The Role of the Nurse Lecturer Situated within a Practice–Education Partnership

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Abstract

Aims and Objectives: To critically explore the nurse lecturers role situated within a practice–education partnership and to identify practice recommendations to operate the role within the context of a partnership in the future.

Background: Practice–education partnerships are increasing being developed to operationalize the healthcare policy that advocates partnership working between Academic Education Institutions and healthcare organizations to educate and train the nurse workforce and to develop nursing. A weakness of the reported partnerships is the lack of evidence of how and which partnership processes enable the nurse lecturer to work in a practice role that effectively contributes towards the aims of the partnership and best promotes the practice based learning.

Research Design: The single embedded case study is used to evaluate the nurse lecturer's role from the perspectives of key stakeholders from within an existing practice–education partnership consisting of one School of Nursing and its partner healthcare organizations.

Methods: Twenty seven one-to-one interviews and 26 focus groups took place with the range of stakeholders groups at the case study site (i.e. nurse lecturer, professional lead, practice education facilitator, student and education manager).

Results: Four key themes emerged:

1. Drivers for the partnership and role of the nurse lecturer.
2. The gap between current role performed and stakeholder role expectations.
3. Academic in Practice (AiP) role conformity: Interplay of three valuing systems.
4. Leadership to drive the partnership.

Conclusion: Embedding the nurse lecturer's role within the practice–education partnership provides a promising approach to sustain a role that best supports practice based learning. Emergent best practice principles for partnership working include: utilising the aims of the partnership as the catalyst to negotiate the practice role performed; and promoting the development of relationships, strong leadership skills and communication as the vehicle to bridge the gap between the current purpose of the role and any future role expectations between key stakeholders. Use of strategies to contest the traditional expectations of the

role is needed to promote role creativity and flexibility to enhance the practice based learning.

Introduction

Partnership and collaboration between Academic Education Institutions (AEIs) and healthcare organizations is a driver for ensuring that nurse education is responsive to service providers and for achieving healthcare results that are the best in the world (DH 2010a,b, NHS HEE 2012). Indeed, in the United Kingdom (UK) partnership and collaboration is an integral component of the Education Outcomes Framework (NHS HEE 2012) whereby all providers and commissioners of healthcare are expected to work in partnership to provide education and training that is delivered to the highest standards and is delivered in a safe environment for patients, staff and learners.

There are similarities between UK and international models of undergraduate nurse education. For example, the student nurse attends an AEI to learn the theory of nursing and engages in practice based learning to develop their practical nursing skills. Nurse Lecturers employed by the AEIs predominantly delivers the theoretical components of the curriculum and educators from within the healthcare organization manage the practice based learning. Practice based educator roles include the practice–education facilitator, clinical facilitator, mentor and preceptor.

The move to an all graduate nursing profession in the UK exposes the student nurse to a curriculum that has a 50% theory and 50% practice weighting, and is reliant on partnership working between the multiple organizations (academic and healthcare organization) for its safe and effective delivery (NMC 2010). Whilst practice based learning is managed by the range of practice based educators, the Nursing and Midwifery Council (NMC) in the UK also expect practice engagement by the nurse lecturer. However, the NMC do not make explicit the role to be performed, nor do they provide a national practice role outline. Instead they identify a range of possible role strategies which include:

- acting as a clinical or link teacher;
- preparing, supporting and updating mentors and practice teachers;
- contributing to practice development and undertaking practice-based education (NMC 2008).

The lack of role clarity for the nurse lecturer when engaging in clinical practice has resulted in perceptions that the role lacks purpose and direction (Clifford 1999, Ramage 2004, Williams & Taylor 2008, Leigh 2012). The lack of role clarity places the nurse lecturer in a less favourable position than their practice based educator colleagues to contribute towards the practice component of the undergraduate nursing curriculum, develop the nurse workforce post qualifying and develop nursing when functioning from within the practice setting. Indeed the role ambiguity has led to a noticeable trend, both in the UK and internationally, of nurse lecturers seeking alternative strategies of maintaining a contemporary understanding of the health care context, but without engaging in clinical practice. Strategies include conducting research and attending conferences (Fisher 2005, Griscoti *et al*. 2005, Barrett 2006, Gillespie & McFettridge 2006, Elliott & Wall 2008).

Whether these alternative strategies are politically, professionally and publically acceptable requires further debate in terms of the risks associated with a nurse lecturer who no

longer participates in practice based learning activities and lacks an understanding of contemporary nursing practice. There is also a perception of an education system that no longer produces undergraduate nurses with the right skills and leadership abilities, which is not isolated to the UK. Healthcare leaders in the USA report competency deficits of the newly qualified nurse on qualification (Nursing Executive Center 2008a,b); something the nurse educationalist strongly contests (Berkow *et al*. 2009). This finding together with the release of the Institute of Medicine's (IOM) report on the future of nursing (IOM 2010a) has been used as the catalyst to re-think the practice–education partnership between AEIs and healthcare organizations as the vehicle to prepare nurses to lead change and advance health (Beal *et al*. 2012).

In response to the healthcare agenda that advocates partnership working to educate the nurse workforce, an increasing number of practice–education partnerships are emerging. The academic–practice (practice–education) partnership is defined as: the mechanism for advancing nursing practice and improving the health of the public (AACN 2012, p38); and a collaborative approach adopted by Academic Education Institutions and healthcare organizations to educate and develop nurses from within the healthcare setting (promote practice based learning) (Leigh 2012).

Indeed, one School of Nursing and its partner healthcare organizations has developed its own practice–education partnership model (Academic in Practice Model). This paper critically explores the role of the nurse lecturer situated within the Academic in Practice Model and provides the evidence of those factors that impact on the nurse lecturer's ability to contribute towards the practice based learning.

Overview of the UK and International Practice – Education Partnerships

A literature search was undertaken to generate the evidence of the nurse lecturers practice role situated within a UK and international practice–education partnership. Five papers were critiqued from the UK evidence base and nine from the international evidence base, incorporating papers from Australia, USA, Canada and Republic of Ireland.

Similarities were identified between the five UK practice–education partnerships in that the aims of the partnerships included operationalizing the practice component of the undergraduate nursing curriculum (Crooke *et al*. 2003, Chapple & Aston 2004, Burns & Patterson 2005, Timmons *et al*. 2005, Brooks & Morriarty 2006). The Practice Learning Team approach was utilized by Chapple & Aston (2004), Timmons *et al*. (2005) and Brooks & Morriarty (2006) to operationalize the partnership and comprised of a group of nursing staff with an education remit of working collaboratively to develop student learning from the practice setting. Practice educator roles included: link lecturer; practice development nurse; clinical educator; and clinical placement facilitator.

A similar UK partnership arose following the need to provide realistic and innovative strategies to ensure that three key elements were addressed to support the undergraduate curriculum: mentor support; effective practice learning environment; and placement allocation (Burns & Patterson 2005). This culminated in the Clinical Practice Placement Unit (CPPU) partnership (Burns & Patterson 2005). The learning organizations' approach reported on by Crooke *et al*. (2003) was a philosophical approach to the whole undergraduate curriculum.

The international practice–education partnerships emerged in response to the need to meet the health needs and health service requirements of a local population. This approach provided an opportunity to prepare the undergraduate student nurse for professional practice whilst at the same time address local nurse recruitment shortages. An alternative

and different partnership approach was the Dedicated Education Unit (DEU), developed by clinicians and academics to educate student nurses from the practice setting (Wotton & Gonda 2004, Randles Moscato *et al*. 2007, Mulready-Shick *et al*. 2009). A further and final partnership was adapted from the DEU approach and was used to provide student nurses with a clinical placement within a Clinical Learning Unit (Callaghan *et al*. 2009).

Several key themes emerge following the review of the models.

Achieving the Aims and Outcomes of the Partnership

According to Gallant *et al*. (2002) and Sullivan & Skelcher (2002), negotiation between the different stakeholders involved in the partnership is required to avoid failure of the partnership and to achieve the partnership outcomes. What can be extrapolated from the review of the practice–education partnerships is that crucial to achieving the partnership outcomes is the need to keep the long-term focus. This is achieved in part through the communications that take place that consistently link back to the compelling reasons for the partnership and the partnerships identified aims and outcomes (Haas *et al*. 2002). To illuminate this point further, Haas *et al*. (2002) provide the example of a new developing preceptor partnership for undergraduate nursing students in which regular meetings between all stakeholders during the planning stage of the model maintained the momentum of the partnership. The content of the meetings focused on working towards the mutually set goals of the partnership, and long-term funding opportunities required to operationalize four factors perceived as important to achieving high-quality practice-based learning experiences for students: essential local school district infrastructures; dynamic college of nursing curriculum; the partnership interface within the community context; and clearly defined programme outcomes (Haas *et al*. 2002).

The Negotiated Role Performed by the Nurse Lecturer

The majority of the reported practice–education partnerships utilize the compelling reasons and aims and outcomes of the partnership as the catalyst to define the practice role that the nurse lecturer will play, with the role negotiated between the academic institution, stakeholders from practice and nurse lecturer. Crucial to the success of this approach seems to be that all partners are aware of the practice role being performed and its impact on the practice based learning, thus eliminating the criticisms of the UK nurse lecturer role that is often misunderstood by nurse lecturers and stakeholders from practice (Baillie 1994, McElroy 1997, Clifford 1999, Duffy & Watson 2001,Williams & Taylor 2008, Leigh 2012).

The negotiated practice role performed by the nurse lecturer seems to be synonymous with best practice principles of partnership working whereby involving the most suitable individuals who have the level of authority to make decisions can empower partners to achieve the aims of the partnership (Frye & Webb 2002, Clegg *et al*. 2005, Brown *et al*. 2006). This is because each partner is provided with the autonomy to implement practice based teaching and learning initiatives in collaboration with the practice staff at the local level, thus negotiating the practice role undertaken to meet the aims of the partnership. Indeed, one of the strengths of the international practice–education partnerships is the defined role that nurse lecturers play in meeting the aims of the partnership. Roles performed include support and preparation for the preceptor (Haas *et al*. 2002, Sowan *et al*. 2004) and the development of specific student related activities (Hall-Long 2004).

Chapple & Aston (2004) report on role flexibility, with the role activities performed by the multiple members of the Practice Learning Team being dependent on the local needs of the clinical learning environment. This has resulted in new ways of working for the nurse lecturer, for example a shift from the 'queen mother' role (Chapple & Aston 2004, p145) that entails a quick visit to say hello to the practice staff, to a role that has more meaning.

New and negotiated roles performed by the nurse lecturer in the practice setting include the facilitation of reflective sessions between the mentor and student, with the nurse lecturer adopting the group facilitator role (Chapple & Aston 2004).

For Crooke *et al*. (2003) and the communities of practice partnership, the role negotiation resulted in the transference of university teaching to the practice setting and has cumulated in a new sense of satisfaction for the nurse lecturer who is viewed as an integrated member of the nursing team by the practice staff. Concurrently, the visible role of the nurse lecturer is reported on as integrating theory and practice and enhancing the relationships between the university and practice setting (Crooke *et al*. 2003).

Strong Leadership

Leadership demonstrated by all individuals in the partnership is synonymous with the notion of leading through influence and not the power of titles and positions (D'Amour *et al*. 2005). Casey (2011) would combine the use of power with the application of effective social skills, thus identifying skills as one of the seven core concepts in her emergent partnership conceptual framework.

The philosophy of the overall practice–education partnership with its vision and purpose for the role of the nurse lecturer clearly defined, is reportedly used as a platform to build the right type of leadership required. This approach is often coupled with the development of robust communication strategies and relationship building to ensure that the right stakeholders can meet at the right time. For example, strong leadership is utilized to reorganize the curriculum in order to operationalize the DEU concept (Wotton & Gonda 2004). Within this example, different roles subsequently emerged for the nurse lecturer and culminated in the development of the 'Principle Academic' and 'Clinical Liaison Nurse', required to operationalize the undergraduate curriculum and to coordinate the practice based learning.
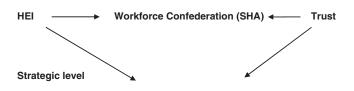
With the exception of one UK partnership (Brooks & Morriarty 2006), all have adopted a strategic approach to the integration of the practice–education partnership with the overall philosophy of the undergraduate curriculum (Chapple & Aston 2004, Burns & Patterson 2005). The journey in becoming a learning organization involved policy makers, strategic leaders, patients, students and educators in becoming members of the learning organization, and indeed members of the learning community (Crooke *et al*. 2003). For Crooke *et al*.'s partnership, the faculty utilized the INVEST Model (Pearn *et al*. 1995) consisting of: inspired learners; nurturing culture; vision for the future; enhanced learning; supportive management and transforming structures. These concepts permeate through their practice strategy.

A weakness of the reported partnerships, particularly from the UK perspective is the lack of evidence of how all the multiple roles of the different personnel work interdependently. Furthermore, there is a gap in the evidence of how and which partnership processes enable the nurse lecturer to work in a practice role that effectively contributes towards the aims of the partnership and best promotes the practice based learning.

Research Aim

The aim of the research study was to critically explore the role of the nurse lecturer situated within a practice–education partnership. Two objectives were to:

1. Critically explore the nurse lecturers role operating within a practice–education partnership, from the perspective of key stakeholders

2. Identify practice recommendations to operate the role within the context of a partnership in the future

HEI $\longrightarrow$ Workforce Confederation (SHA) $\longleftarrow$ Trust

Strategic level

- National policy and priorities, business planning, contracting, policy setting and implementation, workforce planning and development, resources, cross trust issues, standards for and scope of practice placement circuit

$\updownarrow$

Operational Level

- Negotiate "best fit" of educational requirements within trust and knowledge/skills of all educators
- Develop appropriate infrastructure compatible with other layers of the framework and the respective HEI and Trust
- Develop a planning cycle which will include re-defining fitness for purpose, setting goals and evaluating the effectiveness of the partnering arrangements
- Feed information to and from respective organisations
- Support where appropriate activities at the student interface and strategic level *e.g.* Mentorship update, recruitment and selection of staff
- Course development and evaluation

$\updownarrow$

Student Interface

- Assuring quality of the learning environment, mentorship, assessment and evaluation
- Assuring currency of practice placement circuit, mentors and clinical guides
- Assuring pastoral care, equal opportunities and fair treatment of students
- Mentor preparation/updating
- Coordination of practice placement circuit
- Local trouble-shooting

Scheme 1 Levels of Partnership within AiP Model

Research Design

The case study is used to investigate this contemporary phenomenon in depth and within its real life context (Creswell 2007, Yin 2009). Analogous to the single experiment, studying one School of Nursing's practice–education partnership makes this study a descriptive single (Gomm *et al.* 2002) and embedded (Yin 2009) case study.

Case Study Context

The School of Nursing is situated in the North West of England and offers undergraduate, post qualifying and post graduate programmes. Engaging in clinical practice is an expected component of the teaching and learning remit of the lecturer role, thus the role of the nurse lecturer is to contribute to teaching and learning in the university and practice setting.

The practice education partnership model within this case study site is termed the Academic in Practice (AiP) Model (Leigh 2012). The nurse lecturer working in the practice role is called the Academic in Practice (AiP). The model consists of a partnership, which operates between three organizations the AEI, the Workforce Confederation (now Heath

Table 1 AiP Role Outline

To work effectively as a team, taking a risk assessment approach, to ensure the provision of appropriate learning environments, and to provide student and mentor support.

To work in partnership with stakeholders to provide Mentor and Registrant Awareness Study Days. Each AiP to facilitate a minimum of two study days per annum.

To complete and verify the self-assessment (educational audit) document within each placement.

To work collaboratively with all stakeholders and ensure that good channels of communication are in place.

Education England) and practice healthcare organizations (hospitals and community care settings). Between these organizations there are three levels of partnering arrangements; strategic, operational and the student interface (Scheme 1). The partnership priorities and expectations from a strategic level are translated and communicated into operational and student interface activities.

At the time of the study and as a component part of the AiP model, the practice links existed in both NHS and non-NHS organizations. NHS organizations included six community organizations, five acute NHS Trusts, one of which covered five different localities. Non-NHS healthcare organizations included six prisons, seven hospices and two placements for deaf students. Practice links were operated through seventeen AiP teams. All academics in the School of Nursing, excluding designated researchers, Professors, Head of School and some members of School Executive, had a compulsory AiP role. The AiP Lead was responsible for the day to day operation of its AiP team. The role outline of the AIP is summarized in table 1.

The Study Sample

The range of sampling techniques applied to the study are summarized in Figure 1 and resulted in five practice locations (organizations and AiP teams) being studied, spanning the range of seventeen NHS healthcare organizations, encompassing adult, child, and mental health fields of nursing. Each practice organization was studied as a 'micro' case study site together within a single embedded case study approach.
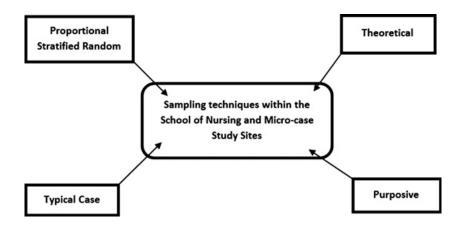

Figure 1 Sampling techniques applied to the Case Study Site

Purposive sampling was used to select a mental health organization and Children's Trust to gain insight into AiPs working in their respective fields of practice. One community and one Foundation Trust were randomly selected for closer scrutiny. The selection of the latter two micro-case study sites were 'typical' or representative (Stake 2006) of the remaining organizations, apart from the prison service and placements for deaf students.

Application of sampling techniques further culminated in the identification of the following sampling groups relevant to the case:

1. AiP - Nurse lecturers working as an academic in practice (AiP)

2. AiP Lead

3. Professional Lead (Members School of Nursing Executive)

4. Students

5. Education Manager (practice organization)

6. Practice Education Lead

7. Practice Education Facilitator

8. Mentors and Associate Mentors

9. Clinical Placement Development Network Manager

10. AiP Model Planner

Data Collection

The semi-structured interview was used as the data collection tool (Yin 2009, Silverman 2010) and depending on the size of the sample was used either on a one-to-one basis with a participant or within the context of a focus group. Data collection ceased when no new information was being produced to inform the emergent themes (saturating the concept). The University Ethics Committee and National Research Ethics Service provided the ethical approval for the study. Participation in the study for all participants was voluntary.

Data were collected between January 2008 and January 2009. A further focus group interview was performed with a group of Practice Education Leads in 2011.

The interview schedule (Table 2) was influenced by the background literature on the nurse lecturers practice role in practice–education partnerships.

Twenty seven one-to-one interviews and 26 focus groups took place with the range of stakeholders groups at the micro case study sites and School of Nursing.

Table 2 Topic areas incorporated into the interview schedules

Compelling reasons for the partnership	Factors that maximize and mitigate against partnership working and role compliance
Purpose and expectations of the AiP role	Communication pathways and impact on the partnership
Role realities of the AiP	Impact of the relationships developed
Purpose of the AiP team	Leadership within the AiP model
Right person in the role (characteristics of the right AiP)	Role development
Role conflict and its resolution	Role evaluation

Data Analysis

All the interviews were tape-recorded and transcribed verbatim and coding schemes generated from the line-by-line analysis of the interview schedules (Graneheim & Lundman 2004). This thematic analysis approach provided the opportunity to identify typical responses and to summarize participants' accounts. This was a comparative process whereby the

various accounts gained from the range of stakeholders were compared with each other so recurring areas were identified and drawn together to gain an understanding of the emergent key areas.

The researcher's supervisor reviewed a sample of the interview transcripts, ensuring that the interpretations of the responses were not affected by the researcher's own feelings related to the context. Also, built into the research methodology was a clear audit trail and reporting mechanisms , thus ensuring participants opposing views were taken into account and reported on as part of the study.

Findings

Following the analysis of the data four key themes are reported on.

Theme One: Drivers for the Partnership and Role of the Nurse Lecturer

The drivers for the partnership can be compared to antecedents or events that happen prior to making the decision that the partnership is required (Walker & Avant 1995) and these were politically and professionally driven (DH 1999, Casey 2011); context specific (Dowling *et al*. 2004, Casey 2008); and required to promote effective practice based learning:

> It's about jointly working and building the relationships with any trust [healthcare organization], it's about working with them to develop new curriculums and identifying the educational needs of registered nurses and develop nursing from within the practice setting' (Professional Lead 5).

Furthermore, one of the original AiP Planners provides insight into the AiP model that should capitalize on the strength of individual nurse academic's from within the role performed in the practice setting. This scenario should promote the role flexibility and reverse the situation reported on by multiple authors of the nurse lecturer disengaging from practice if the role performed is incongruent with his or her role expectations (Baillie 1994, Clifford 1999, Ramage 2004, Grant *et al*. 2007):

> 'It isn't just about support for undergraduate activities, it is quite legitimate to be looking at continuing professional development post qualifying, post graduate issues, (AiP Model Planner 1).

Stakeholders provide insight into the constitution of the actual role performed by the AiP within the range of micro-case study sites. The narrow job outline, which is particularly dominated by the functional tasks seem to have contributed towards the frustrations felt by the AiP and this is perceived as limiting:

> 'I would like to do more [than the educational audit and mentor updates]....
> I would like to go out there and make a difference' (Site Three, AiP Lead 4).

> 'I am constantly trying to get them [practice staff] interested in research as we speak' (Site Two, AiP6).

Mead (1934) introduces the concept of role strain and Major (2003) introduces refers to role mal-integration (Major 2003) both of which can occur due to role duplication and lack of role clarity. These concepts were evident in one micro study site, where lack of role clarity and misunderstandings of where the role boundaries lay between the role of AiP and PEF when providing the practice based learning activities:

> 'I don't know where that boundary lies' (Site Five, PEF 3).

> *'Clarify what their [AiP] role is and what our role is because we are not sure whether we are stepping on their feet and maybe they are wondering whether they' are stepping on our feet' (Site Five, PEF 4).*

Whilst lack of role clarity can lead to role conflict due to incompatible role expectations (Biddle 1986), there is a lack of understanding and evidence at the case study site of how the role can be re-negotiated to effectively contribute towards meeting the healthcare organizations strategic goals and promoting the practice based learning:

> *'We have in our Trust five or six nurse consultants, 16/17 advanced practitioners, loads of nurse prescribers, probably two/three dozen clinical nurse specialists. Most of whom have got Masters, and probably a dozen of whom have got PhDs. So what is it the University could offer that we have not already got?' (Site Five, Education Manager 3).*

Theme Two: The Gap between Current Role Performed and Stakeholder Role Expectations

Congruent with the NMC (2008) position on the compulsory practice role for the nurse lecturer and crucial to the wider role of the nurse academic, a key finding from the case study site is the unanimous view by all stakeholder groups that there is a role for the nurse lecturer in the practice setting. However, diverse ideas are reported on in terms of the required role expectations. This finding suggests a gap between the current purpose of the AiP role performed and the expectations of the role. For example, the professional leads do not prescribe the role to be performed and instead identify high level principles or broad statements of intent that support a responsive and best fit role that meets the aims of the partnership. Emphasis is placed on the relationships developed as opposed to the role performed; the relationship becomes the platform for the subsequent role development and negotiation:

> *'If you come here to do a lecturing job we would be expecting you to develop those relationships and for me that's what it is absolutely got to be about, without those relationships truly being there, you can legislate for anything and it won't happen it will just become a rhetoric wont' it' (Professional Lead 5).*

Less evident are the next logical steps to negotiate or translate the high level principles into meaningful role activities that provide the AiP with the best opportunity to contribute towards: meeting the aims of the partnership; promoting the practice based learning; and complementing other existing practice based education roles such as:

> *'Encourag[ing] collaboration between university and practice organization so not working in opposite directions'* (Site One, PEF 5).

> *'Enhanc[ing] the learning of the student experience together with our practice colleagues who have a teaching and learning remit'. (Site Two, AiP Lead 1).*

AiPs when questioned about their role expectations advocate a practice role that provides them with opportunities to demonstrate clinical currency and knowledge of up-to-date academic teaching, and to build relationships with practice staff and this finding is congruent with the existing evidence base (Fisher 2005, Ousey & Gallagher 2010):

> *'Being an AiP influences my teaching because I am also a teacher on the prep for mentorship module and have done since I came in here. I think partly that influence is how I try and work with the qualified staff who are the next generation of mentors. There's loads of evidence about positive clinical learning*

environments, mentors being welcoming, warming, supportive, etc, etc. That is another way I try and use my AIP role through my teaching role here. I think it can be seen in lots of different ways' (Site Four, AiP 17).

Students also have multiple ideas of what the practice role should look like and these were often different than the expectations reported on by the AiP. Study findings are congruent with the existing evidence base whereby students at the case study site expect that the nurse lecturer is able to incorporate real-life situations into their teaching (Sebastian *et al*. 2004, Blair 2005) and expect nurse lecturers to have presence within the clinical learning environment (Edwards 2002, Shuttleworth *et al*. 2008, McSharry *et al*. 2010). In reality, there are minimal reported collaborations with students in the practice setting and two extreme situations have emerged. Whilst students might feel abandoned by the university when they undertake clinical practice, for others there are perceptions that the role of nurse lecturer is not needed if the mentor is viewed as 'good':

'I think it would be better though if they [AiP] were coming in because if some mentors are good and some are bad and I think if there was somebody else there who could ... who knows the proper practice they'd treat students I think a little bit better and they did show the right way not just a quick way because they want to go home early and things like' (Site Two, Student 3).

Theme Three: AiP Role Conformity: Interplay of Three Valuing Systems

Findings generated from the case study site (School of Nursing and micro case study sites) clearly suggest the impact on the interplay of three valuing systems of the AEI, practice stakeholders and AiPs themselves on achieving the aims and compelling reasons for the partnership and promoting role compliance. This information can be used to acknowledge and deal with any threats to existing sub-cultures that exist within partnerships (Ashcroft 2001, Hay 2010).

Where the AiP values the role and sees a clear purpose to the role, the characteristics of the 'right' or 'innovative' AiP seem to emerge. These characteristics extend beyond having knowledge about professional and political policy and practice based education to include high-level skills associated with effective partnership and collaboration and include: good communication (Carnwell & Buchanan 2007) and being visible; working collaboratively with people in practice; demonstrating strong leadership skills to negotiate the role within the multiple practice settings (Ramage 2004, Stanley 2006); and demonstrating a genuine interest in the role performed in order to promote practice based learning:

'[Being visible to conduct the audit] 'It was also an opportunity for someone to say 'I really don't understand the practice document' and for me to go through it' (Site Three, AiP 18).

'We can influence practice in lots of ways' (Site Two, AiP4).

Congruent with the wider nurse lecturer evidence base (Baillie 1994, Clifford 1999, Ramage 2004), in three out of five micro case study sites, there is evidence of the AiP disengaging from practice because the role has no meaning to them. Within this situation, there is minimal evidence of the AiP developing the relationships with practice stakeholders, a situation that impacts negatively on building the mutual respect and willingness to cooperate for the benefits of achieving the partnership outcomes (Meads & Ashcroft 2005). This type of situation constitutes the disconnected AiP:

'I don't go out unless I have to. I don't look forward to it. There has to be a reason to go out. I certainly don't call for tea and biscuits' (Site Five, AiP 8).

> '*Sometimes you get the feeling as if it's not a role that they [AiP] really want to be doing*' (*Site Five, PEF 3*).

AiPs question the value placed on their role performed by the practice stakeholders and this manifests through the AiPs feelings of frustration due to the: cancellation of pre-arranged meetings; being kept waiting in the clinical area for long periods of time; and being perceived as a nuisance. Similar findings are reported (Camiah 1998, Ramage 2004) demonstrating that this scenario is not isolated to the case study site and that it needs to be reversed:

> '*When I arrived, from a distance, I could see that she wasn't happy that I was there. She was sort of raising her eyes to the roof as if to say 'oh no, I could do without this' type of thing. So it didn't make me feel very comfortable. You have to grit your teeth and just get on with it*' (*Site Two, AiP 7*).

> '*You can make it what you want to be but it is all around how practice values the role*' (*Site Three, AiP 17*).

For the AiPs at the case study site and consistent with the evidence base, AiPs report an AEI valuing system which attributes less value to the practice role, with priority afforded to the classroom teaching (academic) and other role commitments (Baillie 1994, Day *et al*. 1998, Ferguson *et al*. 2003, Grant *et al*. 2007, Williams & Taylor 2008):

> '*I think a lot of the people who have leadership positions, have worked out what the role will be, could be and what we expect it to be and there is often timeframes we are supposed to be heading to but we never really seem to get there, so it makes you think there is a tokenism that is going on or is it the reality of the wills or aversion to concentrate on this role and the universities all tied up in its own policy and its own politics and that's different from the practice organization world out there*' (*Site Five, AiP Lead 3*).

The reported influences and strategies to enhance role conformity are out of the immediate control of the nurse lecturer and require dynamic organizational structures to implement and include strong leadership to support the management of the competing role demands and feedback mechanisms to inform the nurse lecturer of how well they are performing in the role.

Theme Four: Leadership to Drive the Partnership

Strong leadership applied to the practice–education partnership is required to: facilitate productive interactions to bridge the diverse cultures of the lecturer and healthcare organization; share power; and support the development of robust communication in order to challenge any assumptions that limit thinking and action (Weiss *et al*. 2002, Brown *et al*. 2006).

It is not clear who is responsible for ensuring that the AiP and range of practice roles are sufficiently clarified to meet the aims for the partnership. The Professional Leads, for example, have a limited knowledge and understanding of the role performed by the AiP and this is attributed to the flexibility of the role operationalized to best fit the individual needs of the practice organization:

> '*Don't know what all do. I sense it is a real mixed bag*' (*Professional Lead 5*).

Moreover, there is evidence how the AiP role might not always focus high on the agenda within the School of Nursing:

> '*AiP work not on the agenda. We talk about it occasionally*' (*Professional Lead 1*).

Furthermore, the leadership strategies adopted to manage the factors that hinder the partnership working are unclear; these include the time available to function in the role and to manage any competing role demands. A reported requirement of the AiP Lead is to facilitate the process of developing and communicating the vision for the AiP team. Indeed, those attributes associated with the right AiP Lead can promote the innovative AiP situation and include: progressing the AiP team; seeing the bigger picture, attributed to further project work and role extension; enthusing and motivating; building strong balanced relationships; communicating with key influencers in the practice organization; and effectively managing:

> '*Getting the strategic picture. Rethink our team in terms of how we engage, where we engage and how many of us engage in different places*' [in response to practice reconfiguration] (*Site Four*, *AiP 18*).

> '*The enthusiasm of the team leader can help to take that forward [development of initiatives, working together with practitioners on finding evidence for practice, or mini-research, or development projects]*' (*Site Four*, *AiP 18*).

PEFs also expect the AiP Lead role to extend beyond functional management role activities to include a role that defines its vision for the team and provides clear leadership and direction to achieve the vision and to promote the practice based learning. Leadership qualities (Leadership Academy 2011) identified include having a drive for results and focusing on the vision; but also seeing things through:

> '*The AIP team lead is important so that we have a good strong lead who can deliver a very clear vision as to what that team is all about, what they want it to do. And also to maintain the drive, focus and seeing things through*' (*Site Two*, *PEF 1*).

Characteristics that militate against strong AiP Lead leadership have emerged and include the lack of power associated with team members' poor performance and strategies to support the AiP dealing with competing role demands or dealing with situations whereby the AiP role requirements become the role casualty:

> '*I don't have any authority or clout in the role. I'm sort of the meat in the sandwich between role responsibilities*' (*Site Five*, *AiP Lead 2*).

Discussion

Findings from this study strengthen the need to combine the aims and compelling reasons for the partnership with any new and emerging political and professional policy and use as the basis for the subsequent development and negotiation of the nurse lecturer's practice role. The ambiguity and uncertainty around the vision and purpose of the partnership may lead to future partnership innovations (Clegg *et al.* 2005) and can be used to further enhance the practice based learning opportunities.

A key finding from this study suggests that there is no definitive answer as to what the nurse lecturers practice role should look like. Instead, the role should be operationalized to best suit the needs of the partnership and not be restricted by an inflexible role outline dominated by functional role activities. In other words, the answer to the role constitution is embedded within the aims of the partnership and philosophy of the practice based learning.

Application of a role gap analysis, an adapted approach developed specifically by the researcher of this study, should determine the differences between the various

stakeholders' perceptions regarding the current purpose of the role and any current and future role expectations (Leigh 2012) (Figure 2). The role gap analysis could provide the platform for promoting the best partnership conditions for any future role negotiation and the securing of role resources. This could produce the future ideal nurse lecturer's practice role that: best meets the aims for the partnership; capitalises on the knowledge and skills of all educators; has real meaning for the students when undertaking the practice component of the undergraduate nursing curriculum; and ensures that the role remains relevant and compliments other roles charged with educating nurses in the practice setting.

A role gap analysis performed by the most appropriate stakeholders at the different levels of the partnership (strategic, operational and student interface) could promote the informed participation of all involved (Gallant *et al*. 2002). This could also promote the understanding of the relative value that each educator brings to the partnership and support the development of strong relationships and reciprocal trust (Stamper & Masterson 2002,
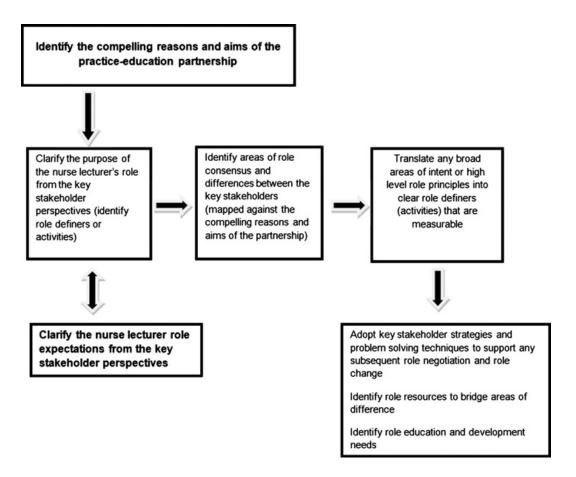

Figure 2 Role Gap Analysis (Identify Key stakeholders from the different levels of the partnership (strategic, operational and student interface))

Meads & Ashcroft 2005, Sullivan-Marx *et al*. 2010). Moreover, where role mal-integration exists (Major 2003) due to the multiple roles now charged with providing the practice based teaching and learning, role re-negotiation would provide role clarity and manage any identified role conflict.

A key feature of the gap analysis is that it can be used in conjunction with recognised problem solving techniques, such as stakeholder analysis and influence mapping (NHS Innovation and Improvement 2008), SWOT analysis (Van Grundy 1998, NIC 2009) and

antecedent mapping (Walker & Avant 1995). Techniques such as, PESTEL analysis, can also be utilized to critically explore the political, economic, sociological, technological, ethical and legal issues impacting on the future direction of the partnership (VanGrundy 1988). The role gap analysis approach provides the mechanism with which to track any changes to the partnership that will occur due to the rapidly changing political and professional healthcare agenda (DH 2010a,b, Casey 2011) and to re-negotiate the practice role that best fits any future aims and compelling reasons for the partnership.

Embedded within the role gap analysis is an approach used to operationalize a critical finding generated from the case study site. The gap analysis requires the partnership particularly at the operational and student interface to translate the often broad areas of intent or high-level role principles into clear role definers which are measurable. This technique further supports the delivery of the aims of the partnership by re-focusing the AiP role on what is required to make the partnership effective and can be used as the catalyst to manage existing role conflict, conflict of ideas and duplication of roles performed. This can be achieved through developing new ways of working (Clegg *et al*. 2005) and through operationalizing the concept of role redundancy (Broderick 1998). At the same time this should support the reciprocal sharing of expertise and provide the opportunity for openness and a willingness to learn from each other (Hanson *et al*. 2000, Banks 2002, Miller *et al*. 2004, Broome 2009).

The key to the nurse academic's practice role operated within the practice–education partnership could lie in leadership development, particularly the development of the qualities expected of the clinical leader (Leadership Academy 2011), including those associated with: the use of emotional intelligence (Goldman 1999); delivering the service (delivering the partnership); leading and influencing change; and developing relationships. Leadership in the partnership context is attributed to all individuals taking responsibility in achieving the aims of the partnership (Hardy *et al*. 2003, Brown *et al*. 2006, Casey 2008) and is synonymous with the notion of leading through influence and not the power of titles and positions (D'Amour *et al*. 2005).

Application of strong leadership skills could better equip the nurse lecturer to find their practice role social niche (Mead 1934) whilst at the same time provide the evidence of how the AEI is meeting its moral obligation of providing the infrastructures and to convert the high level principles or broad statements of intent into clear role activities that support the practice based learning. The lack of consensus on the role activities to be performed will significantly slows down the role transition process (Thornton & Nardi 1975), with the nurse lecturer not truly understanding the expectations of the role. This also works against infusing the role with self-meaning (Crawley & Sabatelli 2008) and achieving role-mastery (Johnson Lutjens 1991), if this is ever achievable.

A challenge for leaders of practice education is to promote the best environment to operate the role within the practice education partnership in the future, taking into account the changing face of healthcare, cost containment programmes both in the AEI and healthcare organization and emphasis placed on teaching in the academic setting and meeting the research assessment agenda (REF 2012). One way to achieve this is to promote a culture whereby the best role, partnership and collaboration principles can be operationalized.

Conclusion

The time is right to be bold and to try something new and allow naturally occurring roles to emerge from within the partnership itself (strategic, operational and student interface). A partnership approach that promotes the best practice principles of partnership working may

offer a promising focus for a sustainability framework of the nurse lecturers practice role and importantly, place the nurse lecturer in a stronger position to promote the practice based learning.

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