to this research. You are verified/approved exempt and may proceed with your research. Please be sure to implement these amended protocols in your participant recruitment and data collection.

Best wishes with your research.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.
APPENDIX F

INTERVIEW GUIDE
Interview Guide

Research Study: The Lived Experience of Expert Clinicians Nurse Transitioning to the Role of Novice Nurse Educators

Introduction:
I would like to start by saying thank you for meeting with me today. As we discussed, I will be recording and transcribing our conversation today so that I can make sure that I have an accurate account of the interview. I will also be giving assigning you a pseudonym to protect your identity on the audiotape as well as my notes and the written narrative.

I will give you the opportunity to review the transcripts at a later date to make sure that I have clearly and accurately described your thoughts in regard to what we are discussing today.

As we talked about on the phone, I am interested in examining the experience of the expert (experienced) clinical nurses transitioning to the role of a novice (or new) nurse educators. I would like to know more about this transition and what it was like for you.

Do you have any questions before we get started?

Opening Prompt: (for guiding purposes only—other questions may be asked as they become implicated)

I am interested in learning more about the experiences you have had as you have moved from clinical practice to nursing education. I would like to hear your story about this transition. Would you share what has this experience been like for you?

Feel free to share anything with me that you think would be helpful. I may ask additional questions to help clarify as we go along.

Follow-up Questions: using the words of the participant will seek further clarification with probes such as:

Can you tell me more about...?
Would you explain what you mean by...?
What happened next...?
That’s interesting, what prompts you to use that word or phrase?
What was that like…?
Could you give me an example of that?
You mentioned earlier that you….can you describe in detail what happened?
APPENDIX G

INFORMED CONSENT FORM
CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators
Researcher: Kim Tucker, MN, RN, CNE
xxx-xxx-xxx
tuck5291@bears.unco.edu
Research Advisor: Faye Hummel, RN, PhD, CTN-A / Research Advisor
Gunter Hall 3210
School of Nursing
College of Natural and Health Sciences
Greeley, CO 80639
xxx-xxx-xxxx
Faye.Hummel@unco.edu

Purpose and Description: The primary purpose of this study is to understand the lived experience of the transition of expert clinical nurses to novice nurse educator. You have been selected as a possible participant because you are (a) in your first, second, or third year of teaching full-time in a pre-licensure Associate Degree in Nursing Program, (b) educational preparation at the Bachelor of Science in Nursing or Masters of Nursing level, (c) have no previous formal teaching experience, (d) have no previous experience as a clinical instructor, (e) have five years or more experience as a Registered Nurse in the clinical setting, and (f) have identified yourself as a clinical expert.

Procedures: If you decide to participate, you will be asked to complete a demographic survey taking approximately 10 minutes. Additionally, you will be asked to participate in a personal interview lasting one to one and a half hours. The interview will be audio taped with your permission and will be conducted at a mutually agreed upon site. The interview will be scheduled at a time that is convenient for you and does not interfere with your teaching schedule. Transcripts of the interview will be made by a professional transcriptionist and shared only with members of the researcher’s dissertation committee. During the analysis of data, the researcher will contact you to offer you a follow-up interview as a way to verify the data. Your name will not appear on any of the shared materials. A copy of the final analysis will be sent to you upon request.

Benefits and Risks: There are no direct benefits to you for participating in this study. You may benefit from participating in this study by increasing your comfort level with
the transition process into the role of nurse educator as you share your experiences with the researcher. You also have the potential professional benefit of knowing you have contributed to the body of knowledge about the transition for expert nurses taking roles as novice educators. The minor risk of participating would be the time commitment for the interviews. Emotional distress may also be a risk if your experience was not pleasant but the risk for participating in this study is not beyond everyday normal activities of life. You have the right to stop the interview at any time and withdraw from the study or resume your interview at a later time, should recalling the experience be too uncomfortable for you.

**Confidentiality:** Any information obtained during this study which could identify you will be kept strictly confidential. The data will be stored in a locked cabinet in the researcher’s office and will only be seen by the researcher and the researchers committee. All digital data will be stored under password protection on the researcher’s computer. Data will be stored for three years after the study is complete. The interview will be transcribed by a professional transcriptionist who will sign a confidentiality agreement. During transcription and data analysis, you will be assigned a pseudonym known only to the researcher. The information obtained in this study may be published in scientific journals or presented at scientific meetings, but the data will be reported anonymous form. Your decision to participate will not be shared with your employing institution.

**Compensation:** There are no costs associated with participating in this study and there will be no compensation for participating in this research.

Participation is voluntary. Please feel free to ask any questions you may have about the study. If you have questions at a later time, you may contact Kim Tucker, Principal Investigator at xxx.xxx.xxxx. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

I understand that I am free to refuse my consent or to discontinue my participation in the study at any time without consequence or penalty and my decision will be respected.

Having read the above and having had an opportunity to ask any questions, my signature below indicates that I have read the information provided, understand it, and have voluntarily decided to participate. A copy of this form will be given to you to retain for future reference.

<table>
<thead>
<tr>
<th>Participant’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Principal Investigator’s Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>________ Please initial here if you consent to be audio taped during the interview.</td>
<td></td>
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</tbody>
</table>
APPENDIX H

DEMOGRAPHIC SURVEY
Project Title: The Lived Experience of Clinical Nurse Experts Transitioning to the Role of Novice Educators

Researcher: Kim Tucker, MN, RN, CNE
xxx-xxxx-xxxx
tuck5291@bears.unco.edu

Research Advisor: Faye Hummel, RN, PhD, CTN-A / Dissertation Chair
Gunter Hall 3210
School of Nursing
College of Natural and Health Sciences
Greeley, CO 80639
xxx-xxxx-xxxx
Faye.Hummel@unco.edu

Participant Demographic Survey:

1. How old are you? ______

2. Gender:
   ☐ Male
   ☐ Female

3. Race / Ethnicity (check one):
   ☐ Caucasian
   ☐ African American
   ☐ Native American
   ☐ Latino/Hispanic
   ☐ Other ________________

4. Years in nursing? ______
5. Educational background? (check all that apply)
   - ☐ BSN
   - ☐ MN or MSN
   - ☐ Specialty area of Master’s degree?
     __________________________________________

6. Years (or quarters) in education setting? ______

7. Number of other full-time faculty in the nursing program / department in their first, second, or third year of teaching? ______

8. Number of students in ADN nursing program? ______

9. Number of full-time nursing faculty?____ Number of part-time faculty? ____

10. Tenure-track position:
    - ☐ Yes
    - ☐ No

11. Currently working in a practice setting in addition to teaching? (circle one)
    - Yes  No
    If yes, how many hours per week? _________

12. Level of students teaching (check one):
    - ☐ First Year
    - ☐ Second Year
    - ☐ Both

13. Teaching responsibilities:
    - Classroom ______%
    - Clinical ______%
    - Lab ______%
    - Simulation ______%
    - Other ______%
14. Type of orientation received at institution? (Check all that apply)

☐ Orientation to campus  
☐ Faculty handbook  
☐ Computer / software /technology orientation  
☐ Nursing mentor  
☐ Mentor outside of nursing  
☐ Clinical orientation  
☐ Instructional resources  
☐ No orientation  
☐ Other:  
________________________________  
________________________________

15. Other responsibilities at the institution? (Check all that apply)

☐ Student advising  
☐ Student club advising  
☐ Nursing department committees  
☐ Institutional committees  
☐ Joint appointment with practice setting  
☐ Institution-run health center / clinic  
☐ Other:  
________________________________  
________________________________