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# Expert Clinician to Novice Nurse Educator. Learning from First-Hand Narratives

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SPRINGER PUBLISHING COMPANY

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Dr. Sorrell earned a BSN from the University of Michigan, an MSN from the University of Wisconsin, and a PhD from George Mason University. Her scholarly interests focus on philosophical inquiry, writing across the curriculum, qualitative research, and ethical considerations for patients with chronic illness. In addition to research on the role of novice nurse educators, she has used interpretive phenomenology to explore ethical concerns in the lived experience of patients and caregivers with Alzheimer's disease. Findings from the research were presented in a video, *Quality Lives: Ethics in the Care of Persons With Alzheimer's*, and a play, *Six Characters in Search of an Answer*, both of which received Sigma Theta Tau International Media Awards. She is co-author of a book with her daughter, Christine Dinkins, *Our Dissertations, Ourselves: Shared Stories of Women's Dissertation Journeys.*

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Dr. Cangelosi earned her diploma in practical nursing from the Loudoun County School of Practical Nursing, an ADN and BSN from Shenandoah College, an MSN from Marymount University, and a PhD in nursing from George Mason University. Dr. Cangelosi's research has focused on the education of nontraditional nursing students, especially RN to BSN and accelerated second-degree students, faculty, and programs. She has also concentrated her research on clinical nurse educators and their preparation for clinical teaching. Findings from her research have been presented at national and international professional conferences and published in the leading professional nursing education journals.

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*To the talented and patient clinical nurse educators who continue to guide learning for new nurses.*

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# Preface

*I am buckling my seatbelt to explore the educator's role. It is a short distance ride. However, the next ride could possibly be with an educator in the driver's seat—my seatbelt will still be needed. But I will further investigate to ascertain other items to take on the trip.*

—Melody

The nurse educator role often looks deceptively simple. Compared to the complexity of bedside care for a patient with multiple comorbidities and hour-by-hour monitoring, watching over students to guide their learning may appear easy. Yet, when experienced nurse clinicians try out this new endeavor for the first time, they often describe themselves as frustrated and uncertain about how to best implement the role. Through years of experience as clinicians, nurses often arrive at a comfort zone where they know what to do for their patients in order to keep them safe and enhance their healing. When moving to the nurse educator role, however, many of the usual guidelines for practice may no longer seem relevant.

Nursing education today is faced with many challenges. The need for education of more nurses, the increasing numbers of individuals who want to enter nursing education programs, and the shortage of nursing faculty to teach these aspiring students have raised new questions about how best to prepare the nursing workforce for the present and future. A January 2014 report by the U.S. Bureau of Labor Statistics estimated that employment of registered nurses will grow by 19% between 2012 and 2022—faster than the average for all other occupations (Bureau of Labor Statistics, U.S. Department of Labor, 2014). A need for over 1 million new nurses is projected for 2022 (Robert Wood Johnson Foundation, 2014). This increased demand for nurses is due to a variety of factors. People are living longer and older people often have more medical problems than younger people, creating a need for nurses to educate and care for more persons with various chronic illnesses. In addition, nurses will be needed to care for the increased numbers of individuals who will have access to health care services as a result of the 2010 Patient Protection and Affordable Care Act. Also, financial pressure on hospitals to discharge patients as quickly as possible is likely to create a need for more nurses to care for patients at home or in long-term care centers.

How are schools of nursing going to accommodate these new nurse applicants? There is a critical shortage of nursing faculty, which limits the number of students who can be enrolled at a time when the need for nurses is growing quickly. In a report by the American Association of Colleges of Nursing (AACN), *2013–2014 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, almost two thirds of respondents cited faculty shortages as the reason for not accepting all qualified applicants. The report revealed that 79,089 qualified applicants were denied admission to U.S. baccalaureate and graduate nursing programs in 2012 because of insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints (AACN, 2014). A lack of nursing faculty is also an international problem, with qualified student applicants turned away in such countries as Canada, China, Australia, and Malaysia (Reid, Hinderer, Jarosinski, Mister, & Seldomridge, 2013).

Although accrediting agencies call for nursing faculty educated with a graduate degree, this is difficult in today's health care climate. Nurses with doctorates still comprise less than 1% of the U.S. population. Increasing numbers of nurses are pursuing graduate education, but the job market for these nurses is growing faster than jobs for RNs, meaning

that schools of nursing that want to hire faculty with a graduate degree are competing with the 50,000 new positions projected for nurse anesthetists, certified nurse midwives, and nurse practitioners—all of which usually come with a much higher salary than nurse educators receive (Robert Wood Johnson Foundation, 2014).

With both nursing education programs and clinical agencies stretched to the maximum to meet the needs of their institutions, there is an immediate need for creative options to increase the supply of competent nurse educators who can effectively teach vital clinical skills to future nurses. Experienced nurse clinicians offer a valuable option. Yet, they are often asked to function as clinical nurse educators with little or no education for the role. They may receive an orientation to their assigned hospital but, for the most part, are left to themselves to figure out how to teach. Some of them find a way through their frustrations to become effective faculty. Many, however, give up in frustration and return to their previous clinical role. This not only leaves the aspiring nurse educator with a feeling of failure, but also negatively affects nursing programs that may be critically short of clinical faculty.

As the nursing faculty shortage grows, more nurse clinicians are going to find themselves working with students, either as adjunct faculty or hospital preceptors. Too often, these novice nurse educators are on a journey without readable signposts. How do you keep the patient safe while allowing the student nurse to practice doing something for that patient for the first time? If some students are slow to catch on to what seems simple to you, how long should you wait before you fail them? If you let weak students continue in the nursing program, at some point, one of them may unwittingly harm a patient. But if a student fails, do you have enough evidence that, given enough time, the student would have been able to pull the pieces of a puzzle together and become a competent and caring nurse?

First-hand narratives in this book from nurse clinicians, faculty, and students explore questions like these. All of the narratives are from qualitative research studies. We are nurse educators who taught together in a graduate nursing program designed to prepare nurse educators. Stories in Chapters 1, 2, 4, and 5 were collected during 4 years of a successful Clinical Nurse Educator Academy that we initiated to address the need to prepare experienced clinicians for new roles as clinical nurse educators. Stories in Chapter 3 are from a qualitative research study that was implemented with nursing students who described caring and

uncaring experiences with clinical nurse educators. This chapter also includes stories from research studies on cultural diversity and bullying. Chapter 6 focuses on aspects of the clinical educator role related to critical and ethical thinking. Chapters 7, 8, and 9 contain reflections of nurse educators looking back on their first teaching experiences in a school of nursing or hospital. Finally, Chapter 10 discusses strategies for clinical nurse educators to use in addressing recommendations by the study, *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard, & Day, 2010). Some participants from the Clinical Nurse Educator Academy also share their thoughts after an 8-year journey from their original exposure to the nurse educator role.

Information in these chapters is intended to apply to clinical nurse educators teaching new nurse graduates, as well as nursing students. For readability, however, the term "student" is often used to refer to either a new graduate nurse or student nurse since they are both "students" of the nurse educator. Pseudonyms are used for all of the research participants whose stories are included here but the stories are exactly as told to the researchers. In carrying out the research, we found that the journey of assuming a new role as clinical nurse educator is only partly explained by the actual "how to" course work that nurses may receive during their formal education. Participants described unexpected challenges and transformations in their own identity and relationships that are a vital part of learning a new professional role.

The quote at the beginning of this preface from Melody, a participant in the Clinical Nurse Educator Academy and an expert clinician, illustrates the mix of both excitement and anxiety that novice educators often face. We wanted to write this book because we have seen clinicians struggling with transitioning to this new clinical educator role. As several of the research participants commented, many nurses take on the clinical educator role without the opportunity to explore with faculty and peers what to expect in the role and how to implement it effectively. This book illustrates the difficulties of moving into a new role as a novice, offering perspectives of a diverse group of participants who lived with the experience and learned. The book is not designed to be a step-by-step prescription in how to implement the clinical educator role but, instead, a stimulus to engage aspiring or new clinical educators in thinking about situations they may encounter and to help them transition to their new role. Nurse educators already practicing in that role

may also find that the stories help them to think about the challenges and wonderful benefits of being a clinical nurse educator.

Stories in this book show how clinical nurse educators make an important difference for students and new graduates. Many of the stories were told through tears, as research participants remembered how someone stepped in at a critical time to help or to reassure them that they had done well for their patient. But, there are also stories about faculty or colleagues who failed to support them in their learning. And, faculty themselves share insights into what they wish they had done differently to guide students in their learning.

Stories are an important way of capturing the narratives of our lives. In Barry Lopez's book, *Crow and Weasel*, Badger states, "If stories come to you, care for them. And learn to give them away where they are needed" (Lopez, 1990, p. 48). The stories in this book speak of common experiences, emotions, and challenges faced by students, new graduates, and faculty across different nursing programs and different clinical specialties. The stories give voice to the challenges and opportunities inherent in the clinical nurse educator role. We hope that this book will be read by both new and experienced nurse educators who may gain support, perspective, insight, inspiration, and guidance from stories of those who struggled to make a difference in learning for their students.

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Part I

# The Journey From Clinician to Educator

Chapter 1

# Moving From an "Expert" to a "Novice" Role

*The concept of expert to novice is not new to me. In part, because I have had so many roles in nursing. I like to challenge myself and try something new. Each time I try something new, it is with angst that I am, once again, a novice!*

—Jill

In response to the nursing shortage, many schools of nursing have increased recruitment and enrollment of nursing students (Culleiton & Shellenbarger, 2007). Although this is necessary to meet the increasing health care needs of today's society, it seriously exacerbates the ongoing nursing faculty shortage. Lecture-style classrooms may be able to accommodate more students with less impact on faculty numbers; however, clinical teaching and some of the more learner-focused active methods of teaching that are becoming increasingly more popular in nursing classrooms require a higher faculty-to-student ratio. Depending on the clinical setting, the clinical agency policies, and the respective state board of nursing mandates, faculty-to-student ratios in the clinical setting can range from 1:15 to 1:6, and even 1:1 in a preceptor model of instruction. Unfortunately, as the numbers of nursing students increase,

the numbers of nursing faculty may not. The aging faculty who are close to retirement, the lower salaries in academia, and an insufficient pool of potential nurse educators in graduate programs (American Association of Colleges of Nursing, 2014) are all cited as factors in the ever increasing shortage of qualified nursing faculty.

At present, nursing schools are attempting to expand their programs to accommodate the increasing numbers of applicants required to fill the over 1 million new nursing positions that projections indicate will be needed by 2022 (Robert Wood Johnson Foundation, 2014). At the same time, hospitals are struggling with how to address the "preparation-to-practice" gap that has been identified. New graduate nurses constitute over 10% of the nursing staff for a typical hospital and this number is certain to increase in the future. A national survey of schools of nursing and hospitals showed that although 90% of nursing faculty believe that their graduates are prepared to provide safe and effective care, 90% of hospital-based educators are questioning the practice readiness of new nurse graduates (Nurse Executive Center, 2008). Thus, many hospitals are implementing nurse residency programs in an effort to accelerate practice readiness of new graduates. Experienced nurse clinicians at these institutions will be called on to serve as clinical educators for these new nurses.

Many of these expert clinicians have not yet experienced what it is like to teach and find themselves, once again, a novice. They may have a bachelor's, master's, or doctoral degree, but no experience or formal preparation in teaching and learning (Anderson, 2009; Schriner, 2007). Benner (1982) has characterized a novice nurse as a beginner who must have rules to guide practice, because there is no experience from which to draw conclusions. The rules, however, are context-free, so that the novice does not know which rules are most relevant in a real situation or when an exception to the rule should be considered. This type of discretionary judgment is developed through experience. Thus, it is important to identify ways to enhance competency and confidence of expert clinicians as they move into a new educator role.

## THE STORIES

Nursing history is rich in stories, but a focus on the science of nursing has sometimes obscured the stories of real life experiences that can teach us so much. In an effort to address the need for mentoring of new

clinical faculty, the authors designed and implemented a Clinical Nurse Educator Academy to prepare experienced clinicians for new roles as part-time or full-time clinical nurse educators (Cangelosi, Crocker, & Sorrell, 2009). Through written narratives, 32 nurse clinicians shared their perspectives as they prepared for new roles as clinical nurse educators. This chapter presents stories focused on participants' responses to the following interview prompt:

> Think about what it is like to move from a role as an "expert" to a "novice." Describe an incident that reflects your concerns about moving from the clinician to the clinical nurse educator role.

Jill's comment at the opening of this chapter reflects the essence of other participants' comments: Moving to a new role as clinical nurse educator left the nurse clinician once again feeling like a novice. The participants, however, did not see the novice role as negative, but rather a time for them to learn new skills. Although being a novice was described as being "unsettling," "uncomfortable," and causing "mixed feelings," these participants embraced the chance to be a novice again and forward their career goals.

## Embracing the Novice

April clearly verbalized the benefits she realized from being a novice:

> I have been a nurse for 32 years. I have been a novice many times. I have been an expert a few times. … Being a novice makes me feel young. … I allow myself to be a novice, to not know everything and to learn from others and the job itself.

Anne shared her feelings about why she embarked on the transitional journey toward the role of clinical nurse educator:

> The most memorable events in my career of feeling good about making a difference have been the times I had to hold my breath, put fear aside, and dive right in!

Veronica described how she realized that putting herself in the role of "student" again was providing her with important new skills and self-confidence:

> I absorbed all of what had just happened, and I processed what it all meant to me. Suddenly, I felt rejuvenated—and free. I didn't have to be the Perfect Teacher. I could make mistakes. And moreover, I could make those mistakes in front of everyone, and it would still be okay.

Susan described her reflections about putting herself in the role of a novice so frequently, coming to the conclusion that it was the right thing for her:

> I did have an "a-ha" moment or personal epiphany today when I realized that by trying on many nursing-related hats throughout my professional career, I often keep myself at the level of novice—not always, but often enough to note this. What is that about? Does it protect me from assuming responsibility? I don't think so, since most of my positions have been in management, and I seem to always rise to a leadership role of some kind. Still, I think it's important for me to consider the possible secondary gain in frequently returning to the level of novice. Or am I just a lifelong learner who is not uncomfortable in the role of novice?
>
> I have played a lot of roles, and learned a lot along the way, including how to become very good at most of my jobs, which means that I have learned how to learn, or at least how I learn best. Isn't this the point of the journey in the first place? If one is not learning, not growing, one is stagnating, or worse. I am passionate about lifelong learning, for myself, and encourage it in others. …But in order to learn, one must start at a position of incompetency, which can be very uncomfortable, and for many adults, intolerable. This is why people stop learning. They can't stand exposing the fact that they don't know something. If you can stand to feel temporarily and

> situationally incompetent, the world can teach you so many things!

Eileen described how being a novice again had helped her understand how her students may feel. This gave her a great deal of personal and professional satisfaction:

> I had forgotten how anxious students are about accomplishing simple tasks. I was forced to begin thinking about nursing from the novice point of view. The observations and conclusions made on a daily basis by seasoned nurses are not something that can be taught in a 4-hour clinical. … If we put ourselves in the place of the student and remember what it was like for us, we have an opportunity to make a huge difference in a student nurse's professional journey.

Ellyn also reflected on what had helped her when she was first a novice nurse and how she now wanted to help others love the nursing profession:

> We all must remember that we also were novices once. Those who took the time to nurture and mentor us have done us a great service; moreover, they are the reason why we stuck it out through rough times and helped us to learn to love the nursing profession.

Although it was clear that participants appreciated the necessity of feeling like a novice as they transitioned to the nurse educator role, they also faced this transition with a mix of excitement and anxiety. The theme "leaving my comfort zone" that emerged from analysis of the research interviews illustrates these ambivalent feelings.

## "Leaving My Comfort Zone"

Joanie described how it was difficult to leave her comfort zone to enter an area where she was a novice again, but she knew it was an excellent opportunity, even though she still had considerable fear about it. Her detailed reflection is included here because it captures the ambivalence

about the transition to the novice role that so many of the participants seemed to feel:

> Advancing in my clinical nursing career was a process that was gradual, unassuming, and rather comfortable. I worked as a newly graduated nurse in med–surg (because that's what one usually did in the '70s), and then switched to a specialty area. Over a span of 28 years, I became increasingly competent and proficient in the pediatric and newborn arena. I climbed the clinical ladder as far as I could go. I became certified in my field and was considered somewhat of an expert. With ever-increasing knowledge, experience, and confidence, I felt accomplished, credible, and well respected. All was right with the world! Why would I upset this perfectly stocked apple cart?
>
> When another opportunity became available, however, I decided to leave my comfort zone and forge ahead. This was a scary proposition for me, however, because this particular opportunity wouldn't have me advancing at the bedside and this didn't follow the natural progression of my career path. Woe is me!
>
> I thought that I had a fairly good grasp of what the job entailed. … I was pumped and excited to get those new nurses assigned to good preceptors, to orient students to the NICU [neonatal intensive care unit] and to do the best that I could in this new role. Although I was definitely a beginner in this new role when I started almost 4 years ago, and received only minimal orientation, I wasn't too apprehensive and felt that if I came upon an unfamiliar situation I could probably "just wing it." I had a positive attitude, good intentions, and support from management. Plus, it meant a pay raise and no holiday/weekend requirements. This might just work out fine. And then I had my "a-ha" moment.
>
> Shortly after starting this new position, I took a trip to California and brought along some nursing journals to read in the plane. I don't remember which particular state we were flying over at the time, but I do remember that I was in the plane when I read something that really gave me a jolt. It was an article about clinical experiences for nursing students

> and the responsibilities of both student and instructor. The student is owed (and deserves) an instructor, preceptor, and/or unit facilitator, who is well versed and properly educated on evidence-based methods regarding knowledge acquisition, effective teaching strategies, and supportive relationship building. The "new" and "old" hires merit someone who understands how psychomotor and social skills are acquired and enhanced and where each person is on their career journey. Good intentions can only go so far.
>
> I knew then that although I had many years of life and career experience, I was a mere babe in the area of staff and student development. I also realized that I must further my formal education and keep current on issues related to this new endeavor because that is what is owed to those whom I support and orient. Hopefully, I have become increasingly competent, proficient, and credible in this new role. However, I don't think that I ever will (or should) become too comfortable in this position. There is too much at stake for that to happen.

The fact that Joanie remembers so vividly, 4 years later, her "a-ha" moment, when she realized with a jolt the career change that she was about to launch, suggests the impact that this career change has on experienced clinicians comfortable in their work. As noted in the preface, another participant in the study, Melody, also anticipated challenges ahead and was buckling her seatbelt in preparation:

> I am buckling my seatbelt to explore the educator's role. It is a short distance ride. However, the next ride could possibly be with an educator in the driver's seat—my seatbelt will still be needed. But, I will further investigate to ascertain other items to take on the trip.

Most of the participants in the study received very little formal preparation before they began their new role. Fiona described how she had to plunge in without much help on her first day as a nurse educator, figuring things out on her own:

> The call was a plea to work on a medical–surgical floor with a group of students in their last clinical rotation.

> The regular instructor had become seriously ill and was no longer able to work. After depleting all of the reasons I could not accept the offer, I finally agreed. I was told where to go, when to go—and that a contract would be forthcoming. I was instructed to assign these students to patients and to oversee their performance. I was reassured that it would be an easy assignment and that I would be fine. The regular faculty was a phone call away and would check on me. That was the beginning of my adjunct career and the extent of my mentorship for that clinical rotation. I was given a list of clinical objectives and an evaluation sheet for each student and the rest was up to me. The visit from the mentor never occurred.

Fiona reflected further on her realization of the importance of the nurse educator role and the responsibility that ensued with accepting this role:

> If I could only use one word to describe my move from a role as a clinician to a nurse educator, it would have to be fear. … I don't believe I had any idea of what a full-time educator's role was. … I had been transformed from a very autonomous home health nurse to a scared rabbit. The realization that I was now responsible for educating the nurses of the future—the very nurses who would probably be taking care of *me*—hit home.

In summary, it was clear from participants' stories that they were excited about becoming a novice again because they would gain new skills that they could use to share their extensive clinical knowledge with students. At the same time, however, this transition into the novice role created fear and stress, especially because most of them got little to no formal preparation for their new role. The sense of responsibility that came with the clinical nurse educator position only added to the stress.

All of the stories from participants illustrated how transitioning from the expert clinician to the nurse educator role caused the participants to reflect on their strengths and weaknesses, successes and problems in the transition process. Veronica's description of her transition into a preceptor role captures the feelings and emotions that can come with this role change. She was excited at the opportunity to share her

knowledge with others, but found the transition road a rocky one. She tells her story with brutal honesty and an engaging sense of humor:

> Shakespeare once wrote, "The fool thinks himself to be wise, but the wise man knows himself to be a fool." When I first became a preceptor on my labor, delivery, and recovery unit, I thought myself very wise indeed. My 2½ years of experience put me worlds ahead of my newly graduated preceptee, Kathy, and I was ready to bestow upon her the treasure trove of my knowledge. By the end of that preceptorship, and more so with each preceptorship I take on, I found myself squarely fixed in the humble seat of "student," and I learned an important lesson: The more you teach, the more you learn you have to learn.
>
> When I took on Kathy, I intended to teach quite a bit. I was going to teach her the essentials of labor and delivery, to be sure, but I was also going to teach my coworkers what a great and knowledgeable nurse I was. It would take some hindsight to see, but I was also trying to inculcate in myself a sense that I was, in fact, a capable and intelligent nurse. It wasn't really about Kathy. It was about me.
>
> Throughout that semester, I attached myself to Kathy's hip, ready to pounce on any teaching opportunity, and prepared to catch any mistake that she made. As it turned out, Kathy, who had completed a nurse internship the previous summer, was already quite capable. In fact, her preceptor the previous summer had taught her much of the essentials that she needed to know. I steamed, shuffled my shoes, and pondered: Surely there must be something I could teach her. I mean, after two-and-a-half years of nursing, I must be smarter than she is…right?
>
> Over the next 10 weeks, I bombarded Kathy with articles to read, protocols to memorize, and pop quizzes over which to hurdle. At first, she obliged me. Then she ignored me. But soon, after 8 weeks, Kathy fired me.
>
> I'll never forget the call I got from the new hire coordinator, Judy. She said that Kathy had come to her and said that, although I was, she assured Judy, a very good teacher, she felt that, personality-wise, we just didn't mesh

that well. Kathy had offered that, since she and a coworker of mine, Doris, got on so well that one day I was sick and Doris had taken on Kathy, perhaps Doris and I could share Kathy as our orientee?

I was disappointed, baffled, and completely humiliated. Here, I had built myself up to be the Ultimate Preceptor, a Great Nurse Educator in the making, yet I had gotten fired from my first job. I was a failure, and everyone on the unit would know it, but most of all, I would know it.

I learned a very important lesson from that experience: Precepting is not about me; it's about the person I am with. Absorbing Jean Watson's theory, I learned that we—myself and my orientee—are partners in the teaching–learning process: that I can offer her helpful knowledge, and she can offer me helpful knowledge. We are both teachers, and we are both learners. Moreover, it's not just about what I want to teach. It's about what the orientee wants and needs to learn. Every teaching–learning experience has to be tailored to that person, or else, for that person, it will be impersonal, irrelevant, and ignored.

Since Kathy, I've had two wonderful precepting experiences. … Every student has been different, and every one has taught me so much. Hopefully, I've taught them something, too! But in the end, I'm not so much teaching them, I think, as helping them to achieve what they latently have the ability to achieve. And I have tried to stay humble, yet I don't have to try hard: Both of them are quick to tell me if they disagree with me or if they question me. I take that as a good thing, because it means they feel like they can communicate freely with me, like equals, and that they haven't shut me out. …

I have a long way to go in learning how to teach, and in fact, I don't think you can ever become a "perfect teacher," because there's always more to learn. Still, I think I've improved, and I'm on a better path than the one on which I started. As I poise myself to dive into the pool of being a clinical instructor next year, I must admit, the diving board feels quite wobbly beneath me. What if I slip? Or what if I put too much or too little effort into my approach?

> Or, recalling my memories from first grade, what if I lose my focus and do a back-flop? What if all this practice does not, in the end, prepare me for the big event? Well, I may not ever be Greg Louganis, and I may end up with a sore back, but I'm willing to get my feet—and legs, and chest, and hair—soaking wet.

## REFLECTIONS FOR NEW NURSE EDUCATORS

Most studies of role transition in the workplace have focused on students transitioning to new nurse graduate positions or staff nurses transitioning to practitioner positions. There has been little research focused on the transition from clinician to nurse educator (Duffy, 2013; Spencer, 2013). Studies have pointed out that nurse clinicians who leave the security of their clinical position to assume a nurse educator role often describe their experience as stressful, frightening, and overwhelming, with feelings of apprehension, ambivalence, and uncertainty about their career move (Spencer, 2013, Weidman, 2013). It was clear from interviews with participants in this study, however, that clinicians also approach this transition with excitement and a genuine desire to share their knowledge with others.

### A New Paradigm

Benner (2001) noted that expert clinical nurses find it difficult to address a problem by breaking it down, step by step, in a specific situation because they have accumulated experience that allows them to act intuitively, without having to rely on rubrics or rules to formulate answers to clinical problems. Yet, when thrust back into the novice role again, this step-by-step approach is exactly what is required for the novice to make the transition. Thus, this requires the expert to make a paradigm shift in the relearning of new information as a novice and leads to stress and frustration (Weidman, 2013). Weidman found that when she asked clinicians in her study why they decided to transition to nurse educators, they overwhelmingly responded that they wanted to share their expert knowledge through teaching. Thus, as suggested by participants in the study described here, expert clinicians may

know *what* they should teach, but need help in knowing *how* to teach (Spencer, 2013).

## Preparation for Transitioning to the Novice Nurse Educator Role

Estelle shared this reflection after attending some of the sessions of the Clinical Nurse Educator Academy:

> It is a very challenging journey for the new nurse educator to become a novice again. … It would be a good idea to develop a pathway for the novice faculty and it should include all the skills needed to be successful faculty and how to achieve those skills. The checklist should also include different levels according to individual pace, personality, culture, and learning style.
>
> In the service area or hospital where new graduates are hired, they get at least 3 weeks of theory and 3 months of practice with a preceptor one on one. Why should it be different for a new educator who is also new to the field? Are we preparing our educators to be successful in their field? Are we providing enough support and enabling environment? … I strongly felt when new faculty talked yesterday about their new career as educators they definitely looked overwhelmed and overworked. If an expert clinician wanted to be an educator in her 40s, she doesn't want to change her career and then fail. … The question is: What kind of mentoring are we providing?

Naomi had been a clinical educator for a short time previously, but had enrolled in the academy to learn more about teaching. Her story also reflects the lack of preparation she received for this role:

> My first experience as a clinical educator was many years ago. My qualifications for this job were clinical experience and a willingness to work with students. There was no formal education or orientation offered for my new responsibilities. Not knowing what I should know about clinical

> education was a bit like playing pin the tail on the donkey. I realize now that I didn't know enough to ask meaningful questions. I was in my own world. The nursing school provided me with a copy of course objectives, the student textbook was available, and a copy of the labs the students had completed.
>
> I remember being so excited about beginning my new role in clinical teaching; I wanted to share everything I knew. These students were also enthusiastic about being in the clinical setting. They were like little sponges absorbing as much as they could, or at least most of the students were like this. It is mentally challenging and exhausting trying to find ways to engage these other students. Now I realize my teaching style may have been the problem. … Had I known then what I know now, I might have possibly stayed in that teaching arena. … A workshop such as the Nurse Educator Academy that covers specific topics would have been a dream come true. I didn't realize how much I didn't know about what I was doing until I'd been in the role for several years.

It is clear from Estelle, Naomi, and other research participants, as well as the literature, that clinicians often receive very little formal training in how to teach in their new role as clinical nurse educators (Duffy, 2013). Researchers in one study of 75 clinical nurse educators found that 31% of the educators had received no training at all for their new role (Suplee, Gardner, & Jerome-D'Emilia, 2014). Clinicians hired as part-time clinical nurse educators in their own institution may not even have opportunities to work alongside full-time faculty, who could help to mentor them in the challenges they are likely to face in clinical teaching (Spencer, 2013).

Poindexter (2013) noted that competencies associated with expert nurse educator practice have been identified, but expectations for entry-level competencies have not been clearly identified. Thus, Poindexter implemented a national survey ($n = 374$) to identify administrators' perceptions of expected competencies of entry-level novice educators for a full-time teaching position in the nursing program. Although the survey focused on full-time teaching positions so findings may not be generalizable to novice faculty who are assuming part-time

clinical educator positions, it is interesting that the perceived competencies varied according to the mission of the institution. Although expectations for novice educators in nontenure positions focused on teaching and practice, expectations from research-intensive institutions placed high value on conducting research and emphasizing scholar role competencies. Thus, for part-time clinical faculty in research-intensive institutions, it would be important to clarify how expectations for these faculty differ from those of full-time positions.

Novice nurse educators are expected to assume entry-level teaching positions with specific levels of established competencies, but it is not clear how they will gain these competencies, given that preparation for their role is so limited. In Poindexter's (2013) study, competency related to leadership was consistently ranked high in expected levels of performance across all types of institutions. This raises questions for school of nursing or hospital personnel who are recruiting nurse clinicians for faculty roles. In addition to nursing practice skills and assuming the role of a novice nurse educator, is it realistic to expect leadership and scholarship competencies? How do novice nurse educators obtain the guidance needed to develop appropriate competences that are deemed important in an academic environment?

A variety of models are described in the literature for orienting and preparing expert nurse clinicians for the nurse educator role, but there is little consensus in the literature to support a single approach (Flood & Powers, 2012; Gilbert & Womack, 2012; Reid, Hinderer, Jarosinski, Mister, & Seldomridge, 2013). Feedback from the Clinical Nurse Educator Academy described here confirmed that structured information sessions were helpful, but the most important element was the opportunity for participants to share stories with each other about their background, goals, and fears in moving into a novice nurse educator role. Most of them had been so busy in their own clinical roles that they had not experienced opportunities to share ideas with each other. In the busy context of education and health care today, it is difficult to plan and implement extensive preparation programs for new nurse educators, but it is important to provide simple opportunities for them to share stories of goals, fears, successes, and failures. There is a need for more research on the experiences of clinicians in transitioning to the role of the nurse educator so that we can better prepare nurses for this important role.

## Strategies for Successful Transition to the Novice Nurse Educator Role

- Identify your reasons for deciding to transition to the educator role so that you will know what you hope to gain from the experience.
- Identify the strengths that you bring to the educator role, as well as areas where you believe you need more guidance.
- Share your ideas and concerns with others in the nurse educator role.
- Find a mentor whose advice you trust.
- Keep a journal that describes your experiences so that you can judge your progress and competence in your new role.

## Questions for Reflection

1. A colleague tells you that she has decided to pursue an adjunct nurse educator position in order to advance her position on her clinical career ladder. How would you respond?
2. A friend in your hospital has been asked to be a preceptor for a new graduate. She is a fairly new graduate herself and is unsure if she can be an effective preceptor. What advice would you give her?
3. Do you think the competencies for part-time nurse educators should be the same as those for full-time nurse educators?
4. What do you think are the most essential competencies for novice nurse educators to bring to their new role?
5. What do you think are the most common areas of preparation that novice nurse educators need?

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