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Preceptorship Practice in Healthcare Institutions in Ghana: A Situational Analysis

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PRECEPTORSHIP PRACTICE IN HEALTHCARE INSTITUTIONS IN GHANA: A SITUATIONAL ANALYSIS

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ABSTRACT

PRECEPTORSHIP PRACTICE IN HEALTHCARE INSTITUTIONS IN GHANA:

A SITUATIONAL ANALYSIS

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Preceptors play a vital role in supporting nursing/midwifery students and new employees' transition and assimilation into their new role. Furthermore, with the increasing focus on educating more qualified nurses and midwives to meet health-related United Nations Sustainable Development Goals, there is a need for a more standardized and coordinated approach to preceptorship training. As former Head of the Nursing/Midwifery Training Institution in Ghana, I observed first-hand that the system of preceptorship needs improvements. Published literature on preceptorship has shown that the practice plays a vital role in healthcare delivery. However, most of the existing literature preceptorship is from developed countries, with little research from developing countries like Ghana. This study explored the practice of preceptorship in selected nursing/midwifery and healthcare institutions in Ghana. Situational analysis was used to examine the complex dynamics of the preceptorship program. It consists of three main procedural tools: situational maps, social worlds/arenas maps, and positional maps. Several important factors were found to impact preceptorship in Ghana. Key ones were motivational (monetary) challenges, lack of training of preceptors, politicking related to the development of preceptorship manuals, supervision, and outdated procedure guidelines for on-the-job teaching students. The study offers a series of recommendations to improve preceptorship practice at micro, meso, and macro levels. Additionally, they may enable regulators and policy makers in Ghana to formulate policies

leading to a more robust preceptorship program to strengthen the skills of nursing/midwifery profession. This dissertation is available in open access at AURA (https://aura.antioch.edu) and Ohio LINK ETD Center (https://etd.ohiolink.edu/etd).

Keywords: Ghana, preceptorship, midwifery, nursing, health care training, leadership situational analysis

Dedication

I dedicate this work to my father, Reverend George Annan Bonney of blessed memory. He is the reason for my ability to rise this far in my academic pursuit to the point of obtaining a Doctorate degree. Early on in my life, when I was about the age of 10 years, he took active interest in my education and that of my siblings. I remember very well that any time he came home from work, the first question he asked was, “Have you done your homework?” To avoid these questions and others related to our academic progress, I made it a point to complete all my school assignments and also memorized a few lines of a book I had read to impress him. Though this was a ploy to please him, I cultivated a reading habit which has stayed with me till now. My father ensured that our school fees were promptly paid and did not miss any opportunity to remind us of the importance of higher education, especially, for the girl child. Mr. Bonney has passed on to glory but the pieces of advice and the encouragement he gave have been the underpinning reason why I have been able to make it this far. His memory will forever be with me.

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CHAPTER I: INTRODUCTION

Preceptorship is an important concept that has gained prominence in nursing literature. Preceptorship is noted to play a vital role in healthcare delivery because of the complex and challenging nature of the healthcare environment. Today, the healthcare environment has become complicated because of the increasing roles in healthcare delivery arising from increasing occurrences of several diseases, which has resulted in the introduction of many health disciplines in educational institutions. Furthermore, with the increasing focus on educating more qualified nurses and midwives to address the call for the health-related Sustainable Development Goals, the critical need for a more standardized and coordinated approach to preceptorship cannot be over-emphasized (Ghana Ministry of Health, 2015). Therefore, this development requires well-trained healthcare professionals, including nurses/midwives, to take up future roles in their various specialties. One of the best ways to do this is through a preceptorship program which seeks to adequately prepare nursing/midwifery students who are critical in clinical settings worldwide and to take up the challenge and function effectively as nurses and midwives in the delivery of maternal, neonatal, and general healthcare.

According to Dias and Khowaja (2017), the nursing/midwifery curricula consist of theory and clinical practice. Clinical aspect seems to play more than half the formal nursing education (Jamshidi et al., 2016). Further, preceptorship is one of the clinical components in nursing education; preceptorship refers to the orientation and training that a newly registered nurse or student nurse in a facility goes through in order to become acquainted with the job environment and acquire extensive knowledge and skills to be able to perform effectively in his/her role as a nurse (Myrick, 2002).

According to Koontz et al. (2010), the competent nurse has insight, awareness, and the ability to distinguish important from non-important information, as well as the clinical experiences that contributes to development. Koontz et al. indicated that the competent nurse is patient focused and the ability to manage multiple patients, demonstrates efficiency by careful planning and time management skills, and has confidence in their actions. However, because of the difficulty in reconciling theoretical knowledge with clinical, preceptorship has been a widely and acceptable alternative for clinical teaching and has been accepted by many institutions across the world (Lalonde & McGillis Hall, 2017). Preceptor responsibilities should be clearly defined, and training should include communication and conflict management, as well as prepare the preceptor for potential challenges that may arise and provide strategies on how to address these issues (Carlson, 2013; Robitaille, 2013). The goals of this initiative were manifold. They included strengthening preceptorship for students who were yet to complete college and for newly qualified ones to experience maximum benefits of their nursing and midwifery education, in terms of knowledge, skills acquisition, confidence and professional socialization. Another goal was to increase the body of knowledge in nursing and midwifery, while also ensuring the effective development of students, so that these students could in turn provide a higher quality of care to patients.

Problem Statement

Recognizing the importance of preceptorship, in the early 1990s the Ghana government invited nurses from various regions in Ghana to participate in preceptorship training. The nurses who were trained as preceptors were then supposed to prepare more preceptors in their respective regions in order to enhance clinical teaching and learning, but the system could not be sustained (Ghana Ministry of Health, 2015). Preceptorship has not well been established, and clinical

teaching has been influenced by external stakeholders involved in nursing/midwifery education. The external stakeholders are the policy makers of the nursing/midwifery institutions responsible for policies in the Ghana Ministry of Health (MoH), the Nursing and Midwifery Council of Ghana (NMCG; the regulating body), and the Ghana Health Service (GHS). Decisions taken at this level can positively or negatively impact the profession.

Over the years, there has been an exodus of nurses to the developed world, thus creating shortages in the country. In order to intervene in the shortages, a policy to increase the intake of students in nursing/midwifery schools by more than 200% between 2007 and 2011, according to the Ghana Human Resource for Health Plan (Ghana Ministry of Health, 2015) was initiated, with little increase in human and material resources allocated to nursing/midwifery education. This approach also presents supervisory problems with the high student/preceptor ratio and when the assigned preceptors are not on duty. Additionally, as seen in the reviewed literature, preceptors who receive formal training in clinical teaching serve as liaisons to bridge the gap between theory and practice. However, in Ghana, preceptors supervise more than five students each, and this reduces their effectiveness (Hilli & Melender, 2015; Oosterbroek et al., 2017). These issues limit students' creativity and do not afford them ample opportunity to seek clarification when needed (Ghana Ministry of Health, 2015). Furthermore, with the increasing focus on educating more qualified nurses and midwives to address the call for the health-related Sustainable Development Goals, a critical need for a more standardized and coordinated approach to preceptorship cannot be over-emphasized (Ghana Ministry of Health, 2015).

Published literature on preceptorship has shown that the practice plays a vital role in healthcare delivery because of the challenging nature of the healthcare environment (Myrick, 2002); however, most of these studies come from developed countries (Hilli & Melender, 2015;

Oosterbroek et al., 2017), with little research on the practice of preceptorship being conducted in developing countries like Ghana. Additionally, curriculum guidelines developed for preservice and post graduate residency education in Ghana (Ghana Ministry of Health, 2015) assert that preceptorship is a key component of the professional preparation of students and residents and is widely implemented by many academic institutions, with varying degrees of success. However, because there are no uniform guidelines or consistent evaluation methods of the model, there have been inconsistencies in the implementation approach used by different institutions and clinical education is suffering as a result. As a nurse and midwife leader, manager, and educator/scholar/practitioner in the MoH, I believe it is important that there be a clear and efficient system of preceptorship in which there are dedicated and committed preceptors who are responsible for the clinical area, as well as passionate clinical instructors from the universities, colleges, and health facilities who can help their students to be skillfully engaged.

In reflecting on my past as a professional nurse-midwife developing through the ranks, I observed first-hand systemic problems with the way clinical teaching is delivered in nursing and midwifery education across the country. With my experience as a newly qualified registered nurse and a midwife back in Ghana, I came to appreciate the importance of preceptors in helping with student nurse/midwife transition and assimilation into the clinical environment. My personal observation is that, prior to the introduction of preceptorship in Ghana during the 90s, clinical instructors or nurse educators from the faculty of nursing and midwifery training institutions and the hospitals had ample time for students in the clinical settings. Usually, there were 20 to 25 students in a class. The clinical instructors were allocated between 1 to 3 students per units in the hospitals. Because of the small number of students, the clinical instructors and experienced charge nurses/midwives shared the responsibilities of teaching and supervising

students. I felt a responsibility to give back to the tutelage I received from the experienced nurses and midwives and to help the newly hired and student nurses and midwives. Since then, my interest in clinical teaching and the preceptorship concept has only grown further. Indeed, Hyrkas and Shoemaker (2007) opine that preceptor provide support and assist students to become familiar with the clinical environment and the provision of patient care. Additionally, inadequate preceptor support, lack of equipment in clinical settings (sometimes as basic as lack of blood pressure equipment), and inconsistencies in the evaluation process are challenging for the provision of optimal clinical education. To add to the challenge, laboratories for skill acquisition prior to entering the healthcare environment are poorly equipped in most schools of nursing and access to simulation resources is scarce. Preceptorship is an incredibly valuable component of nursing and midwifery education because it influences the quality of a nation's nurses and midwives. Thus, I am of the opinion that it is an area that deserves special attention. I can see how that role has informed my thinking as a scholar-practitioner.

The system approach introduced by Von Bertalanffy (1968) emphasized the value of integrating and the important role each part of a system plays to make it work effectively. Given this perspective, it is essential that the various components and actors which impact on preceptorship which occur within a system are explored. Systems theory ensures that all related components work together to achieve the systems' objectives. In this way the meso, micro, and macro components of the system will be explored. Data will be contextualized with a review of the literature on clinical education in Ghana and situational analysis.

The Clinical Teaching for Nursing/Midwifery Education in Ghanaian Context

After Ghana's independence in 1957, there were concerns that the British model of nursing education was insufficient, as it promoted rote learning and task-oriented clinical

practice. Then in the 1960s, a North American World Health Organization (WHO) consultant was engaged to plan and implement a post basic two-year diploma course to help prepare nursing tutors, administrators, and supervisors (Akiwumi, 1992), and this introduced a problem-solving approach to teaching and learning in nursing education. As nurses' roles expanded, the evolution of nursing education and practice in Ghana changed in order to keep pace with the dynamics and health demands engendered by the expansion of health knowledge and technology, as well as the move to increase specialization within the healthcare system (Akiwumi, 1992). The current levels (both diploma and baccalaureate) of professional nursing education in Ghana use similar clinical teaching approaches. In Ghana, formal clinical nursing education started in the early 1990s in the form of preceptorship, when nurses were invited from various regions by the NMCG in collaboration with the MoH to participate in a preceptorship workshop (Atakro & Gross, 2016). Preceptorship is a one-on-one clinical education model in which an educational relationship provides preceptees with access to proficient role models within a fixed and limited time frame (Moore, 2009). In a collaborative model of preceptorship, the preceptor, faculty, and student form a triad to facilitate the student acquisition of clinical competence. Although the faculty member has ultimate responsibility for student learning outcomes, the preceptor is empowered to conduct formative and summative evaluations of the student's clinical performance and learning outcomes (Billings & Halstead, 2009). It is important to note that the proper use of preceptors requires that planning and education be done to ensure an understanding of the roles of preceptors and faculty. The notion underlying the formal preparation of preceptors in Ghana was to create a liaison between hospitals and health educational institutions to facilitate the connection of theory to practice (Asirifi et al., 2013).

Evidence Based Significance

Preceptorship practice is an important aspect of nursing practice as it provides opportunity for novice nurses or student nurses to learn and acquire needed professional knowledge and skills to make them more confident, effective, and efficient in their professional role as nurses (Benner, 1984). Acquiring such knowledge makes the role of the preceptor critical in the process. Thus, preceptors have proven to be an important resource in nursing practice with the knowledge, experience, and skills they impact on students and novice nurses on preceptorship program. The importance of the preceptor, precepting new nurses and nursing/midwifery students as well as the entire preceptorship program are incredibly significant to nursing practice.

According to the American Nurses Association (2010), advanced practice nurses have the responsibility to mentor other nurses and colleagues and serve as a role model by advancing clinical and professional practice and experience. Preceptors serve a vital role in supporting a new employee's transition and assimilation into their new role and should be selected and carefully trained based on pedagogical concepts (Carlson, 2013; Robitaille, 2013). Preceptors' welcome new employees into an organization and guide them through the orientation process and beyond. Preceptorship practice is an important aspect of nursing practice as it provides opportunity for novice nurses or student nurses to learn and acquire the necessary professional knowledge and skills to make them more confident, effective, and efficient in their professional roles as nurses. Acquiring such knowledge makes the role of the preceptor critical in the process. Thus, preceptors have proven to be an important resource in nursing practice with the knowledge, experience, and skills they impart to students and novice nurses in preceptorship programs. The importance of the preceptor, precepting new nurses and nursing students, as well

as the entire preceptorship program are incredibly significant to nursing practice (Omer & Moola, 2019). Preceptor responsibilities should be clearly defined, and training should include communication and conflict management, as well as prepare the preceptor for potential challenges that may arise and provide strategies on how to address these issues (Carlson, 2013; Robitaille, 2013).

Effective Preceptorship Practice

Since the 1980s, the preceptorship model has become a cornerstone of clinical nursing education. However, the literature shows that there are some pervasive challenges to the effective practice of preceptorship. The first key challenge involves the actual selection of preceptors. If preceptorship is to be effective, then it is vital that selection must be careful, and criteria are established. Research indicates that the most important features of a preceptor are personal qualities, clinical and teaching skills, and motivation (Burke, 1994).

Helmuth and Guberski (1980) argued that the preceptor needs to be self-confident, responsible, and accountable for education/service-oriented practice, to be able to adapt to changes and feel secure as a practitioner and role model. They also thought that preceptors must be able to demonstrate, analyze, critique and act skills in new primary care clinical situations, and finally must be able to relate to patients especially in educative services. In Ghana, selection of preceptors is a challenge because of the lack of any real incentive for experienced nurses to precept.

Another challenge revolves around the preparation of preceptors. Evidence in the literature shows that preceptors perform better when they are educated through a preceptorship program. Al-Hussami et al. (2011) conducted a study with the purpose of implementing and evaluating a preceptor training program among nurses. Results showed that participants'

knowledge on preceptorship improved significantly after a preceptorship education program (Al-Hussami et al., 2011). Currently, there is no formal structure for educating preceptors in Ghana (Asirifi et al., 2013). In order to prepare the preceptors, it should be made clear to them what constitutes their role. Shamian and Inhaber (1985) concluded that preparation should include a description of this role and the expectations from it, introduction to adult teaching and learning theory, teaching theories, and the art of giving and receiving feedback as well as evaluation.

Finally, to ensure that a preceptorship program continues to function and develop, preceptors should have the nurturance and support they need from the institution, management, and peers. In addition to preceptors deriving satisfaction from the intellectual stimulation and responsibility of their role, more tangible rewards such as promotion, status, educational development, and financial gains would be a fair recognition of their demanding role.

Ghana Health System and Preceptorship

Health service in Ghana operates a decentralized administrative structure with the country divided into 16 regions, with the Greater Accra region being the home of the national capital. The decentralized structure is very hierarchical in nature from national to the sub-district, which follows a four-tier system: national, regional, district, and sub-district levels. Health care is also decentralized along the administrative structure with the community level serving at the first point of the primary health care system. There are also clinics and health centers at the sub-district which are often manned by nurses and headed by physician assistants. At the district and regional levels are hospitals which are headed by medical officers and provide the secondary

level of health care. The tertiary level is provided by the teaching hospitals which are in the Northern, Ashanti, Greater Accra, Volta, Bono Ahafo (Sunyani), and Central regions of Ghana.

The health care system in Ghana is confronted with the formidable task of improving and guaranteeing the health and well-being of the Ghanaian people. The system has the responsibility of combating illnesses associated with poverty and lack of education, while at the same time dealing with a growing population, inadequate funding and resources, and an increasing burden on the health care system due to the HIV/AIDS epidemic (World Bank, 2019). While Ghana's GDP per capita—$2,202.13 in 2019 according to the World Bank (2019)—has come a long way, the country continues to face economic challenges that are reflected in the nation's poor health sector. According to the Ghana Ministry of Health (2015), these are a few of the challenges that the health sector faces:

1. Continuing inequities in access to essential health services especially in deprived areas
2. Slow improvement in neonatal, infant, and maternal mortality
3. Weak and ineffective coordination of blood services
4. Weak systems and structures for performance monitoring, supervision, and management
5. Inadequate number of tutors in health training institutions

Against a backdrop of "brain drain," the recruitment of health workers, particularly physicians, remains a challenge and has created daunting shortages in the health sector. As health workers age and recruitment remains stagnant, these shortages have hindered the operational capacity of many lower-level facilities, including community-based health planning and services (CHPS). The training of physicians is also low relative to the country's needs. These low levels of training are attributed mainly to pre-service training being concentrated in just a few cities.

Responding to this, the national government, since 2014, has been implementing efforts to set up tertiary teaching hospitals as training grounds for physicians in more regions and districts to render cardio-pulmonary resuscitation.

Generally, Ghana has been facing a shortage of healthcare personnel. The doctor-to-patient ratio was 1:10,000 in 2010 and 1:9,043 in 2014 while the midwife to patient ratio was 1:1077 in 2010 and 1:1374 in 2014 (Ghana Health Service, 2015). More concerning is that the distribution of the health workforce is largely skewed to the two popular urban cities in Ghana: Accra and Kumasi (Ghana Health Service, 2015) while rural hospitals have fewer and less qualified health personnel. Consequently, the small health workforce is compelled to work for extremely long hours without rest amidst poor working conditions. This results in substandard healthcare with most health workers feeling that they are not being rewarded commensurately for their efforts (Adua et al., 2017). With these challenges in mind, it is clear to see why the choices of how to use Ghana's scarce resources to positively affect health care are important. Following periods of severe health workforce shortages in Ghana, in 2006 the Government—through the MoH—responded by embarking on a drive to expand and liberalize (allow profit-driven private sector participation) the training of health workers especially nurses and midwives, which translated into increased enrolment in the various nursing and midwifery training schools resulting in the production of nurses and midwives at levels that outstripped the Government's projections at the time and the available fiscal capacity to absorb the new graduates (Asamani et al., 2020).

In Ghana, preceptorship has become the most common teaching approach used in clinical education in nursing. Recognizing the importance of preceptorship, the Ghanaian government introduced the practice in the early 1990s to enhance the effectiveness of clinical teaching.

Senior and qualified nurses from various regions of Ghana were trained as the first cohort of preceptors in 1990 (Ghana Ministry of Health, 2015). This first cohort of preceptors were then supposed to act as facilitators to prepare more preceptors in their respective regions of Ghana to enhance clinical teaching and learning (Ghana Ministry of Health, 2015). As a further step to effective health services delivery, the nursing and midwifery educational institutions in Ghana formally introduced preceptorship in nursing education as the primary source of teaching and supervision in the clinical settings (Asirifi et al., 2013), thereby mandating all nursing students to undergo this training before final completion of their nursing education. This preceptorship component of their curriculum is known as clinicals.

Although the concept of preceptorship has been ingrained into the teaching curriculum in Ghana, it is poorly implemented because of myriad challenges. Such challenges include lack of common understanding for implementation of preceptorship model between nursing schools and health service delivery facilities administration, for example, hospitals, community health centers, and teaching hospitals. Thus, there is no shared knowledge between nursing schools and these facilities. Additionally, the roles of nursing preceptors in Ghana have not been defined or recognized and accountability for student learning is diffused among staff nurses (Asirifi et al., 2013). Furthermore, there is a huge discrepancy between the number of students to be trained and the number of trained preceptors and lecturers. This great variation meant that the students to be trained continually suffered from a lack of access to the preceptors they need. Moreover, with increasing number of students flooding the ward, there is little or no collaboration between nursing and midwifery educational institutions (Asirifi et al., 2017).

Some of these studies, particularly in Ghana, showed that a high student to preceptor ratio resulted in limited attention to student nurses (Asirifi et al., 2019). Also, the studies showed that

external stakeholders—NMCG and MoH, the Ghana Health Service (GHS), Health Training Institutions (HTI), and health care facilities—play a critical role in ensuring a successful preceptorship program (Ghana Health Service, 2015). The current study will further examine the nature of preceptorship in Ghana by specifically looking at perspectives from implementors. Also, the study will assess the preceptorship program in Ghana from the perspectives of the external stakeholders or policy makers and regulators of nursing and midwifery council education in Ghana.

Purpose of The Study

The purpose of this dissertation is to explore the practice of preceptorship in the Ghanaian context using selected students from nursing/midwifery institutions, tutors/faculty, policymakers—MoH, GHS, NMC, and Ghana nurses and midwifes association, Ghana college of nurses and midwives, nurses/midwifery managers, preceptors, directors, administrators in hospitals, the universities schools of nursing/midwifery and documents on the situation in the healthcare institutions—in order to gain visibility into the workings of the preceptorship program in Ghana. In its current form in Ghana, preceptorship faces some significant challenges that weakens its effectiveness (Asirifi et al., 2019). Similarly, a study conducted in South Africa identified challenges in preceptorship such as ineffective communication between preceptors and preceptees, and inadequate preparation, which challenged learning outcomes (Lethale et al., 2019). In doing this, the qualitative method of situational analysis will be utilized to examine the factors that may enable its effective and productive implementation. Systems theory was applied when necessary. As preceptorship occurs within a system which is interdependent, it becomes important that the entire system and its various components are explored to be able to identify that part of the system where silent voices and, major gap exist and to proffer solutions.

Study Goals

The researcher seeks to explore the current model of preceptorship as it is practiced in Ghana with the aim of identifying the barriers to an effective and robust preceptorship program in Ghana as well as examining the factors that may enable its effective and productive implementation. The goals of this initiative are manifold. They include strengthening preceptorship for students who are yet to complete college and for newly qualified ones to experience the benefits of their nursing and midwifery education in terms of knowledge, skills acquisition, confidence, and professional socialization. Another goal is to increase the body of knowledge in nursing and midwifery, while also ensuring the effective development of students, so that these students could in turn provide a higher quality of care to patients. Generally, the primary objective of the study is to explore the nature of preceptorship practices in healthcare delivery services in Ghana. The secondary objectives include the following:

1. To examine the model/standard practices of preceptorship in selected healthcare training institutions in Ghana.
2. To identify challenges associated with preceptorship practice in clinical teaching in nursing/midwifery education in Ghana.
3. To explore the enabling factors in preceptorship practice in healthcare delivery in Ghana.
4. To assess the role of stakeholders (external/internal) in the implementation of preceptorship in Ghana.

Research Questions

The following are the central research questions addressed in this research:

1. What is the nature of preceptorship approaches and practice in nursing/midwifery education in Ghana?

2. What are the challenges associated with preceptorship practice in clinical teaching in nursing/midwifery in Ghana?
3. What are the enabling factors influencing preceptorship practice in clinical teaching in nursing/midwifery in Ghana?
4. What is the role of stakeholders (external/internal) in the implementation of preceptorship in Ghana?

Significance of the Study

Preceptorship is an important concept that has gained prominence in nursing literature. It refers to the orientation and training that a newly registered nurse or student nurse in a facility goes through to become acquainted with the job environment and acquire extensive knowledge and skills and to be able to perform effectively in his/her role as a nurse (Myrick, 2002). Experienced nurses who provide this education and training to these new nurses or student nurses are called preceptors. Preceptorship is noted to play a vital role in healthcare delivery because of the complex and challenging nature of the healthcare environment. For instance, Myrick (2002) reported that preceptorship fostered critical thinking through preceptor role modeling, facilitating, guiding, prioritizing, questioning the student's knowledge base, decision-making skills, and actions.

Further, the preceptorship approach to clinical teaching creates an opportunity to connect nursing education and practice, foster an ethos for critical thinking for both preceptors and preceptees, and contributes to professional development (Billay & Yonge, 2004; Dube & Jooste, 2006; Myrick & Yonge, 2005). Recognizing the importance of preceptorship, the Ghanaian government in the early 1990s invited nurses from various regions in Ghana to participate in

preceptorship training. The nurses who were prepared as preceptors were then supposed to prepare more preceptors in their respective regions to enhance clinical teaching and learning.

A comprehensive exploration of preceptorship in selected nursing/midwifery training and healthcare institutions in Ghana will give an insight to current preceptorship program as it obtains in Ghana and thereby offer opportunity for recommendations for improvement. Additionally, this research work will serve as a useful document to assist National and Institutional health services policy makers within Ghana to formulate policies and hold discussions that could lead to a more robust preceptorship program that will translate to effective health services delivery via the training of efficient nurses and mid wives. Furthermore, it could serve as useful public information for the global audience.

Preceptorship practice is an important aspect of nursing practice as it provides opportunity for novice nurses or student nurses/midwives to learn and acquire needed professional knowledge. Furthermore, preceptorship enable them to have requisite skills to make them more confident, effective, and efficient in their professional role as nurses (Jamshidi et al., 2016). Acquiring such knowledge makes the role of the preceptor critical in the process. Thus, preceptors have proven to be an important resource in nursing practice with the knowledge, experience, and skills they impart to students and novice nurses on preceptorship program. The importance of the preceptor, precepting new nurses and nursing students as well as the entire preceptorship program are incredibly significant to nursing practice (Myrick, 2002).

Position of the Researcher

My research study explored the barriers and enablers of preceptorship from multiple data sources. It sought to give a broader and detailed understanding of the phenomenon from different local levels, hence using the qualitative methodology of situational analysis. It is my hope that

these theoretical principles will help me to take a philosophical position grounded in constructivist and interactionist perspectives. Thus, the philosophical and epistemological underpinnings of this proposed study will be pragmatism, symbolic interactionism, and constructivism from Blumer (1969), Cooley (1998), Dewey (1981), James (1909/1975), and Mead (1937) to mention but a few. Insights from these scholars in terms of meaning, knowledge acquisition, and learning are relevant when exploring and analyzing issues of a social nature that are complex and multi-dimensional as in the case of understanding the barriers and enablers of preceptorship, which the current study explored. From the perspectives of these epistemological standings, there is no objective truth to discover, but all is acquired when people take action to obtain it as well as interact with the environment. Symbolic interactionism for instance is centralized on symbols, self, mind, taking the role of other action, social interaction, and society. It sees humans as social thinking beings who define, interpret, and actively participate in their environment, learn, and understand through interaction. The interaction between people helps to understand perspectives of others and aid individuals to learn their roles. The focus of symbolic interactionism is causally related to nursing education and preceptorship where nursing students, tutors, preceptors, and policy makers all interact in a way that impact on preceptorship practice. As a result, I utilized these paradigms and intentionally positioned myself within the process of understanding the phenomenon into details in a natural but complex and interrelated setting. Being part of the healthcare system for many years I have had some understanding of the context of the current study and its ability to aid in data collection and put systems and structures in place.

Study Methodology

In choosing a methodology, the researcher takes into consideration his or her skills and expertise as well as the phenomenon that is being investigated and the research questions. Being a professional nurse/midwife and educator in leadership role with years of experience in Ghana, and as a PhD scholar practitioner, I familiarized myself with several interesting concepts and areas and settled on situational analysis as my methodology of choice. Additionally, because of the nature of preceptorship practice in Ghana, situational analysis is perfectly suited to examine this concept in more detail.

According to Clarke (2005, 2014), situational analysis considers the broader perspective of the situation by focusing on the social ecology and situation, which helps the researcher to explicitly account for individual, collective, and contextual factors as well as interrelatedness of data. In effect, situational analysis considers the various discourses that seek to shape humanity or the situation (Clarke, 2014).

Situational analysis consists of three main tools which are applied to overly complex situations and provide robust analysis. These tools consist of three main mapping procedures: situational maps, social worlds/arenas maps, and positional maps. *Situational maps* descriptively present the human, nonhuman, and discursive elements in the situation. *Social worlds/arenas maps* are created for meso-level analysis of the social arenas/social worlds within which collective actors, human, and nonhuman elements are engaged among themselves. They are grounded in symbolic interactionism theory (Blumer, 1969) and focus on the collective understanding individuals make of the situation (Clarke & Star, 2007). *Positional maps* provide a depiction of the differing positions or controversies present within the situation of inquiry. These

maps also allow for the articulation of “silences” and analysis of the “space between” positions (Clarke, 2005). That is, they unearth the silent voices to be heard.

Together these mapping strategies provide new ways of looking at the situation and offer more thorough analysis. The purpose of constructing these maps is to get the researcher thinking about the different elements within the situation and the relationships between the elements (Clarke, 2003, 2005, 2014). The study utilized purposive sampling and main data were derived from one on one (primary) in-depth interviews with participants who have adequate and extensive knowledge of the phenomenon to be explored.

Limitations of the Study

The study was limited to selected nursing institutions in selected regions of Ghana and covered 11 of the 16 regions in the country. The focus of the study was restricted to the developing world context which becomes a major limitation to the study. Further the concept of preceptorship in this study was only third and fourth year nursing/midwifery students in the colleges and school of nursing/midwifery, preceptorship, and tutors/lecturers/faculty members, nursing/midwifery heads, administrators, directors, ward managers, and in-charges, and will not include novice nurses who also need extra training to enhance their knowledge and skills.

Operational Definitions

The following operational definitions were used in this study:

Clinical education: Application of the knowledge, skills, and relevant attitudes that nursing students learn in the classroom to a real-life clinical setting or situation through guidance and supervision by staff nurses, preceptors, nurse managers, or clinical instructors.

Clinical instructor: A nurse educator who guides, supervises, and evaluates practical experience and educational preparation of nursing students in the clinical setting or who

facilitates such activities in collaboration with preceptors or staff nurses who are performing such activities.

Clinical teaching: The process of teaching students to put theory into practice in a healthcare or community environment (or other places where nursing practice exists).

Clinical setting/field/site: Health care agencies, including hospitals, community settings, etc. in which student nurses are assigned to undertake their clinical experience.

Clinical instructor: A nurse educator who guides, supervises, and evaluates practical experience and educational preparation of nursing students in the clinical setting or who facilitates such activities in collaboration with preceptors or staff nurses who are performing such activities.

Faculty: Nurse educators who teach at the universities or the college educational institutions. They may or may not be engaged in clinical teaching but have influence over how student clinical practice is planned, implemented, and evaluated.

Healthcare services: Use of health care providers to deliver services to achieve the best possible health outcomes of individuals, families, and the community.

Healthcare system: The approach to organizing people, institutions, finance, and other resources to deliver health care services to meet the health needs of a population.

Healthcare institutions: They are organizations that provide health service and related services to inpatient and outpatient care, such as diagnostic or therapeutic, laboratory, pharmacy, and other health services.

Nurse educator: A registered nurse who is qualified to teach and who is teaching nursing students in the university or college educational institution.

Nursing student: An individual pursuing nursing education at the baccalaureate or diploma level in a nursing educational institution in Ghana. These nursing programs in Ghana lead to eligibility for licensure at the RGN level.

Preceptor: A clinical nurse who provides practical experience and educational preparation to nursing students ideally on a one-to-one basis.

Professional nursing education: Nursing education that leads to licensure as a registered general nurse (SRN in Ghana).

Stakeholders: Individuals involved in nursing education in Ghana such as clinical faculty, academic faculty, staff nurses, clinical agency preceptors, students, recent graduates, Nurses and Midwife's Council for Ghana, Ghana Nurses' and Midwives Association, and Ministry of Health for Ghana.

Chapter Summary and Outline of Succeeding Chapters

This chapter explored the background of the study by setting the study in context. It continued to examine preceptorship situation in the Ghana Health System. Also, this chapter presented the objectives, questions, purpose, significance, study methodology, and limitations of the study as well as operational definition.

Chapter II critically reviews literature of the study by first explaining how literature searches were done to obtain relevant information for the study. The definition of preceptorship was used to examine the concept of preceptorship from global, African, and Ghanaian perspectives. Theories and concepts relevant to the study are discussed after examining the nature of preceptorship. Issues are explored of developing preceptorship programs, standard practices of preceptorship, preparation of preceptors, barriers of preceptorship, enablers of preceptorship, support for preceptors, and approaches to preceptor evaluation of students.

Finally, I discuss reflection, summarize of key themes, identify gaps, and reach an overall conclusion.

Chapter III is focused on the methodology of the study and begins with some general methodological background. It continues with a historical perspective of situational analysis that explains the concept and its characteristics. Other issues discussed are study design, study area, target population, inclusion and exclusion criteria, sampling, data collection, situational analysis, data collection tools, data collection procedure, data transcription, data analysis, coding, memo writing, field notes, constant comparison, ethics, trust worthiness, challenges. The chapter ends with a description and reflections on adjustments in the research that were made due to global COVID-19 pandemics.

Chapter IV covers the analysis of data derived from in-depth interviews, focus group discussions, and discourses using Clarke's (2005) situational mapping strategy which was the analytical technique used for the study. The first section of this chapter starts by presenting the various maps that were created from the beginning of data gathering and the final maps utilized for discussions in the study. In this way, it begins with messy maps, ordered, relational, social worlds/arenas, and positional maps which come at the end. The second section provides the interpretation of the key maps that ended up in the final stage of the study for discussions in the next chapter.

Chapter V discusses the results of findings and relate it to the literature of the study supported with direct quotes from respondents. After that, I continue to highlight the limitations of the study and its implications for research, practice, and policy. I focus the discussions on the key issues arising from the study and note which issues are critical to the broader framework of the preceptorship paradigm under study. I began with the challenges of the preceptorship model,

proceed to the enabling factors of preceptorship, and then talk about the major contentions which form potential issues affecting the model. I then highlight the main silent voices, new findings from the study, relate findings to the two main theories, and, finally, look at study limitations and implications for research, recommendations, and conclusion.

CHAPTER II: LITERATURE REVIEW

This chapter explores the existing literature on the relationships of various studies about the specific topic (Cook et al., 2012; Greenhalgh & Peacock, 2005). It systematically identifies relevant studies, allows for consolidation of studies on a particular topic, builds on previous knowledge, and identifies omissions or gaps in the literature (Grant & Booth, 2009). It helps researchers glean the ideas of others interested in a particular research question and lets them read about the results of other similar or related studies (Onwuegbuzie et al., 2012). The purpose of this specific literature review was to explore published work on the challenges of preceptorship practice in nursing/midwifery and health facilities and to capture the factors that enable its effective implementation.

Search Approach

The following six main electronic databases were searched: PsychInfo, EBSCO, ERIC, CINAHL, PubMed, and Google Scholar. The main keywords used during the search included the following: preceptorship, origins of preceptorship, preceptorship and nursing, barriers of preceptorship, enablers of preceptorship, nursing preceptorship, preceptorship and standards, international perspectives on the practice of preceptorship, clinical training, nursing students, Africa, and Ghana. The criteria for inclusion were empirical articles published in English, articles published in the past 10 years. These included empirical articles on preceptorship, empirical articles published in peer review journals, other documents; archival materials, formal and informal documents in the public domain and empirical articles being quantitative or qualitative or both. Titles and abstracts of articles were scanned to ensure relevance and were retrieved and read to gather the most important information related to the research question.

Additional sections of this review comprise seven main bodies of literature: the definition of preceptorship, the international perspective on preceptorship, systems theory, Benner's (1984) "novice to expert" nursing theory, development of a preceptor training program, standard practices of preceptorship, empirical studies on preparation of preceptors, barriers of preceptorship in healthcare delivery, enablers of preceptorship, and preceptors' evaluation of students in preceptorship, and a closing summary of key themes and identifying gaps in literature.

Defining Preceptorship

Definitions of preceptorship differ slightly from each other depending on how the specific institution or author is applying the model of preceptorship in practice; however, what they all have in common is the establishment of preceptorship for a defined period of time where learning occurs from an experienced, competent role model. Preceptorship has been defined as a

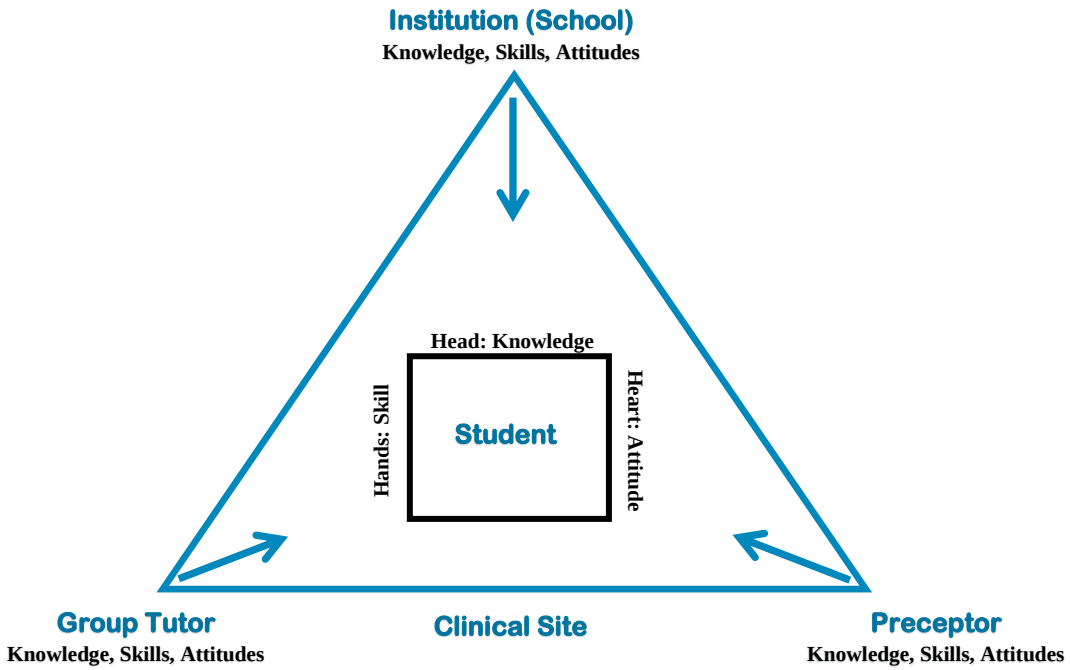
> frequently employed teaching and learning method using [staff] as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced [staff member] (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role. (Rose & Best, 2005, p. 5)

Myrick (2002) reported that preceptorship fostered critical thinking through preceptor role modeling, facilitating, guiding, prioritizing, questioning the student's knowledge base, decision-making skills, and actions. The preceptorship approach to clinical teaching provides an opportunity to connect nursing education and practice. Preceptorship facilitates critical thinking for both preceptors and preceptees, and contributes to professional development (Billay & Yonge, 2004; Dube & Jooste, 2006; Myrick & Yonge, 2005). Moreover, support from preceptors enables newly hired and student nurses to apply knowledge, skills, and qualities in the clinical setting to facilitate the transfer from novice to expert. Although, published literature on preceptorship has shown that the practice plays a vital role in healthcare delivery (Myrick, 2002),

most of these studies come from developed countries (Hilli & Melender, 2015; Oosterbroek et al., 2017), with little research on the practice of preceptorship being conducted in developing countries like Ghana. Figure 2.1 shows the staff and other non-human elements within the "triad" responsible for educating the student: the nursing and midwifery institution (school), tutor, and preceptor.

Figure 2.1

Triad of Education for Preceptorship



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The diagram shows the staff and other non-human elements within the triad responsible for educating the student: the nursing and midwifery institution (school), tutor, and preceptor. The triad has the clinical site on its base where students applied the theory, they have learned in the classroom into practice using clients under supervision. Overall, the purpose of preceptorship is to assist new staff and/or students to adapt to their roles, develop clinical skills and thus gain

job satisfaction (Lee et al., 2009). Additionally, preceptorship provides an opportunity for lifelong learning and support for continuing professional development, thus possibly contributing to improved recruitment and retention.

The literature reveals that preceptorship faces challenges in African countries such as Ghana and South Africa. A study conducted in South Africa identified challenges in preceptorship such as ineffective communication between preceptors and preceptees, and inadequate preparation, which challenged learning outcomes (Lethale et al., 2019). Similarly, Asirifi et al. (2019) identified that the challenges preceptors face in Ghana weakens effectiveness.

The concept of preceptorship goes back to the 1960s in the United States where its principal aim was to socialize the novice nursing graduate into a clinical practice area. The actual term, "preceptorship," was first used by Kramer (1974) to describe how nursing students were being taught (Billay & Yonge, 2004). Since then, the concept has been applied to various professions and, as a result, there has emerged a variety of definitions of preceptorship as well as various synonymous terms in the literature. Kaviani and Stillwell (2000) described preceptorship as a short-term teaching and learning relationship with an experienced role model with the goal of assisting the newly qualified practitioner into the clinical environment. Nisbet (2006) described preceptorship as follows:

> A short-term process of support and guidance, whose purpose is to integrate, support and assist the development of professional competence and to enable newly qualified practitioners to consolidate their knowledge and reflect on their practice, thus promoting independence and clinical proficiency. (p. 52)

According to Alspach (2000), preceptorship is an organized program, which facilitates the integration of nursing/midwifery students into their future roles as professional nurses/midwives. In brief, it refers to orientation and training that a newly registered nurse or

student nurse (or midwife) in a healthcare facility goes through to become acquainted with the job environment and acquire extensive knowledge and skills to be able to perform effectively in his/her role as a nurse/midwife (Myrick, 2002). This process creates educational awareness, where the student experiences and learns from role modeling, effective assessment, immediate feedback, and meaningful evaluation. Preceptorship is considered to be community-based teaching in which the teaching of a medical or nursing novice by a preceptor is undertaken in an office or clinical setting (Hilli & Melender, 2015; Myrick & Yonge, 2005) with the aim of supporting student nurses to apply theoretical knowledge, skills, and qualities in a clinical setting to facilitate the transfer from novice to expert.

Benner's (1984) novice to expert theory identified the five levels of experience that highlight the stages of knowledge and skill acquisition that student nurses/midwives go through to gain competence. In the earlier stages, it was shown that clinical teaching enhanced the connection between theory and practice. Intriguingly, preceptorship has been found to be one of the leading clinical teaching approaches in contemporary nursing practice that serves to strengthen this connection (Hilli & Melender, 2015; Myrick & Yonge, 2005). Therefore, preceptorship programs need to be effective to facilitate true learning and skill development for both students and newly hired staff nurses. Furthermore, it is worth noting that preceptorship fosters critical thinking through preceptor role modeling, facilitating, guiding, prioritizing, and assessing of the student's knowledge base. It also enhances the student's decision-making capabilities, staff acceptance, and contributes to overall professional development (Dube & Jooste, 2006; Myrick, 2002; Myrick & Yonge, 2005). Experienced nurses who provide this education and training to the new nurses or student nurses are called preceptors and

preceptorship is noted to play a vital role in healthcare delivery because of the complex and challenging nature of healthcare environment.

International Perspectives on the Practice of Preceptorship

According to the Bureau of Labor Statistics, U.S. Department of Labor (2018), employment of registered nurses is expected to grow 15% from 2016 to 2026, which is much faster than the average compared to all other occupations. This figure is aligned with Medas et al.'s (2015) estimate suggesting that by 2020, there will be a shortage of more than 400,000 nurses in the United States alone. Consequently, institutions must provide nursing graduates with the support they need to build the confidence and clinical reasoning skills required for the delivery of safe patient care (Little et al., 2013).

In the late 1970s, nurse residency programs (NRP) were established to decrease "reality shock" (Kramer, 1974, book title). In the 1980s, the emphasis shifted to change theory and constructive abatement for handling of "transition shock" (Duchscher, 2009, p. 1103), resulting in increased retention and improved performance. Since the 1990s and with the increasing recognition of nurses as full-fledged professionals, many NRPs are now based on Merton's three-stage theory of professional socialization:

- knowing—the academic stage (becoming);
- transition stage—initial three months post-hire; and
- affirming/integrating—the integration stage, four months to one year (Kramer et al., 2013).

Goals of the transition stage of professional socialization in nursing is similar to medical internship or clerkships and include clinical skill development and practice (Benner & Wrubel,

1982) as well as practice in planning, organizing, and providing safe care to selected patients under the guidance, support, and protection of a preceptor.

Residency programs are critically important due to the current shortage of nurses and because the aging population of experienced nurses are approaching retirement. The aging nursing workforce will compound the nursing shortage problem. Thus, it is vital that new nurses are comfortable and confident in their roles (Theisen & Sandau, 2013). Nursing Residency Programs facilitate the integration of Newly Licensed Registered Nurses (NLRNs) into a professional practice role through competency development in seven management areas. NLRNs consistently identify seven management skills as areas of very high concern during their transition and integration into professional practice—delegation, collaborative nurse-physician relationships, feedback to promote self-confidence, autonomous decision making, prioritization, constructive conflict resolution, and getting my work done/utilizing the nursing care delivery system (Kramer et al., 2013; Kramer & Schmalenberg, 1977; Schmalenberg & Kramer, 1979). In a nationwide preparation-practice gap survey (Berkow et al., 2009), more than 5,000 frontline nurse leaders ranked NLRN lack of proficiency in these seven areas as the very lowest of 36 competencies that are essential to safe and effective nursing practice.

Kramer et al. (2013) conducted a study to find out what NRP components and strategies were effective in each area; they found that some strategies were identified as effective in developing competency in more than one of the seven management issues. For example, similar strategies were mentioned for delegation, prioritization, and for getting work done areas. Other strategies were identified as effective for collaboration and clinical autonomy. In particular, the study strongly recommended implementation of the following two components/strategies: creation of a Preceptor and/or Clinical Coach Council in the hospital committee structure and the

delivery of Evidence-Based Management Practice (EBMP) projects. These Councils foster development of training and education programs for Preceptors and Clinical Coaches as well as promotion of formal and informal discussions of role enactments and performance improvements. The projects were helpful not only to NLRNs but also to experienced nurses who explained: “EBMP [Evidence-Based Management Practice] projects stimulated me to improve my practice. When I helped my resident with her EBMP project, I learned the steps of evidence-based practice that I had not learned in school.”

In Canadian undergraduate nursing programs, preceptorship is typically described as a formal one-to-one relationship between a nursing student and registered nurse that extends over a pre-determined length of time (Canadian Nurses Association, 2004). Sedgwick and Harris (2012) offer a critique of the undergraduate nursing preceptorship model in Canada and explain why it might be a good idea to question the effectiveness of the model in the face of persistent challenges.

Since the 1980s, the preceptorship model has become a cornerstone of clinical nursing education. Given that the use of the model is extensive, most Canadian programs are very dependent on preceptors to guide their students (Pringle et al., 2004). Furthermore, because of its wide use, many nurse scholars believe that preceptorship provides the perfect medium to bridge theory and practice (Myrick & Yonge, 2005) and a way to facilitate the transition from student to graduate nurse role for the majority of nursing students (Heath & Australia Department of Health and Ageing, 2002). However, from an education and health sector perspective there is still significant concern about the clinical learning and teaching components of undergraduate nurse education (Barnett et al., 2008). Indeed, ongoing restructuring within the Canadian health care system juxtaposed with mandated increased seats in nursing programs has taxed clinical practice

settings beyond their capacity. The unstable nature of the clinical practice setting as a learning environment coupled with the challenges associated with a faculty workforce shortage illuminates the limitations of the preceptorship model of clinical instruction.

These limitations ultimately create challenges for students in meeting program objectives. Although Canadian nursing programs are faced with many challenges, Sedgwick and Harris (2012) believe that some of these challenges may very well undermine the effectiveness of the preceptorship model of clinical education. Indeed, many programs are faced with organizational and operational challenges. For example, inconsistent selection practices and preparation of preceptors (Udlis, 2008) as well as pressures to conform to the curriculum and traditional academic calendar (Mannix et al., 2006) suggest that programs have little control over the quality of the learning experience. Furthermore, because the clinical setting is characterized by high patient acuity levels, shorter patient hospital stays, staff shortages coupled with an increased casualization of the workforce, mandatory overtime, and a heavier workload, one is left to wonder if the current healthcare setting is an optimal learning environment (Hall, 2006).

Not only are nursing programs faced with a limited number of clinical placements, but clinical sites can often make ineffective use of students' time and provide a varying quality of learning opportunities. If nursing programs are faced with a faculty shortage, that may imply that faculty members do not have the breadth of expertise required to provide the clinical teaching and supervision that students need, and preceptors want (Sedgwick & Yonge, 2009). It is a concern then that regardless of Lusted's (1986) call to critically examine teaching and learning practices and, by extension, clinical nursing education models, schools of nursing are becoming increasingly dependent on the availability of preceptors as students complete their program and more experiences are sought for them in highly specialized practice areas (Pringle et al., 2004).

In the United Kingdom, nursing education has been university-based since the mid-1990s, but despite careful preparation and assessment of student nurses, it has been considered necessary to provide a period of additional support for newly qualified nurses (NQNs) to help them settle into their new role and responsibilities. It has been recognized that the transition from student to registered nurse can be a difficult one for NQNs (Whitehead et al., 2016). Because the move from the apprenticeship model of nurse education to the university-based system raised concerns about the preparedness of the practitioners from the new system, the nursing regulatory agency, the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, recommended that all NQNs undertake a period of preceptorship.

In the context of nursing in the UK, preceptorship has a specific professional description: "The process through which existing nurses and midwives provide support to newly qualified nurses and midwives" (Nursing & Midwifery Council, 2008, p. 46). The regulator went on to explain that preceptors should have at least one year's experience and a teaching qualification. This specificity is in contrast to the variety of definitions for preceptorship in overseas literature. In some countries outside of the UK the term 'preceptorship' is usually used to describe a nurse who teaches students and other learners in the clinical area (Sharples & Elcock, 2011).

Whitehead et al. (2013) conducted a systematic review of the published literature related to the development of preceptorship in supporting NQNs in the UK and found that there is strong evidence that the newly qualified nurse benefits from a period of supported and structured preceptorship, which translates to improved recruitment and retention for the employing organizations. Not only do these newly qualified staff benefit from this kind of structure, but all of the papers agree that they require a period of support following qualification because even when the NQNs can be shown to be competent, they often lack the self-confidence to be

autonomous professionals (Kelly & Ahern, 2008). Robinson and Griffiths (2009) found that the majority of the studies drew attention to "the need for investment in resources such as development of preceptorship programs, training courses for preceptors and work organization that safeguards time for preceptees and preceptors to work together" (p. 17). These constraints are similar to those faced in other countries; thus, they paint a familiar picture and reveal how much progress needs to be made with regard to the global advancement of preceptorship.

In a case study, Whitehead et al. (2016) investigated a UK hospital's preceptorship program with the intention of using the findings to improve the type of support given to NQNs. From their earlier literature review, they already knew that the following issues were important in creating an environment conducive to effective preceptorship: a managerial support framework; recognition and status of role of preceptors; protected time for preceptors and preceptees; educational preparation of preceptors; and that there were existing measurement tools for the outcomes of preceptorship. Therefore, they explored the issues raised in the review in more depth and this led to a number of additional findings including the need for a peer support network for preceptors, technological support processes, and the individualization of preceptorship needs. Further research in this area will be focused on identifying ways to improve preceptorship processes.

In Ethiopia there have not been studies on the utilization and application of nursing preceptorship programs in nursing education. Currently, the quality of nursing practice in Ethiopia is under much needed revision and scrutiny, largely due to the fact that most novice graduates are reported to be lacking the required clinical skills. Thus, introducing preceptorship programs in teaching hospitals and healthcare institutions is one of the fundamental strategies to provide quality healthcare for the public and continue the growth of nursing as a profession.

Because the concept and application of nursing clinical preceptorship is still in its infancy in Ethiopia, the role of nurse educators in teaching clinical skills to students still takes center stage. The Global Nurse Capacity Building Program/Nurse Education Partnership Initiative ran some of the pioneer projects in training preceptors and introducing mentorship programs in Ethiopia (Gossaye & Dohrn, 2013).

The need for implementing a nursing preceptorship program, especially in relation to nurse educators, has been supported by many authors. For instance, it was found that while nurse educators were expected to accompany student nurses, a shortage of staff limits them to lectures in the classroom, resulting in minimal student accompaniment whereas this shortage also makes it difficult for a nurse educator to spend enough time with each student (Cele et al., 2002; Monareng et al., 2009). Additionally, nurse educators that accompany students were also found to manage demonstration of procedures to each student once or twice a week only, instead of daily. Another study found that the ratio of students to nurse educators was too high to allow for effective student supervision in clinical practice, signaling the need for preceptorship (Kemper, 2007). The recommended ideal preceptor to student ratio is one to one (Udlis, 2008).

In Ethiopia, nursing educators are often assigned as clinical instructors for undergraduate students usually beginning from the second year of the four-year program. The nurse educator is not usually accessible to the students at all times, and a clinical instructor or nurse educator is usually assigned to a large group of students, which results in minimal one-to-one practical learning and demonstration sessions. The apparent gap between theory and practice is one of the demanding issues in nursing, both locally and globally. Group interviewees that involved nurse educators showed major areas of concern such as shortness of clinical placements and lack of collaboration between clinical areas and educational institutions, while there was also a mutual

agreement that a theory-practice gap exists, and measures are needed to halt these issues (Corlett, 2000).

Teferra and Mengistu (2017) conducted a study to examine the overall knowledge and attitudes of nurse educators towards clinical preceptorship. According to the results of the study, less than half of the nurse educators who participated in the study were found to have adequate knowledge regarding nursing clinical preceptorship and its related concepts. However, the overwhelming majority of respondents had a favorable attitude towards nursing clinical preceptorship and its application. More importantly, it was found that existing knowledge towards nursing clinical preceptorship among the educators tended to increase with advanced education and longer teaching experiences. Institutions should focus their efforts towards implementing an integrated approach of clinical preceptorship by embracing preceptorship as the core of clinical learning for nursing students, starting with improving the awareness and understanding of the model among nurse educators

Preceptorship in Ghana

In Ghana, preceptorship has become the most common teaching approach used in clinical education in nursing. Introduced in the 1990s, preceptors receive formal preparation in clinical teaching and serve as a liaison to bridge the gap between theory and practice. Contrary to preceptorship as portrayed in the nursing literature (Hilli & Melender, 2015; Oosterbroek et al., 2017), preceptors in Ghana may supervise more than five students at a time with no reduction in their patient workload. Preceptors and their assigned students do not necessarily work the same shift over the entire clinical rotation (Asirifi et al., 2013; Asirifi et al., 2017) and students assigned to a preceptor may be at different levels in their education or from varied disciplines.

While preceptors are identified as the nurses primarily responsible for clinical teaching on clinical units, staff nurses, charge nurses, and in-service coordinators also teach and supervise students (Asirifi et al., 2017). Evaluation of student performance is done by the preceptors or the nurses who supervise students in the setting and submitted to faculty for grading (Asirifi et al., 2013; Asirifi et al., 2017). Clinical faculty members tend to spend limited time in clinical agencies, in part because of assignment to multiple agencies and the amount of time needed to travel between agencies because of severe traffic congestion (Asirifi et al., 2017). In addition, preceptors expect extrinsic rewards such as more pay for their clinical teaching responsibilities. Relationships with students tend to be hierarchical rather than collaborative. In the existing system, power is skewed towards stakeholders like the GHS, NMC, MoH, and the nursing training institutions. These stakeholders hold more power because of their size and authority in the form of legal mandates and government support. Thus, in order to make any sort of significant progress, there needs to be strong collaboration among these groups.

Because of the aforementioned stakeholders' power, groups that end up being marginalized include preceptors and nursing students. For example, in order to address the shortage of nurses, the MoH—jointly with the GHS—implemented a policy to increase the intake of students in nursing schools by more than 200% between 2007 and 2011. However, this was accompanied with little increase in human and material resources allocated to nursing education. Therefore, the provision of optimal clinical education became more challenging, with issues such as poor student supervision in clinical settings, inadequate preceptor support, and inconsistencies in student evaluations arising (Asirifi et al., 2017).

As a consequence of the aforementioned and other challenges, preceptors become less effective at advancing nursing education. By not including the input of preceptors in designing

policy, preceptors' clinical and teaching expertise is marginalized. This results in preceptors feeling devalued and experiencing low self-esteem. These feelings, in turn, affect how they engage with students. Without meaningful engagement and positive nursing role models, students lose interest in nursing careers, and this contributes to the nursing workforce shortage. Evidence in the literature shows that preceptors perform better when they are educated through a preceptorship program. Al-Hussami et al. (2011) conducted a study with the purpose of implementing and evaluating a preceptor training program among nurses. Results showed that participants' knowledge on preceptorship improved significantly after a preceptorship education program. Currently, there is no formal structure for educating preceptors in Ghana (Asirifi et al., 2013).

For preceptorship to become an effective component of nursing education in Ghana, there must be a strong collaboration between nursing training institutions, nursing and midwifery council and the GHS, where preceptors and faculty members are regularly trained on preceptorship model. Regular education on precepting will encourage preceptors, faculty, and students to work together in establishing clear objectives, implementation procedures, and evaluation measures in the preceptorship teaching experience (Asirifi et al., 2013). A survey by Aguwe et al. (2008) concluded that motivations for physicians participating in preceptorship programs included opportunities for continuing medical education credits, faculty development, and other academic-related benefits. In contrast, the roles of nursing preceptors in Ghana have not been well-defined or recognized and accountability for student learning is diffused among staff nurses (Asirifi et al., 2013).

As stated, there is no common understanding between nursing schools and the GHS for the proper implementation of the preceptorship model in Ghana. This presents a serious problem

because it results in an extremely inconsistent level of quality among new nurses. Preceptorship should be redefined by NMCG, GHS, and MoH, in partnership with educational institutions and representatives from health care agencies. Collaborative preceptorship in which preceptors, faculty, and students combine efforts is important in helping students achieve their clinical education goals. There is also a strong need for nursing schools and the GHS to provide better incentives to preceptors and faculty. Perhaps through continuing nursing education credits and faculty development opportunities for nurse preceptors and faculty respectively, so as to ensure effective participation from these groups.

As a result of staff shortages, it is not uncommon to have more students than staff assigned to a particular unit. The inability to provide personalized attention negatively influences students' satisfaction with the clinical experience and subsequent learning. Fewer staff may reduce opportunities for students to be exposed to effective role models and mentors who can be vital to the students' professional development (Atakro & Gross, 2016). Asirifi et al. (2013) conducted a study to explore the perceptions of Ghanaian nursing students, preceptors, and nurse educators regarding their preceptorship experience and found that clinical teaching was heavily influenced by stakeholders such as the MoH and the NMCG. Participants in the Asirifi et al. (2013) study believed that these stakeholders should organize more formal preparation for preceptors because doing so would positively impact their experience. Asirifi (2011) quoted a nurse educator she had interviewed for her dissertation who had:

> highlighted the importance of collaboration in training preceptors: "The school should be in the lead role in identifying the nurses interested in teaching students. Then we [the school] must write to the MoH, NMC and the Regional Health Directorate so that we collaborate to train the preceptors." (p. 21)

Most of the preceptors in her study indicated that they had been specifically educated to supervise students in clinical settings. Also, preceptors were given formal preparation to liaise

with the nursing educational institutions to teach students. One preceptor whom she interviewed described why nurses were trained as preceptors:

> It was identified that when the students come for clinical attachment in the hospitals, they go wayward. Nobody supervises them so some experienced nurses and midwives were prepared as preceptors to help the tutors teach students, especially when the students go for clinical practice in the hospital. (Asirifi, 2011, p. 22)

Another preceptor quoted by Asirifi (2011) expressed her concern about being provided preceptorship preparation only once in her entire nursing career: "We had the training only once and since then we have never had any preceptorship workshop. I was trained in the year 2004. That was the only training I had" (p. 22). Another participant had to precept by virtue of her experience in nursing:

> I did not get any official training for the preceptorship program, but it is through my length of experience in nursing that I am using in teaching". Another student believed that "preceptors should go through in-service training monthly so that they would be abreast with current trends in teaching students." (Asirifi, 2011, p. 22)

Furthermore, most of the preceptors in the Asirifi study reported that the workshop they had was incomplete. One preceptor explained that the workshop was supposed to be in two phases, the introductory phase, and the main content of preceptorship phase. "Participants were taken through the introductory phase. The second phase of the workshop did not come off" (Asirifi, 2011, p. 22).

Based on these accounts, it should come as no surprise that the participants in Asirifi's (2011) research recommended that they be given adequate training and preparation to function effectively as preceptors.

Systems Theory

While precursors of systems theory can be traced back several centuries, the framework developed mainly after World War II (Arnold, 2014). In simple terms, the theory considers organizations not as an assemblage of parts but as wholes. "A system is an organized or complex

whole—an assemblage or combination of things or parts which form a complex unitary whole" (Johnson et al., 1964, p. 9). The different and inter-related parts of the system are called *sub-systems*. The various sub-systems are arranged according to a scheme so that the complete system is more than just a sum of its parts. This ensures the efficient functioning of the system as a whole.

Every system has a boundary which separates it from its environment. The central thesis of systems theory is the need for taking a holistic view of a system to ensure that all of its components work to make the entire system function as efficiently as expected (von Bertalanffy, 1968). In this regard, Mizikaci (2006), looking at how to apply the systems approach to evaluation higher education programs, recognized the complementarities of endeavors, approaches, and actions to achieve set objectives. A systems approach is a holistic effort to coordinate all aspects of a problem towards an achievement of specific objectives. When applied to education for instance, a systems approach will focus on learners, teachers, course content, learning experiences, and instructional methods. Systems theory is characterized as goal-seeking and consists of inputs and outputs operating within internal and externa environment. Systems have boundaries which can be permeable and impermeably preventing flow of information and work. Emphasis is on interdependency to achieve organizational or the goal of the system.

The exploration of preceptorship which takes place within a complex system of interlinking components requires the study of the whole system component through due diligence, document reviews, formal and informal interviews with relevant stakeholders, observation, reflexivity, among others. Systems theory depends on the social, technical, and managerial components of its system to achieve its goals and objectives. Thus, in systems theory, there are social, technical, and managerial systems as critical components of a system. The social

system for instance requires a culture change in organizational culture (values, norms, attitudes, roles expectations, communication) and quality of relationship between and among individuals, reward structure, behavioral patterns.

The technical system emphasizes tools and machinery to transform the inputs into output. In the case of preceptorship inputs consist of the following: students and faculty characteristics (needs, expectations, and interest); financial resources effectively used in facilities (classrooms, instructional equipment, programs, curriculum, courses, schedules), support services (transportation, food, and recreation), measurement of output (assignments, examinations), evaluation of the programs (students, preceptors), and achievement of output (skill development, competency).

The managerial system entails formal design, division of responsibilities, and administrative activities (planning, organizing, directing, coordinating). Systems theory holds that a system may be more effective when it is holistically examined, taking into consideration all components, issues, and actors within the system.

Benner's Novice to Expert Nursing Theory

Learning is the process whereby knowledge is created through the transformation of experience. Experience is then translated through reflection into concepts, which, in turn, are used as a guide for active experimentation in new experiences (Curran, 2014). Benner's (1984) nursing theory identified five levels of experience: novice, advanced beginner, competent, proficient, and expert. These five levels or stages identify the acquisition of knowledge and skill through nursing experience and portray the steady progression from novice nurse to expert nurse, as each stage builds upon the previous one (DeSandre, 2014; Dracup & Bryan-Brown, 2004; Koontz et al., 2010).

Novice Stage

According to Hnatiuk (2012), the novice nurse takes on a new or unfamiliar role and generally has no practical experience in which to relate to patient outcomes. Novices tend to be nursing students and use rule and fact governed logic to base their actions and are limited and inflexible when it comes to considering the context of a situation. Novices have limited confidence, limited critical thinking, and clinical judgment, and therefore are unable to use discretionary judgment. They have difficulty seeing the big picture, are task oriented, and tend to memorize; tell them what to do and they will do it (Hnatiuk, 2012). Therefore, they may have difficulty prioritizing patient care and organizing tasks. Preceptors should understand that nurses in the novice stage are learning to translate new knowledge as they gain experience, and that this process takes time (Downey, 1993). Novice nurses should be told and shown what to do, while provided with one-on-one support, and as they gain more experience, they will progress to the advanced beginner stage.

Advanced Beginner Stage

The advanced beginner tends to be a new nurse graduate in the first few years of practice and who demonstrates marginally acceptable performance (Downey, 1993; Hnatiuk, 2012). They tend to view all aspects as being equal, have trouble multitasking, and concentrate on remembering rules in order to provide safe patient care (DeSandre, 2014). According to Koontz et al. (2010), advanced beginners focus on task completion, not patient management. The teaching focus for the novice and advanced beginner lies with priority setting, aspect recognition, and confidence building. The preceptor will help the novice nurse and advanced beginner to gain the inherent proficiency required in an uncertain clinical setting (Dracup & Bryan-Brown, 2004). According to Downey (1993), preceptors should encourage critical thinking skills and provide

individualized support that targets organization and priority setting, as these nurses perceive recurrent, meaningful patterns in the clinical setting.

Competent Stage

The competent nurse has insight and an awareness and ability to distinguish important information from non-important information; clinical experiences contribute to this development. Koontz et al. (2010) indicated that the competent nurse is patient focused and can more easily manage multiple patients, demonstrates efficiency by careful planning and time management skills, and has confidence in their actions; however, still lacks visualization of the whole picture. The competent nurse has been in practice for about two to five years and the teaching focus of the competent nurse should focus on decision-making games and simulations that provide practice in planning and coordinating patient care (Downey, 1993). Competent nurses will then progress to the proficient stage as they continue to gain experience and the acquisition of knowledge.

Proficient Stage

The proficient nurse has broad experience and is intuitive with expanded personal and professional awareness (Koontz et al., 2010). The proficient nurse has the experienced based ability to look at the whole picture, and as they perceive meaning from different situations, they anticipate and recognize subtle patient cues in order to understand situations as complex entities (Koontz et al., 2010). The teaching focus of the proficient nurse would emphasize case studies and inductive teaching strategies (Downey, 1993).

Expert Stage

The expert nurse has extensive experience, demonstrates clinical reasoning, anticipates the unexpected, and can make holistic decisions, as they have an intuitive grasp of the situation;

they understand what is needed and why (Koontz et al., 2010). According to Dracup and Bryan-Brown (2004), expert nurses do not get caught up in the technical aspects that the novice might, and they use critical thinking and judgment to adapt care to the unique condition of each patient. The teaching focus for the expert nurse lies in finding new challenges and professional development. Dracup and Bryan-Brown suggested that the expert nurse become a preceptor. The expert nurse can advance clinical and professional practice experience by becoming a preceptor and participating in a preceptor-training program.

Development of a Preceptor Training Program

Preceptors lack effective support in understanding their role, in training, and from colleagues (Duteau, 2012). In order to support preceptors and facilitate an effective preceptorship, a preceptor-training program must be developed. Organizational commitment and a collaborative evidence-based approach are required to implement and facilitate a successful preceptor-training program (Smedley, 2008). A preceptor-training program is simply a dedicated educational program designed to train and equip the preceptor with the skills and abilities required to effectively precept the preceptee. A preceptor-training program should provide preceptors with the tools needed to effectively fulfill the role (Duteau, 2012).

The preceptor-training program should include educational elements focused on understanding learning styles, conflict management, evaluation and assessment, clinical teaching strategies, collaboration, and establish how to best match a preceptor and preceptee (Duteau, 2012). Matching the preceptor and preceptee is not an easy task. Personality clashes can occur. In order to minimize poor placements, criteria for preceptor characteristics, qualifications, and selection should be designed as part of the program. According to Duteau (2012), “Criteria should include clinical expertise, willingness to act as a role model, the desire to teach and foster

learning, excellent communication skills, and evidence of ongoing teamwork" (p. 41). Preceptors should be welcoming, nurturing, supportive, foster growth and professional development, and skilled at providing feedback.

How to best accommodate learning needs and schedules should also be taken into consideration when planning to develop a preceptor training program. According to Krampe et al. (2013), when planning a preceptor-training program, the learning needs of both the preceptor and preceptee should be examined, along with the logistics of when and how the training will occur. Krampe et al. developed a five-module curriculum in which they covered topics such as innovations in nursing education, clinical learning, student issues in clinical education, the dynamic relationship of preceptor and preceptee, and the nurse preceptor's role in evaluation.

Characteristics of each module included an outline, objectives, a PowerPoint presentation, a five-question post-quiz, and specific learning objectives. The course was approximately four and a half hours long, offered four and a half contact hours of continuing education credit, and was also time that was compensated by the organization (Krampe et al., 2013). According to Sandau et al. (2011), preceptors require specific tools to effectively perform their role and to develop critical thinking in themselves and in their preceptees. Preceptors should be provided guidance on how to share their stories with preceptee's, in order to facilitate critical thinking. Training should also include deflection of lateral violence and respect for diversity; this can be accomplished by role play (Sandau et al., 2011). Sandau et al. (2011) also stated that training should include information on how to actively coach the preceptee, how to deal with the preceptee that may have a different personality, leaning style, and ethnic background, and how to provide effective feedback.

Ulrich (2011) discussed the need for preceptors to be competent at precepting. While there are varied ways for preceptors to gain competency, Ulrich suggested that the preceptor have knowledge and training of adult learning theories and learning styles, specific learner populations, teaching and precepting strategies, communication and coaching strategies, and have an understanding of learner assessment and evaluation. A preceptor-training program should include the development of competence, critical reasoning and judgment, and confidence (Ulrich, 2011). According to Singer (2006), untrained preceptors may contribute to turnover, early burnout, and job dissatisfaction. Preceptor-training programs maximize support for preceptors and must be carefully designed. Singer presented the preceptorship conceptual framework that was developed by Craven and Broyles (1996). This framework includes interlocking rings that include and depict the preceptor, preceptee, administrative support, educational support, and incentives. These five areas create the foundation for a successful precepting program. Preceptors should learn how to identify characteristics of Benner's stages of novice to expert during precepting training (Sandau et al., 2011). During training preceptors should be taught how to tailor their approach to the preceptee based on these stages and adult learning principles.

An effective preceptor-training program should include clearly identified preceptor-preceptee roles and responsibilities and delineate where to find the time for precepting (Sandau et al., 2011). Preceptor-training should include a clinical coaching plan that outlines specific goals, activities, and measurable outcomes, which should encompass and consider adult learning principles in order to foster the progression of the novice through all core competency requirements. Specific planning for critical thinking development can occur through weekly meetings, case scenarios, documentation tools, discussion and/or problem solving, and valid and

reliable tools for competency verification that identify specific, measurable criteria for assessment (Sandau et al., 2011).

Standard Practices of Preceptorship

The literature search revealed that there were no generally accepted practice standards for preceptorship because every institution formulates its own preceptorship program to address its unique situation. While the approaches differ from country to country and within different healthcare settings, they all share certain commonalities and incorporate certain procedures as components of their preceptorship program. Thus, standard practices are determined by understanding the overall concept of preceptorship and its significance. In other words, standard practice is guided by the objectives behind preceptorship, the roles expected of preceptors and preceptees, the support and development that should be extended to preceptors and preceptees, as well as the organizational commitment required to make the program successful. For instance, Health Education England (2016) in developing a framework for best practices for preceptorship—after extensive engagement of stakeholders from all fields of professional practice and settings in healthcare—came out with a standardized practice that incorporated the aforementioned elements. These elements have become the basic standard of preceptorship practice and framework for all healthcare organizations in London. The Nursing Midwifery UK, in their guidelines for employers, registrants, and program leaders in approved institutions have also incorporated these domains as guidelines for an effective preceptorship program. Within this standard practice and guidelines, there are also additional domains which according to Health Education England (2016) are indispensable and useful in any preceptorship program. A standardized preceptorship practice must thus answer or incorporate the following questions and issues.

Who is Preceptorship for?

Preceptorship should be available to all newly registered nurses. The overall aim of a preceptorship program is to develop confident and competent practitioners. Preceptorship may be utilized by an organization for student nurses, other nurses such as overseas nurses, return-to-practice nurses, or new to general practice nurses, and is also pertinent for allied health professionals. This is not a comprehensive list; it is an organizational decision as to who can access preceptorship (Health Education England, 2016). The Preceptor/Preceptee Charter sets out the responsibilities and expectations for both preceptor and preceptee. The preceptee or newly registered nurse is responsible for engaging fully in the preceptorship program. This involves a number of activities including completing induction and other required training, attending regular meetings with their preceptor, actively seeking feedback, escalating concerns, reflecting on their professional practice, and taking ownership of their own development (Health Education England, 2016). Preceptees should be encouraged to utilize their preceptorship period and develop their portfolio towards NMCG revalidation. It should be recognized that although formal study days are important, learning is achieved in a variety of ways including observation, workplace learning, e-learning, experiential learning, reflection and working with others. The preceptee should be encouraged to make full use of all of these opportunities for learning. Responsibilities may include the following:

- completing all organization and local induction, statutory and mandatory training;
- attending study days and doing all required training to complete my preceptorship;
- observing and adhering to organization values;
- participating fully in the preceptorship program by preparing for and attending meetings as scheduled with my preceptor;

- working collaboratively with my preceptor to share my reflections and identify learning and development needs;
- seeking feedback from others to inform my progress owning my learning and development plan;
- practicing in accordance with specified code;
- identifying and meeting with their preceptor as soon as is possible after they have taken up post;
- identifying specific learning needs and develop an action plan for addressing these needs;
- ensuring that they understand the standard, competencies or objectives set by their employer that they are required to meet;
- reflecting on their practice and experience;
- seeking feedback on their performance from their preceptor and those with whom they work (health education England, 2016).

Preceptor Role

The clinical preceptor is a nurse/midwife from the clinical placement provider with minimum of three years of clinical experience and has a recognized skill in the area of practice. He/she should have completed a structured and formal preceptorship/clinical supervision course. Each clinical preceptor shall be assigned to a maximum of two students at any one time. The clinical preceptors will receive assistance, guidance and support from the clinical placement coordinator and clinical instructor in performing their preceptor roles and responsibilities (Health Education England, 2016).

They may volunteer or be asked to undertake the role by their lead nurse, line manager, or clinical nurse managers. Research shows that the best preceptors are those who are volunteers and have more recent experience of being newly registered. A preceptor should have no more than two preceptees at any one time. Some organizations may adopt a team preceptorship model. The role of the preceptor is to provide guidance to the preceptee by facilitating the transition into their new role. The preceptor supports the preceptee to gain experience and apply learning in a clinical setting during the preceptorship period. A role descriptor for a preceptor would include the following activities:

- providing support and guidance to the newly registered nurse;
- acting as a role model and critical friend;
- facilitating introductions and promoting good working relationships;
- participating in all preceptorship activities including completing required training, preparing for, attending, and documenting regular scheduled meetings;
- providing timely and appropriate feedback to the preceptees;
- liaising with manager about preceptees progress as appropriate;
- advising on learning and development needs, facilitating a supportive learning environment, and signposting learning resources;
- providing honest and objective feedback on those aspects of performance that are a cause for concern and assist new registrants to develop a plan of action to remedy these;
- facilitating new registrants to gain new knowledge and skills;

- being aware of the standards, competencies, or objectives set by the employer that the 'new registrant' is required to achieve and support them in achieving these (Health Education England, 2016).

Length of Program

Any standard practice of preceptorship should stipulate the duration or period of the program. A review shows that duration may differ and depends on the healthcare facility and institutional arrangement. On average, preceptorship duration ranges from three weeks to 12 months. There is no generally accepted duration for preceptorship. During the preceptorship period there should be certain expectations of both the preceptor and preceptees about engagement in relationship and completion of defined competences (Health Education England, 2016).

Protected Time for Preceptors

Protected time should be allocated for both the preceptor and the preceptee, which should be supported by the organization. The purpose of this protected time is to support the NRN, build confidence and competence, consolidate learning, and build resilience. This can be achieved through a combination of working together with a preceptor, reflection, action learning, supervision, and work-based learning. The provision and format of this protected time may vary dependent on the working environment.

Recommended Requirements for the Preceptor/Preceptee Relationship

The following are broad guidelines for the interactions of preceptors and preceptees:

- The preceptee and the preceptor should work alongside each other at least four working days in the first month.
- Regular formal meetings during the preceptorship period

- Half-day initial training workshop for preceptors—blended learning approach

Review Meetings Between Preceptor and Preceptee

It is recommended that there are formal review meetings between the preceptor and preceptee at regular intervals during the preceptorship period. The following steps should be taken:

- initial meeting to set expectations and learning plan;
- interim meetings to monitor progress, share reflection and further consider development needs;
- final meeting to establish competence and sign off after duration of program.

The purpose of these meetings is to provide a supportive safe place for the preceptee to reflect on their progress and experience. Meetings should be documented briefly, and this record dated and signed by both the preceptor and preceptee. The timing of preceptorship meetings may be amended, and outcomes shared with the appropriate manager, in order to inform decisions about the probationary period.

Preceptor Support and Development

Preceptors should be prepared for their role and offered some development in understanding the preceptorship program and skills required. Ongoing support for preceptors should be available from the organization leads.

Preceptorship Lead

Each organization should have an appointed preceptorship lead who is responsible for overseeing the preceptorship program which may include the following activities:

- identifying preceptors, knowing who they are and providing appropriate level of preparation and support;

- identifying all newly registered nurses requiring preceptorship and others for whom preceptorship is deemed beneficial;
- allocating or delegating the responsibility for identifying preceptors in time for the preceptees start date;
- monitoring and tracking completion rates for all preceptees;
- performing regular checks that the preceptor/preceptee relationship is working satisfactorily;
- identifying any development/support needs of preceptors or preceptees;
- measuring the effectiveness and impact of preceptorship programs on retention and staff engagement.

Organizational Commitment to Preceptorship

Preceptorship requires organizational commitment to support the program, the preceptorship lead, preceptors and the preceptees. Organizations are responsible for monitoring the programs and measuring success against key performance indicators. According to Nabolsi et al. (2012), an appropriate system of support from the organization helps the preceptee to adapt comfortably to the clinical environment and is effective for clinical learning.

Preceptee Development

Preceptees should be provided with learning opportunities, including study days/sessions. The content, frequency, and running of these study days/sessions, however, will depend on the organization's needs. The purpose of this is to ensure that the preceptee is able to meet the required clinical and professional competences by the end of their preceptorship period. Areas should include clinical practice, communication, teamwork, leadership, professionalism, and

integrity, research and evidence, safety and quality, facilitation of learning and development of self and others.

Learning Methods in Preceptorship

Several learning methods from review were identified as approaches to preceptorship. The most utilized learning methods included reflective practice, shadowing, one-to-one support, attitudinal, and behavioral learning such as role modeling (Health Education England, 2016).

Empirical Studies on Preparation for Preceptors

One area in which there is much variation is regarding the preparation of preceptors. Edmond (2001) argued that staff nurses are the best suited to facilitate clinical learning, role transition, and professional socialization of students and novice practitioners; their ability to do so is well-documented in research (Carlson et al., 2010b; Kowalski et al., 2007). However, simply because a nurse is an expert clinician does not mean that he or she will make an expert preceptor. Preparation is necessary for any role and preceptorship is no different. Reporting on a process improvement project, Kowalski et al. (2007) suggested that a lack of preparation is one reason for burnout and dissatisfaction for nurses who work as preceptors. It is often expected, though, that nurses will assume this role without incentive or adjustment to workload (Yonge et al., 2002). As such, preceptors should have clear responsibilities provided in order to help prepare them for this role (Rogan, 2009). The following discussion reveals current research findings focused on the preparation of nurse preceptors.

In Sweden, Carlson et al. (2010a, 2010b) used ethnography to describe strategies and techniques used by preceptors to teach undergraduate nursing students. Data sources included field notes, observations, and focus group interviews. Three categories were found as important techniques for preceptors: adjusting the level of precepting, performing precepting strategies, and

evaluating precepting. The authors also described seven subcategories in their findings. Based on the findings of their study, preceptors think it essential to have a first meeting with the student prior to the initiation of the preceptorship. This allowed the preceptors to develop some idea about the student's abilities so that the level of precepting could be appropriately adjusted. Further, preceptors expressed the importance of creating a trusting relationship to enhance the feeling of security for the student. By doing so, preceptors reported that the preceptorship experience was enhanced. These two components supported the use of the preceptors' reported teaching strategies of demonstrating, questioning, reflective thinking, and assessing. This study indicated that nurse preceptors use methodical strategies and techniques to facilitate student learning during preceptorships. What is not known from the study was how much, if any, preparation was provided to the preceptors prior to assuming the role. The authors recommended that to support preceptor role development, information about pedagogical strategies should be provided and that preceptors should be given the opportunity to create learning opportunities that meet the requirements of the academic institution.

In a descriptive study, Rogan (2009) used Mercer's role attainment theory to examine the type of preparation nurse preceptors believe is required to complete their job. She also researched differences in perceptions about preceptor preparation based on years of nursing experience, area of practice, or years of preceptor experience. Study participants completed the *Preparation of Nurses Who Precept BSN Students Survey*. This asked participants to rate 33 content areas pertaining to preceptor preparation as "essential," "useful," or "not needed." The study found that preceptors overwhelmingly identified role responsibilities as the most essential content element. Setting priorities and organizing workload and preceptor roles were the second and third most essential content elements, respectively. Only descriptive statistics were reported.

In discussing study implications, Rogan suggested that preceptor preparation should focus on teaching/learning strategies, adult learning principles, communication, values and role clarification, conflict resolution, assessment needs of the preceptee, and evaluation of preceptee performance with the desired outcome of "cultivation of a greater sense of comfort in the preceptor role" (Rogan, 2009, p. 566). She also asserted that nurses with adequate preparation can enhance their current practice and therefore become better role models for preceptees.

Zahner (2006) used repeated measures design in a pilot study to determine the effectiveness of a web-delivered preceptor course for nurses who work in public health settings. The study was conducted over one semester with measurements taken before the course (time 1), throughout the course (time 2), and at the end of the semester (time 3). Time 1 knowledge was assessed using a mailed survey consisting of nine knowledge questions. Four on-line video vignettes were used to illustrate important concepts in the interactions between preceptor and preceptee in these types of health settings, and nine modules were used to provide course content. The same nine questions from Time 1 were provided among a total of 36 knowledge questions included in module quizzes completed throughout the nine modules (Time 2). Participants were allowed the entire semester to complete the course. At the end of the semester, participants completed the same nine knowledge questions for the Time 3 measurement.

Repeated measures ANOVA indicated statistical significance in knowledge levels over time ($F = 55.603$, $df = 2$, error $df = 11$, $p < .0001$). The difference between Time 1 and Time 2 was statistically significant ($t = -10.25$, $p < .00001$). The difference between Time 1 and Time 3 was also statistically significant ($t = -4.95$, $p < .0003$). Zahner (2006) reported that study participants were satisfied with the individual modules and the format of the web-based delivery

system. She did note, however, that the time it took for the participants to complete the course was an issue.

Heffernan et al. (2009) described a comprehensive evaluation of a preceptor course in the workplace in Ireland, where preceptorship is a required part of nursing education and practice. Nurses serving as preceptors had to complete a preceptorship course. The initial course was 16 hours, provided in two eight-hour days, and contained information about changes in nursing education nationally and internationally, clinical learning environments, principles of assessment and feedback, learning theories, clinical support networking, and competency as well as several other broad topics. After two years of precepting, a required 4-hour update course was required.

The pedagogies of choice for these courses included lecture, discussion, group work, and interactive forum. The study consisted of two phases. In Phase I, the authors transcribed over 520 evaluation forms and conducted three focus group interviews with 12 participants in each. The transcribed data were analyzed using thematic analysis. Four themes emerged during Phase I:

- Theme 1: Importance of preceptor characteristics
- Theme 2: Demonstration of preceptor characteristics
- Theme 3: Specific knowledge demonstrated by preceptors
- Theme 4: Specific skills demonstrated by preceptors

Those findings were used to construct a new 74-item, Likert-type questionnaire used during Phase II. The internal consistency of the final instrument was $\alpha = .919$. This questionnaire was administered to 191 preceptors and 208 students. Findings related to Theme 1 indicated that students consider being supportive of students and being approachable as the most important characteristics preceptors should have. Preceptors also rated support and approachability as important, but rated communication skills as of highest importance. For Theme 2, preceptor

confidence and knowledge were reported by students as being consistently demonstrated. Students ranked being approachable and being supportive third and fourth, respectively. Interestingly, preceptors ranked being supportive of students as their best demonstrated characteristic and being approachable as their least demonstrated.

In Theme 3, both students and preceptors ranked understanding of the role of the student and the importance of orientation to the clinical area as highest. In Theme 4, there was a noted difference in ranking between preceptors and students regarding communication skills. Preceptors ranked communication skills as of lowest significance, whereas students ranked it as highest. Further, students rated preceptors' ability to challenge them as very low, whereas preceptors ranked it much higher. These results suggest that preceptors and students differ in their perceptions of preceptorships. Of significant importance were the differing perceptions regarding preceptors' ability to challenge thinking. This difference in perceptions indicates a need for further exploration of nurses' preparation as preceptors. The authors suggested that preceptor preparation requires support networks and consistent education updates with follow up evaluations.

In Australia, Henderson et al. (2006) conducted a longitudinal, descriptive study to evaluate nurse preceptors' perceptions of a two-day educational workshop and subsequent organizational support to prepare them for their roles. In the study, preceptors were used for new graduate nurses hired as new staff. I included this research because the population was similar to my specified population, with the exception that the students had already graduated from the educational institution. Furthermore, there are excerpts of transcripts in the article where participants directly referred to both new graduates and students. Therefore, it can be surmised that participants considered both when discussing their role as preceptor. The authors conducted

focus group interviews with 36 preceptors who had received preceptor training in a local tertiary care setting. They reported that the program is open to all registered nurses with at least one year of experience and who demonstrate interest in and aptitude for the role.

The preceptor preparation course consisted of a two-day workshop where preceptors primarily received information about preceptor roles and responsibilities, preceptee needs, adult learning, effective teaching and performance assessments, and strategies for effective preceptorships. Six focus groups were conducted two to three months and four at six to nine months after the workshops. The focus groups' discussions lasted for about one hour. Nurses who could not attend focus groups were provided with one-on-one interview sessions lasting approximately 30 to 45 minutes.

Study results indicate that preceptors were satisfied overall with being a preceptor, with the personal growth that takes place as a preceptor, and with perceived learning opportunities from others. There were, however, some negative perceptions and feelings, such as frustration, reported. These also include the perceived lack of time needed to serve as an effective preceptor, perceived lack of support from the educator in facilitating learning opportunities, and perceived lack of organizational support for the role of preceptor.

In Henderson et al.'s (2006) study, preceptors also reported that a support network was desired, and the authors suggest that these results indicate the importance of organizational support for preceptors. There is wide consensus in the literature that preceptors need some type of preparation. What is less clear is the best practices for preparing preceptors. The studies described here provide initial insight into various preparatory methods for preceptors, including teaching strategies, and preceptors generally reported satisfaction with the processes. Even so, the notion of support, or the lack of support, permeates the literature. The incongruence between

preceptors' reported satisfaction with preparatory methods and lack of support suggests that preparation and support are intricately interwoven and perhaps more so, that the amount or type of support required or requested by preceptors in order to sustain them in their roles is not understood.

Barriers to Preceptorship in Healthcare Delivery

My review of empirical studies on preceptorship acknowledged the crucial role of preceptorship in health care delivery (Chen et al., 2011; Goss, 2015; Muir et al., 2013). Nevertheless, several studies report that major barriers affect preceptorship, and that the preceptor role is challenging and stressful (Chen et al., 2011; Hautala et al., 2007; Liu et al., 2010; Muir et al., 2013; Panzavecchia & Pearce, 2014; Richards & Bowles, 2012). Valizadeh et al. (2016), in a study of the challenges of preceptors in working with new nurses, found that lack of prior notice of appointing preceptors to their additional role, lack of clear goals, objectives, and guidelines were major barriers to preceptorship as preceptors felt more stressed and had low confidence with which to discharge their duties well. Preceptors lamented that they were not aware and not mentally prepared to precept, which affected effective delivery. Whitehead et al. (2016) in a UK study on preceptorship pointed out that inadequate training was a major barrier to a successful preceptorship program. Hautala et al. (2007) and Watson et al. (2012) also reported that excessive workload, working in isolation, lack of adequate support, lack of appreciation, and role ambiguity are major barriers of preceptorship.

In her review about building a preceptor support system, Goss (2015) noted that inadequate appreciation of the contribution of the preceptor and lack of some form of external reward system remains a barrier to preceptorship and has an adverse effect on the program. Additional barriers to an effective preceptorship model have to do with limited time for

supervisors, institutional politics, and inadequate infrastructure (Alspach, 2000; Burns & Northcutt, 2009; Hautala, 2007). Insufficient time remains a challenge for preceptors to assess nursing student's clinical competence during preceptorship as well as lack of motivation.

Webb et al. (2015) conducted a study investigating incentives and barriers to precepting nurse practitioner students and found that the leading barriers were time factors and productivity demands. The most highly rated incentives were credit toward professional recertification, program information, access to clinical references, and remuneration. Preceptors cited a professional obligation as the most influential factor. This is consistent with other studies showing a desire to "give back" as an incentive. This professional responsibility motive to precept could be effectively emphasized in recruitment materials.

Matua et al. (2014) carried out a study in Oman to determine the challenges encountered in establishing preceptor-preceptee relationships and that negatively affected clinical teaching practices for the preceptors and skill acquisition on the part of the preceptees. They found that understanding and addressing preceptors' unique challenges in building a relationship in preceptorship was vital for patient care. Preceptees who had supportive preceptor-preceptee relationships often became more competent nurses, leading to better patient outcomes. Furthermore, improving preceptorship was seen to be beneficial for preceptors as well as preceptees. Preceptors who had rewarding preceptee relationships were motivated to continue providing exemplary patient care as they act as role models for their preceptees. Matua et al. identified four challenges to preceptorship and ten strategies to encourage relationship-building between preceptors and preceptees. The challenges included discrepancies related to the application of theory to practice; lack of trust and readiness to commit to a preceptorship

relationship; insufficient time to invest in relationship-building, and a perceived lack of knowledge in nursing trends.

Dennis-Antwi (2011) conducted a study on the state of preceptorship in Ghana, Ethiopia, Uganda, and Zambia with a view to assessing current systems of preceptorship in supporting students to acquire clinical skills for competent quality care. Among other findings, Dennis-Antwi identified challenges ranging from young and inexperienced midwives, inadequate numbers of midwives in the clinical sites due to high turnover, heavy workload, and having few available competent tutors to implement strong preceptorship approaches. Other challenges included lack of interest in precepting on the part of preceptors as a result of no remuneration or perceived self-benefit, and large student numbers that make effective follow up by preceptors difficult.

Asirifi et al. (2019) conducted a study on clinical education in Ghana to examine current issues in clinical nursing education in one school of nursing in Ghana. Most participants indicated the major challenges of clinical teaching as: teaching multiple students from different agencies, levels, and disciplines; heavy workload and patient care responsibilities of preceptors; preceptors' shifts not always coinciding with student clinical hours; lack of incentives to motivate preceptors to teach; lack of clarity of clinical expectations; inadequate student preparation for clinical practice; and, lack of clarity in relation to students' clinical evaluations. Most of the preceptors indicated that they often supervised multiple students from various institutions or various healthcare disciplines simultaneously. Asirifi et al. argued that meeting each student's needs is complex and there is a tendency to make learning experiences similar for all students. Giving students full responsibility for the nursing care of specific patients may not fit with a unit where team nursing is practiced but could encourage deliberative planning in

relation to clinical objectives. Students could be responsible for reminding a preceptor of objectives, communicating learning needs that remain unmet, and suggesting clinical opportunities that would enhance their learning. Genuine clinical practice, as opposed to observation, enhances skill and knowledge development.

Preceptors usually have heavy clinical, as well as teaching responsibilities. Perhaps students could assume many of the patient care activities under the supervision of the preceptor. In doing so, the preceptor role could become similar to the clinical instructor role when a group of students is assigned to one or two units and each student provides full patient care for one or more patients under faculty and unit staff guidance. The preceptor ensures that patients get safe nursing care by checking and supplementing each student's knowledge and skill, providing necessary teaching, and supervising skills such as wound dressings until the student becomes competent. The students, however, share the clinical workload. A graduate nursing student whom Asirifi et al. (2019) interviewed, indicated that "in some clinical settings . . . they don't really have trained preceptors because of the staff shortages. It therefore poses heavy workload for the few preceptors available to teach the students" (p. 152). Most participants in the Asirifi et al. study indicated that preceptors receive inadequate to no incentives to motivate them to teach. One faculty member stated:

> There should be some kind of reward system, not necessarily money, but if there's a way of winning points that would contribute to the preceptors' academic advancement . . . give them some points for entry into schools or contribute to their professional promotion, it would be useful. (Asirifi et al., 2019, p. 153)

This is consistent with the findings in Atakro and Gross's (2016) review, in which one respondent mentioned that though he was trained as a preceptor, it was difficult to combine his role as a preceptor and as an employee of the GHS since there was no additional motivation from the training institutions and hospital. Motivations for physicians participating in preceptorship

programs can include opportunities for continuing medical education credits, faculty development, and other academic-related benefits (Aguwe et al., 2008).

Enablers of Preceptorship

Enablers of preceptorship are those factors that may have a positive impact on the practice of preceptorship or that can contribute to the effectiveness of preceptorship. Some studies posit that preceptors' personal qualities and attitudes play a major role in the success of any preceptorship program. Hill and Lowenstein (1992) asserted that preceptors' attitudes and qualities such as being assertive, non-judgmental, adaptable, and willing to precept are essential ingredients for a successful preceptorship program.

According to Boyer (2008) and Patton (2010), the ability of preceptors to self-reflect, be honest, organized, objective in evaluation, and to have a general concern for their preceptees are essential enabling factors as well. Letizia and Jennrich (1998) argued that factors such as clinical expertise, teaching skills, and motivation are critical factors that will enable one to be a successful preceptor. A study of the preceptorship experience in clinical education in Ireland by McCarthy and Murphy (2010) revealed that preceptors were not prepared to compromise patients' care needs in relation to preceptorship. This reinforces the point that preceptors' individual values and attitudes play a significant role in the success of preceptorship. Whitehead et al. (2016) added that preceptorship is highly dependent on the skills of preceptors and formal training towards such role. Valizadeh et al. (2016) also found that lack of support from the nursing study unit, supervisors, and head nurses reduced preceptors' morale and negatively impacted on the success of the preceptorship program. In the same study, a lack of clear goals, objectives and guidelines of the preceptorship program resulted in inconsistencies, uncertainty,

and confusion among preceptors and new nurses, which resulted in the preceptorship program not achieving its intended results.

Hautala et al. (2007) found that preceptors were highly satisfied with the role of hospital managers in supporting them in their work. Luhanga, Dickieson, and Mossey (2010) sought to determine if a one-to-one relationship is key to effective preceptorship validates the fact that if preceptors are supported to have time with their preceptees, they are able to deliver effectively. From the study, managers' support in terms of balancing preceptors' workload, providing preceptors with free educational materials, coordinating work shift, offering array of professional development, leadership, time management, and prioritization of skills resulted in successful preceptorship.

Myrick and Yonge (2005) asserted that the role of educational supervisor in terms of training of preceptors, assessing, monitoring, and supervising preceptor program is essential in ensuring the effectiveness of preceptorship program. According to Chen et al. (2011), a supportive and fostering environment is required to overcome the barriers of preceptorship and ensure an effective program. Kaviani and Stillwell (2000) reinforced this point that preceptors require the support of their co-workers, nurse educators, and the organization to make preceptorship effective.

Similar sentiments are shared by Yonge et al. (2002) in that preceptors need the support of educators and managers especially as they work with new nurses. Odelius et al. (2017) conducted a literature review evaluating the value of implementing preceptorship in nursing and found that organizational commitment and culture were critical in establishing, implementing, and sustaining effective preceptorship programs. Currie and Watts (2012) also concluded that organizational commitment is essential for successful preceptorship programs.

As early as 1990, research on support for nursing preceptors can be found (e.g., Bizek & Oermann, 1990). These works from more than three decades ago demonstrates the lack of progress nursing has made with this aspect of preceptorship. Even now, one of the most common reports from preceptors is that they feel unsupported by faculty and other nursing administrators (Landmark et al., 2003; O'Callaghan & Slevin, 2003). Nonetheless, nurses still express desire to assist in educating students and want their professional judgments considered in the student evaluation process (Levett-Jones et al., 2006), so continued efforts should be made to support them.

Several research studies described current attempts to elucidate information about support for preceptors. Yonge et al. (2002) used a descriptive, exploratory research design to study the nature of stress in the preceptor role and to identify the kind of support needed to make the experience valuable. Using a Likert-type survey designed by the authors, preceptors were asked about the levels of stress in the preceptor role ranging from nonstressful (1) to extremely stressful (5). The authors reported that 75% of respondents indicated some level of stress as a preceptor, but none indicated it was extremely stressful. The most common sources of stress were the sense of having added responsibilities at work and the extra time required of the preceptorship. It was also reported that preceptors felt responsible for students' work, including any mistakes that might have occurred, and that this also increased stress levels. Additional stress was reported if students were ill-suited for the clinical area, lacked confidence, or lacked skills. Based on the study results, the authors recommend that nursing faculty use strategies designed to lessen preceptors' burdens, screen students for suitability for placement, and assess the suitability of the preceptor as well. Aside from the general recommendations already mentioned, discussion about the kind of support required to enhance this experience is lacking.

Landmark et al. (2003) conducted a qualitative descriptive study to gain insight into, and identify, what participants experience in the role of clinical supervisors of nursing students. Data were collected in three focus groups, each of which lasted 90 minutes. Transcripts were analyzed using content analysis. Three areas of importance were identified and include: didactics, role functions, and organizational framework. Regarding didactics, nurses reported a need to support students in making the connection between practice and theory; however, they also recognized that they, themselves, needed supervision in order to be competent in their role. Novice nurses, in particular, reported an inability to support students through reflection on practice as they, themselves, had little experiential knowledge. The authors did not provide a definition of novice nurses. When discussing role function, nurses reported feeling that the role was not adequately recognized by others. Additionally, nurses reported that professional self-confidence and self-awareness influenced their ability to adequately supervise nursing students. Within the area of organizational framework, nurses indicated a need for communication from faculty members about expectations. Not only were expectations about student performance needed, but expectations were needed regarding the responsibilities and the demands of being a clinical supervisor to students. The authors suggest that these findings indicate a need for clarification of the role of the nurse in the clinical supervision of students.

In Sweden, Carlson et al. (2010a) conducted an ethnographic study designed to describe conditions for precepting in a clinical context. The authors used observations, focus groups, and field notes as data sources to collect information about preceptor-student relationships, obstacles and support for preceptors, organization, and routines for precepting. Study results identified three themes to describe conditions for precepting: (a) the organizational perspective, (b) the collaborative perspective, and (c) the personal perspective. Time was a repeated element

throughout the study. Nurses reported that precepting often presented an added responsibility on top of their clinical work, particularly if nothing was known about the student prior to his or her arrival. Furthermore, nurses reported feeling stressed and inadequate for the role because of time shortage; and they stressed the importance of feedback from students and faculty members. Nurse preceptors found collegial support from their co-workers to be invaluable in creating a positive learning experience for students. This support was enhanced by the shared initiative to find learning opportunities and the temporary handing over of the preceptee to other nurses, which also allowed the preceptor to find additional time. The authors found that although time was a repeating element in all conditions, nurse preceptors' value personal satisfaction, growth, and competence over monetary or other material incentives.

In their descriptive survey research from the United Kingdom, Pulsford et al. (2002) aimed to glean information about mentors' perceived levels of support in undertaking the role, and factors that would allow them to carry out the role more effectively. The total sample for this study was 198. Survey results indicated that 32 participants had been a mentor for less than one to five years while 35 had from six to 10 years of experience. Sixty-seven participants had perceived the most support for their role from their colleagues while 23 found the least amount of support from their managers. Thirty-six participants indicated they would like more support from faculty in higher education institutions. According to the authors, nurses serving in the role of mentor to nursing students must attend annual updates provided by the higher education institutions. Although most participants reported attending an update within the past 12 months (n = 35), the next highest number (21) had never attended an update. The most frequently reported reason for non-attendance was staff shortages. Only two participants indicated lack of interest as the reason for nonattendance. The most strongly preferred method of receiving

information from updates was in the form of written information and newsletters. Responding to a question about what would make their role easier or more fulfilling, participants reported a desire for more time to undertake the role, more support from management, partnerships with higher education institutions, more appropriate use of student placements, better ways to document student performance, more motivated students, and extra pay.

Hyrkäs and Shoemaker (2007) explored the relationships between preceptors' perceptions of benefits, rewards, support, and commitment to the preceptor role. The study replicated research conducted in the 1990s by Dibert and Goldenberg (1995) and Usher et al. (1999). The authors used a descriptive, correlational survey design to collect data in two phases. The first phase consisted of nurses who had attended a preceptor workshop and were assumed to serve as preceptors for newly hired nurses. The second phase involved targeting nurses working as preceptors for undergraduate nursing students at a local university. The total sample was 82 preceptors. I have included this study as some of the participants served as preceptors for both newly hired nurses and undergraduate nursing students. The authors used a four-part questionnaire consisting of the Preceptor's Perceptions of Benefits and Rewards (PPBR) Scale, the Preceptor's Perceptions of Support (PPS) Scale, the Commitment to the Preceptor Role (CPR) Scale, and a demographic sheet. They reported a positive correlation between the two subscales, PPBR and CPR. That is, the more preceptors perceived benefits and rewards, the more they were committed to the role. They also reported a positive statistically significant correlation between perceptions of support and commitment to the role. They used nonparametric tests to determine the differences between scale scores and participants' educational preparation, graduation year, attendance at preceptor workshops, age, workplace, and type of nursing. No statistically significant correlations were found between preceptors' years of nursing experience

and scores on the PPBR, PPS, and CPR scales. Additionally, no statistically significant relationships were found between the number of experiences as a preceptor, number of each type of preceptorship, and scores on the PPBR, PPS, and CPR scales. The relationships between educational background and scores on the scales, and age and the scales did not result in statistical significance. There were, however, statistically significant differences among preceptors according to graduation year, workplace, and type of nursing work. Nurses who graduated between 1981and 1990 (M = 74.60, SD = 6.97) rated the benefits and rewards of preceptorship higher than those who graduated in 1991 or later (M = 69.25, SD = 6.85). Nurses working in homecare or nursing home settings (M = 77.80, SD = 3.42) also assessed benefits and rewards of preceptorship as higher than nurses working in other settings. Preceptors of undergraduate nursing students assessed support higher than other preceptors (M = 68.64, SD = 14.51, p = 0.04). The differences were found in the following PPS Scale items: "Support from the nursing coordinator, other staff not understanding of preceptor program [sic] goals, related workload, and time for patient assignments" (Hyrkäs & Shoemaker, 2007, p. 519). The authors asserted that results from this study confirm the commitment of preceptors to their role, particularly when benefits and rewards are available. Further, they suggested that a positive perception of support helps to maintain the nurses' commitment to the preceptor role. The authors report that study findings were congruent with the aforementioned studies by Dibert and Goldenberg (1995) and Usher et al. (1999)

Luhanga, Dickieson, and Mossey (2010) aimed to "explore and describe preceptor role support and development within the context of a rural and northern mid-sized Canadian community" (p. 3). Using a qualitative exploratory descriptive design, the authors conducted semi-structured individual interviews and focus groups to collect data from 22 nurse preceptors

about both the support for and the preparation of preceptors. Data were analyzed using content analysis. Four prominent themes were identified: accessible resources, role complexity, partners in precepting, and role development. Communication with nursing faculty, especially in a timely fashion, was identified as essential for the preceptors, but lack of communication and support from the university were reported as barriers. Regarding their roles as preceptors, nurses stressed the importance of being able to facilitate student success through fostering critical thinking, competence, confidence, and organizational skills. Of significant importance is the recognition by preceptors of their role in evaluating students' performances. This element of precepting was viewed by preceptors as a "substantial component" of their role, but there were mixed responses regarding feeling prepared and supported to carry it out, particularly if a student was unsafe or in jeopardy of failing the course. Preceptors stressed the need for clearer role expectations and guidance in and support for student evaluation. As has been previously discussed, time was also a factor for preceptors in this study. In fact, Luhanga, Dickieson and Mossey reported that preceptors described "the nature of preceptorship as time-intensive as they worked to fulfill their preceptorship responsibilities in addition to their regular practice responsibilities" (p. 10). Although preceptors requested the development and implementation of a preceptor selection process, including formal education geared toward understanding the preceptor role, there were several barriers cited. These included scheduling issues, heavy workload responsibilities, and competing priorities during work. The authors recommended using flexible, creative strategies to prepare and support nurse preceptors. Further, they say that faculty members should be cognizant and proactive in assisting preceptors with student evaluation.

The importance of support for nurses who precept is clearly noted in the literature. It is reported that nurses often experience stress in their role as preceptor and that support from a

variety of sources is desired. Collegial support from co-workers is reported as invaluable and the most frequent source of support. Nurses have reported a need for more support from nurse managers and faculty members. Several authors suggested strategies for faculty, such as screening students, communicating about student expectations, and clarifying preceptor role expectations, that can provide support for nurse preceptors. A particular area of concern for preceptors is in the assessment and evaluation of students.

Preceptors Evaluation of Students in Preceptorship

Evaluation of students during and after preceptorship is an important finding from the literature which has shown quite different approaches and revealing and challenging issues. Seldomridge and Walsh (2006), while reviewing grades for a preceptorship experience, reported an observation of an "unusually large number of high grades and very few average grades" (p. 169) compared to faculty-led clinical experiences. This observation led them to question why this discrepancy existed. The authors conducted a descriptive study to compare clinical grades for students in two different preceptorships, community health and leadership/management, among cohorts from 1997 to 2002. Results of that study revealed 95% of students in preceptorship between these dates received grades of either an A or a B, and the remaining 5% of students received a grade of C. The authors pointed out that grades of C or better were needed in order for students to successfully complete the course. No statistically significant differences were found when comparing group means or in the pattern of distribution. Seldomridge and Walsh made several assertions for the high grades in preceptorship. They said that the extent of preceptors' orientation often includes only the receipt of information about the course from faculty through hand-delivered, regular, or electronic mail. They further noted that, as a result of inadequate preparation and lack of recognition, preceptors may simply find it easier to provide

passing grades as opposed to expending more time and energy to defend a failure. The relationship that develops between preceptor and student may also have an effect on grading, according to the authors. Seldomridge and Walsh asserted that part of the reason preceptors serve in the role is an attempt to enhance the student's experience of transition into practice. This desire to be supportive may in actuality lead to "generosity in grading" (p. 173). To clarify this aspect of precepting, they recommended that faculty should provide preceptors with specific information about course objectives and student evaluations, ensuring that all have the same expectations of the student performance.

Preceptors' perceptions of unsafe student clinical performances were the focus of a qualitative descriptive study by Hrobsky and Kersbergen (2002). They used semi-structured interviews to collect data from four participants. The authors identified three prominent themes: hallmarks of poor performance, preceptors' feelings, and the liaison faculty role. Some of the reported hallmarks of poor performance include students not asking questions, being unenthusiastic about nursing, and demonstrating unsatisfactory skill performance. Hrobsky and Kersbergen stated that preceptors reported feelings of fear, anxiety, and self-doubt in wondering about whether the student would fail if observations were reported to faculty members. The authors concluded that these preceptor statements reflected self-esteem issues, especially when preceptors were trying to communicate this to faculty. Preceptors also identified three liaison faculty roles that they found beneficial during preceptorship: listening, being supportive, and following up after the preceptorship. Hrobsky and Kersbergen (2002) went so far as to say that assessing unsatisfactory clinical experiences is demoralizing and even "poses threats to preceptors' self-confidence" (p. 553). They recommended that preceptor preparation must be strengthened and include information about liability and accountability issues. They also

recommend that faculty and preceptor relationships be strengthened through frequent dialogue about role expectations and clinical outcomes.

Luhanga et al. (2008a, 2008b) and Luhanga, Myrick, and Yonge (2010) reported on various aspects of the same study focused on the assessment and evaluation of incompetent and unsafe students in a preceptorship. Using grounded theory, the authors explored "the psychosocial processes involved in precepting a student with unsafe practice" in an attempt to identify "effective management and coping strategies that preceptors use" (Luhanga, Myrick, & Yonge 2010, p. 264). An unsafe practice in the clinical setting was defined as "any act by the student that is harmful or potentially detrimental to the client, self, or other health personnel" (Luhanga, Myrick, & Yonge 2010, p. 228). Data were collected from 22 preceptors through semi-structured interviews and analysis was conducted using Glaser's (1978) constant comparative analysis. Five major categories were revealed:

- hallmarks of unsafe practice,
- factors that contribute to unsafe practice,
- preceptors' perceptions and feelings,
- issues related to grading, and
- strategies for managing

Luhanga, Myrick, and Yonge (2010) identified "promoting student learning while preserving patient safety" as a core category (p. 266). They continued that "preceptors have a moral obligation to evaluate students accurately" (p. 267). They also suggested that preceptors must be experts in their areas of practice, and that they must assign or recommend failing grades to students who demonstrate less than satisfactory clinical performances. However, the authors noted that this is an area in which preceptors report feelings of fear, anxiety, self-doubt, anger,

lacking in confidence, and frustration. As a result, some nurse preceptors had not failed students because “they had given the benefit of the doubt to the students who were less than competent” (Luhanga et al., 2008a, p. 267). Other reasons that preceptors did not assign failing grades to incompetent and unsafe students were personal feelings of guilt and shame, reluctance to cause the student to incur additional costs, complacency about the extra workload, lack of appropriate evaluation tools and feeling pressured to help produce nurse graduates due to the nursing shortage. In fact, failing a student was so stressful for one preceptor that she refused to precept after having to do so (Luhanga et al., 2008a).

These feelings may be explained, in part, by preceptors’ perceptions of accountability. Preceptors recognized that it is their responsibility to intervene when situations presented in which patient safety could be compromised (Luhanga et al., 2010b). Further perpetuating the problem were the perceptions that students are ill-prepared for the clinical setting with regard to skill demonstration. Preceptors also reported a lack of time to work with the student as a contributing factor to their reluctance in assigning failing grades. If an error occurred, and the student was dishonest about the situation, preceptors found it even more difficult to trust the student; yet, failing grades were still not assigned. In the rare instances when a failing grade was assigned to an unsafe student, some preceptors experienced relief (Luhanga et al., 2008ba).

Contributing to the feeling of relief is supportive faculty who are communicative with the preceptors, offering advice and guidance in these situations (Luhanga et al., 2008a). Preceptors felt it is important to provide honest feedback to students and their faculty members (Luhanga et al., 2010a). In order to do so, preceptors expect faculty to be more available, especially when unsafe situations arise (Luhanga et al., 2008a). Preceptors also indicated they were more likely to

fail students if needed when faculty were more supportive (Luhanga et al., 2008a). Although it is the faculty member who ultimately assigns the grade for the preceptorship, most preceptors expect their input to faculty to be taken seriously and feel belittled and betrayed if their recommendations to fail a student are not respected.

Luhanga et al. (2008a) further reported that in a few cases, preceptors recommended failing a student and instead, faculty members assigned a passing score. This presents quite a conundrum. By not assigning failing grades or otherwise addressing unsafe preceptee practice, preceptors are seen as negligent in their responsibilities (Luhanga et al., 2008b). However, if nursing faculty expect preceptors to accurately evaluate students, then faculty should engage in behaviors that demonstrate support. Unfortunately, most preceptors reported infrequent visits or even no contact with faculty members during preceptorship experiences (Luhanga et al., 2008b). Although the authors made general recommendations for both faculty and preceptors in dealing with unsafe or incompetent students, there is no identified research reporting specifically on the effectiveness of these strategies.

Summary of Key Themes

One key finding emerging from the literature is the importance of formal preparation for preceptors. In Ghana, there is no formal structure for educating preceptors (Asirifi et al., 2013). On the contrary, preceptors are expected to already have the knowledge by virtue of their rich clinical experience. The story is the same in other nations I reviewed such as Iran and Ethiopia. While some preceptors may be good at teaching and modeling, the majority are not. Furthermore, studies found that more formal preparation would positively impact the preceptorship experience and lead to better outcomes (Al-Hussami et al., 2011).

Another key finding was the limited incentives involved in the preceptor role. One study in Ghana found that the primary support for the role came in the form of verbal encouragement from other senior nurses who espoused the value of the work a preceptor does (Atakro & Gross, 2016). While the intrinsic motivation to teach students goes a long way, other studies argued that extrinsic rewards such as differential pay and sponsored educational opportunities were also important for the success of the preceptor. This is not even to mention that these extrinsic rewards would also make the preceptors more committed to their roles. This is important to recognize because of the heavy workload that many preceptors are forced to bear with little recognition. In fact, this arrangement resulted in significant stress for preceptors in one study from Iran. Evidence has shown, however, that excessive workload is a barrier to effective preceptorship. Thus, it is imperative that a solution to this problem is found.

Several clinical teaching models are used in nursing education. The choice of models for a particular program depends on curricular needs for all levels of students and resources available. In order to implement effective options for student clinical practice, there is the need to assess the extent of any concerns, identify sources and mechanisms of the problem, introduce preventive and/or corrective measures and evaluate the effectiveness of the measures (Taylor et al., 2012).

Furthermore, the literature revealed poor preparation of preceptors prior to preceptorship programs. There were discrepancies and discomfort in poor evaluation of students by preceptors, which affected student evaluation. The literature further showed that lack of effective communication and resources and of effective planning of preceptorship programs were major barriers. Management support and preceptors' personal values were key enablers for effective preceptorship programs. As there is little research or literature on clinical teaching in Ghana, the

present study aimed to provide new insight and knowledge on a topic relevant to all nurses/midwife educators and to significantly contribute to the preparation of competent professional nurses/midwives who can provide safe, quality nursing care to address the health care needs of Ghanaians.

Identifying Gaps in Literature

This review provides the opportunity to evaluate empirical research and performing this review provided the opportunity to assess empirical literature on barriers and enablers of preceptorship and to further identity the strength and limitations in studies conducted within the context as well as gaps.

One major gap is a dearth of studies that explore the barriers and enablers especially in the developing world context. Even in the developed world, studies are old which highlights the need for inquiry into the issues in current context. Most studies also employed quantitative analysis into the phenomenon which lack depth. Most studies either focused on preceptor or student nurses or new hire nurses without looking at the whole concept of preceptorship and how it is practiced. The most commonly utilized qualitative methods have been phenomenology and grounded theory. There is limited research that has attempted to utilize situational analysis. Such studies have applied it within the context of student, nurses, and preceptors without looking at preceptorship. No study was found study in developing region that used Clarke's (2003) situational analysis in the study of preceptorship. There is therefore the need for qualitative analysis that addresses the phenomenon into details and subsequent increase in sample size. This gap has informed current study to employ a situational analysis which addresses issues holistically and in-depth which existing studies has not utilized.

The literature review brings to light barriers and enablers that impact on preceptorship. It has revealed issues that are collective, systemic, universal, and idiosyncratic when it comes to the preceptorship practices. It has further revealed some major gaps in existing literature which therefore underscores the need to have in-depth study into the phenomenon. It also calls for the need to have a broader frame of mind when conceptualizing and operationalizing preceptorship.

CHAPTER III: RESEARCH METHODOLOGY

This chapter discusses the methodology that was used in this project. Methodology is the framework in which a project is being conducted and the choice of a method or methods lies on the researcher. In choosing a methodology, the researcher takes into consideration the research question(s), the phenomenon that is being investigated as well as his or her skills and expertise. This is a purely qualitative study that was conducted in Ghana.

Denzin and Lincoln (2011) defined a paradigm as an interpretive framework that surrounds the researcher's epistemological, ontological, and methodological position. Thus, a sense of some inherent beliefs which guide researchers practice and interpretation of the world. Although there are several research paradigms in qualitative research, the ones considered here were constructivism, interpretivism, symbolic interactionism, and participatory research. This research will be primarily grounded in constructivist. Constructivist or interpretivism posit or assume that there are multiple realities (Lincoln et al., 2011). They further believe that individuals construct their own realities which make proponents of this paradigm inclined to subjective worldview. Constructivist and interpretivism are often based on the active participation between the researcher and participants (Lauridsen & Higginbottom, 2014). They understand that knowledge acquisition is constructed between these two parties.

The present research sought employed a methodology that was congruent with the project and as well as, help in addressing its questions. This qualitative study used situational analysis design; a single method which helped to explore the topic of interest in appropriate and meaningful ways, and it is aligned with the constructivist paradigm. Situational analysis assisted in exploring multiples sources in detail and discovering possible emerging issues other than my foreshadowed research questions. The approach allowed me to explore the phenomenon in detail

by sharing of experiences and examining in detail the issues from three main levels (micro, meso, and macro) of health system which have a major effect on precepting nursing/midwifery students. Specifically, these levels include the micro level which basically comprise those individuals whose activities directly impact on precepting nursing students mainly the students themselves, preceptors and other healthcare professionals, direct interactions at the lower level; the meso level comprising the middle level actors who possess some amount of power to ensure that systems and policies are working and environment conducive for learning and better health outcomes. They include directors, administrators, educators, and care coordinators in organizations or institutions. The macro level comprises major actors who make policy decisions that affect both the meso and micro levels. It also has to do with the political, economic, legal, and regulatory frameworks which affects all other levels. With years of experience at several levels of nursing practice, the researcher believes that understanding preceptorship calls for an enquiry into interrelated and multi-dimensional issues at different levels and several actors. Hence, it is critical that all dimensions are explored to get a broader view of the concept which will enable the researcher to develop analytical scheme that will help.

Study Goals and Objectives

As a researcher I seek to explore the current model of preceptorship as it is practiced in Ghana with the aim of identifying the barriers to effective and robust preceptorship programs in Ghana as well as uncovering the factors that may enable its effective and productive implementation. The goals of this initiative are manifold. They included strengthening preceptorship for students who are yet to complete college and for newly qualified ones to experience maximum benefits of their nursing and midwifery education, in terms of knowledge, skills acquisition, confidence, and professional socialization. Another goal has been to increase

the body of knowledge in nursing and midwifery, and also ensuring the effective development of students, so that these students could in turn provide a higher quality of care to patients/clients. Generally, the primary objective of the study is to explore the preceptorship practices in the institution and healthcare delivery system in Ghana. The secondary objectives were as follows:

- to examine the model/standard practices of preceptorship in selected healthcare training institutions in Ghana;
- to identify challenges associated with preceptorship practice in clinical teaching, in nursing/midwifery education in Ghana;
- to explore the enabling factors in preceptorship practice in healthcare delivery in Ghana;
- to assess the role of stakeholders (external/internal) in the implementation of preceptorship in Ghana.

The concept of preceptorship was explored by seeking information from experiences of actors in the situation. As researcher, I understood in detail how the social environment in which nursing/midwifery students are taught, interact, and prepare them fully to become effective and efficient professional nurses/midwives. I explored the nature of preceptorship in Ghana by specifically looking at perspectives from policy makers, healthcare facilities, educational institutions, Ghana Nurses and Midwife's Association, Ghana Colleges of Nurses and Midwives, preceptors, nurse educators, and student nurses/midwives (implementors). With years of experience at several levels of nursing practice, I believed that understanding preceptorship calls for an enquiry into a complex, interrelated, and multi-dimensional issues at different levels and several actors. Hence, it was critical that all dimensions were explored to get a broader view of the concept which enable the researcher to develop an analytical scheme.

The study employed situational analysis as the main study method. This is an empirical approach that deeply studies social life. A situational analysis is not only a brief moment or short encounter but an enduring moment where one creates relations among many different kinds and categories of elements within their own ecology (Clarke, 2005). According to Clarke (2005, 2014), situational analysis considers the broader perspective of the situation by focusing on the social ecology and situation which helps the researcher to explicitly account for individual, collective, and contextual factors as well as interrelatedness of data. In effect, situational analysis considers the various discourses that sought to shape humanity or the situation (Clarke, 2014).

Situational Analysis—Origins and Rationale

Adele Clarke, a former student of grounded theory co-founder Anselm Strauss and a professor at the Department of Social and Behavioral Sciences at University of California, San Francisco, wrote that grounded theory was progressive, mainly because of its pragmatic roots (Clarke, 2014). Charmaz's (2006) approach sought to reduce complexities through inductive development of theory, but Clarke (2014) disagreed arguing that understanding of a situation should not be homogenized as it will result in a loss of understanding of the complexity of the situation, as well as tensions and differences. Situational analysis evolved from grounded theory through a postmodern turn because Clarke was extremely interested in the distribution of power. To Clarke, a researcher's prior knowledge should be seen as valuable rather than obstructive, which was one of the original precepts of Glaser and Strauss (1967) in their original formulation of grounded theory. In applying these perspectives to nursing/midwifery research, it becomes important that while data is collected from actors within the situation, the researcher's prior knowledge is also considered.

Clarke (2005) contended that these maps make it possible to analyze complex situations from a non-reductionist approach, taking into account interviews, observation, visual materials, historical materials, and other discursive sources of data across multiple settings. She addressed the issue of marginalized positions and voices in the discourse. She argued for the importance of pivoting the center as these marginalized voices are critical to understanding the distribution of power and who has been disempowered, understanding the implicated actors in the situation, and who is influencing the quality of training. In situational analysis the development of interview questions is evolving dependent on the iterative analytic process. Situational analysis shines a light on existing controversies, tensions, and differences. It also helps in designing a framework by utilizing multiple sources of data in conceptualizing a situation.

Situational analysis was employed in this dissertation to provide a deeper reflection of the situation where my own contribution and assumptions were explored in a reflexive manner. By exploring the various positions and relationships within the data, it helped in my rethinking and appreciation of new ways of looking at the situation. In addition, I became more conscious of how power works and impacts the situation as I learn about potential silences. The next session highlights SA and its characteristics.

Characteristics and Tools of Situational Analysis

According to Clarke (2005, 2014), situational analysis considers the broader perspective of the situation by focusing on the social ecology and situation which helps the researcher to explicitly account for individual, collective, and contextual factors as well as interrelatedness of data. In effect, situational analysis considers the various discourses that seek to shape humanity or situation. Situational analysis consists of three main tools which are applied to overly complex situations and provide thick analysis. These tools consist of three main mapping procedures:

- situational maps,
- social worlds/arenas maps, and
- positional maps.

Situational maps descriptively present the human, nonhuman, and discursive elements in a messy form representing the situation. *Social worlds/arenas maps* are created for meso-level analysis of the social worlds/arenas within which collective actors, human and nonhuman are engaged. They are grounded in symbolic interactionism theory (Blumer, 1969), and focus on the collective sense individuals make of the situation (Clarke & Star, 2007). *Positional maps* provide a depiction of the differing positions or controversies present within the situation of inquiry. They also allow for the articulation of "silences" and analysis of the "space between" positions (Clarke, 2005), That is, positional maps can unearth the quieter voices that need to be heard. Together these mapping strategies provide new ways of looking at the situation and more thorough analysis.

Mapping is an iterative process as the researcher moves from what are called messy maps representing initial thinking to more ordered maps constructed on the basis of a greater depth of understanding of the key elements of the situation. The on-going analysis and constant comparative method were used to generate maps for analysis. These maps helped me to move in and around the data, stimulated my thinking and facilitated a more in-depth analysis. I kept track of the order that each interview followed and the questions that emerge from a particular interview which enabled me to gather data from different sources. The next section ushers in the research expedition.

Study Design

In the next section after this, the study area is described with a map of Ghana, images of buildings, a model skills lab with students and a facilitator that were taken on site, target population, followed by inclusion/exclusion criteria and three tables about the participants selected from institutions in the various regions. I outline my approach to sampling, data collection, situational mapping, sampling, data collection, situational analysis, data collection tools, data collection procedure, data transcription, data analysis, coding, memo writing, field notes, constant comparison, ethics, trust worthiness, challenges, accordingly in that order. Finally, the chapter ends with a description of the adjustments made due to the global COVID-19 pandemic.

The study focused on the situation, which is preceptorship practice (nursing/midwifery personnel and students) in the delivery of healthcare. This design of the study was to examine the phenomenon in a natural setting by employing a qualitative situational design utilizing situational analysis for in-depth unstructured and focus group Interview on the examination of the situation.

The population consisted of male and female nursing/midwifery professionals who had worked for over three years within the study area; that study covered external stakeholders (MoH, NMCG, and Ghana Health Service), along with internal stakeholders (students, tutors, lecturers, and directors as unit or departmental head). I also drew on archival materials, manuals, reports, and informal discussions in selected healthcare institutions in the country.

The Study Area

Figure 3.1 shows the map of Ghana (created using mapping software, ArcGIS), with the various study participants—including health training institutions, hospitals, and governmental organizations—depicted. Ghana is a small country located along the Gulf of Guinea and the

Atlantic Ocean in West Africa with a population of about 31 million over 16 regions. The 16 regions have been further divided administratively into 260 local district assemblies. Eleven regions were included in the study. These were Greater Accra, Western, Central, Eastern, Ashanti, Ahafo, Oti, Savannah, Northern, Upper West, and Upper East. One to three districts were chosen from each region for a total of 25 districts. Below are some of the physical images in the social world/arena.

Figure 3.1

Map of Ghana Designed in ArcGIS 10.8

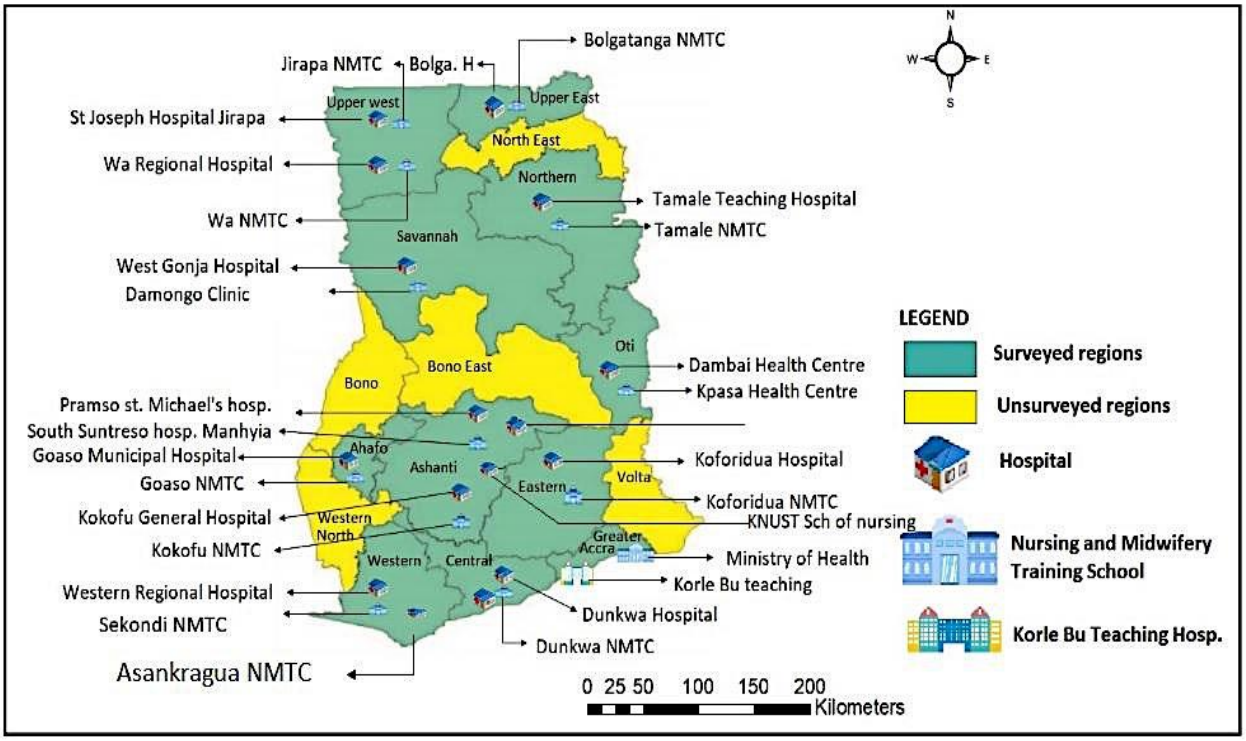


Figure 3.2 shows the buildings that house the personnel of the MoH (left) and GHS, institutions that form part of the external stakeholders which makes policies, regulates, and over sees teaching hospitals. While the GHS building shown in this study represents the headquarters of the GHS, one of the key institutions responsible for implementing policies that affect many participants in the healthcare ecosystem of this research.

Figure 3.2

Buildings of the Republic of Ghana Ministry of Health and Ghana Health Services

Ministry of Health

Ghana Health Services

Note. Photographs taken by author with permission, Republic of Ghana Ministry of Health (see Appendix F).

Figure 3.3. depicts the Western Regional Hospital, one of the key participating institutions of the healthcare ecosystem studied in this project.

Figure 3.3

Western Regional Hospital

Note. Photograph taken by author with permission of Republic of Ghana Ministry of Health (see Appendix F).

Figure 3.4 shows the waiting areas in the Tamale Central Hospital, another participating institution from Ghana's healthcare ecosystem. A significant number of people can be seen waiting to receive care an indication of the shortage of healthcare professionals at this location.

Figure 3.4

Waiting Area in Tamale Central Hospital

Photograph taken by author with permission of Republic of Ghana Ministry of Health (see Appendix F).

Figure 3.5 shows the modern I of the Greater Accra Ridge Regional Hospital which has updated to state-of-the-art infrastructure.

Figure 3.5

Greater Accra Ridge Regional Hospital

Photograph taken by author with permission of Republic of Ghana Ministry of Health (see Appendix F).

Figure 3.6 shows the Goaso Municipal Hospital and its surroundings. The road to access this hospital is elevated and made of rough sand, which can suffer erosion from extended rain, making travel here a challenge for would-be patients.

Figure 3.6

Goaso Municipal Hospital and Surroundings

Note. Photograph taken by author with permission of Republic of Ghana Ministry of Health (see Appendix F).

Figure 3.7 presents images of a senior nurse in the Skills Lab of the Ridge Hospital supervising student nurses/midwives. In the left photograph she demonstrates a procedure while in the right image, the students practice under her direction.

Figure 3.7

Skills Lab at Greater Accra Ridge Hospital

Note. Photographs taken by author with permission of Republic of Ghana Ministry of Health (see Appendix F).

The hospitals, nursing and midwifery training institutions, universities, and organizations were purposely selected to delineate the differences in preceptorship practice and these were based on the following characteristics: geographical location, religious affiliation, and endowed and not endowed sites (*endowed* meaning having the right mix of qualified staff and appropriate infrastructure including having access to primary health facilities as with teaching hospitals or large bed capacity hospitals). The five regions of Ghana that were not included had similar characteristics as the other 11 regions described above. All the selections were made to increase the sample size in other to get a wider perspective of the problem and representativeness.

The target population comprised healthcare professionals and individuals within healthcare institutions. The study covered external (Ministry of Health, Nursing and Midwifery Council, and Ghana Health Service) and internal stakeholders' (preceptors, students/preceptees, tutors/lecturers/nurse mangers, administrators/directors, and heads) in some healthcare and nursing/midwifery training institutions in the eleven regions. One university with a school of nursing/midwifery was selected from each zone of the country.

Inclusion/Exclusion Criteria of Participants

Recruiting started from the macro, meso, and then micro level which captures internal as well as external stakeholders. Within the study set criteria, not all health professionals in the healthcare system were selected, only those who have worked for more than three years used. The following categories of position were sampled: registered nurses and midwives who precept students on the ward and nursing officers, principal nursing officers, nursing, and midwifery administrators/directors/heads of departments/units, in the clinical area.

Members from these groups should have worked through the ranks for several years (at least three). For students/preceptees, I chose only third- and fourth-year students of selected

nursing/midwifery colleges and schools of nursing among the public universities in Ghana. I included these categories:

- lecturers/faculty/tutors who handle students clinicals
- directors or heads in-charge of nursing/midwifery training institutions, and
- education/curriculum developers of the NMCG, the Ghana College Nurses and Midwives (GCNM), the Ghana Registered Nurses and Midwives Association (GRNMA) and the nursing/midwifery officers responsible for policies in the MoH/GHS

Sampling the Population

The study utilized purposive and snow balling sampling technique comprising three main phases sampling procedure. Thus, participants who have adequate and extensive knowledge of the phenomenon were used.

Sample Size

Collis and Hussey (2003) argued that qualitative studies make use of a small sample size because of their ability to provide in-depth and extensive information of the phenomena being studied. Nevertheless, they added that there is no specific sample size in the qualitative study as upon data saturation, researchers can end the process of data collection. Based on that, the study reached the required sampled size after data became saturated. Additionally, qualitative studies in the literature used large sample size such as 20 or 30 participants (Asirifi et al., 2013). Due to the study design, and in order to have a geographically representative sample, a total of 43 participants drawn from across Ghana and among many different institutions were selected as now described.

Contacting Institutions and Participants

Flyers and notices were emailed to the various health facilities, universities, and organizations as well as nursing/midwifery institutions and followed with phone calls. The country has 16 regions and were categorized into three zones or belts—Southern, Middle, and Northern. The 11 regions have 52 nursing/midwifery training institutions/colleges. Twenty six nursing/midwifery training institutions/colleges were selected from the 52 by the primary researcher. There are also nine established universities offering BSN/Midwifery, three of which were selected. The basis for selecting the participants was to cover a reasonable array of nursing/midwifery training colleges and the universities to increase the sample size and get a better representation or the perspectives of the problems besetting the health institutions and facilities in the country. In addition to distributing flyers and notices, I also spoke with participants about the study face to face and/or via virtual space/class. I left my email address and phone number so that interested participants communicated via email or text messages and participated in the interview.

The in-depth individual interviews and focus group meetings were conducted during 2021 from April 15 through June 15. Before the interviews began, various reports, historical/archival materials and informal discussion data were gathered from requisite organizations. Out of the 43 participants who were interviewed in depth, 11 were males and the rest were females. There were also 16 focus groups interviews.

Tables 3.1 shows the participant numbers by gender from central institutions in Accra.

Table 3.1

Study Participants from the Greater Accra Central Institutions

	NMCG	GHS	MoH	GCNM	GRNMA
Females	1	1	1	1	1
Males			1		

Note. NMCG—Nursing & Midwifery Council of Ghana; GHS—Ghana Health Service; MoH—Ministry of Health; GCNM—Ghana College of Nurses & Midwives; GRNMA—Ghana Registered Nurses' and Midwives' Association.

Tables 3.2, 3.3, 3.4 (one for each zone) break down the sample of participants into which of the three regions they came from, what institution they were affiliated with, and then categorized by field (e.g., nursing, midwifery) and position.

Table 3.2

Study Participants from the Southern Zone of Ghana

			POSITION						
REGION	INSTITUTION	FIELD	HTI Heads	Preceptors	Other Hospital Admin	Staff Unit Heads	Tutors/Lecturers /Faculty	Students
EASTERN	Koforidua NMTC	Nursing & Midwifery Training College	1	1			1	1
				1			1	1
	St Josephs' Hosp	Healthcare Institution				1(*m*)		
WESTERN	Sekondi NMTC	Nursing & Midwifery Training College	1				1	1
							1	1
	Sekondi Regional	Healthcare Institution		1				
				1	1			
	Asankragua NMTC	Nursing & Midwifery Training College	1(*m*)				1	1
								1
	Asankragua Hospital	Healthcare Institution		1		1		
GREATER ACCRA	KorleBu NMTC	Nursing & Midwifery Training College	1	1				
	KorleBu Teaching Hosp.	Healthcare Institution	1(*m*)	1			1	1
	Leckma Hospital	Healthcare Institution			1			

REGION	INSTITUTION	FIELD	POSITION					
			HTI Heads	Preceptors	Other Hospital Admin	Staff Unit Heads	Tutors/Lecturers /Faculty	Students
	Ridge Regional Hospital	Healthcare Institution			1			
CENTRAL	University of Cape Coast School of N&M	Nursing & Midwifery Training College					1	1
TOTALS	Individual Interview Participants (Total = 16)		5	1	5	3	2	
	Focus Group Participants (Total = 20)			7			6	7

Note. Participants were female except those marked with (*m*). NMTC means Nursing and Midwifery Training College. N & M means Nursing and Midwifery.

Table 3.3 shows participant characteristics for the Middle Zone which includes the Central, Ashanti, Oti, and Ahafo regions.

Table 3.3

Study Participants from the Middle Zone of Ghana

REGION	INSTITUTION	FIELD	POSITION					
			HTI Heads	Preceptors	Other Hospital Admin	Staff Unit Heads	Tutors/Lecturers /Faculty	Students
CENTRAL	Dunkwa NMTC	Nursing/Midwifery Training College	1(*m*)	1 1			1 1	1 1
	Dunkwa Municipal Hospital	Healthcare Institution Nursing/Midwifery Institution			1	1		
AHAFO	Goaso NMTC	Nursing/Midwifery Training College	1(*m*)	1				1 1
	Municipal Hosp.	Healthcare Institution		2	1		2	
OTI	Ketekrachi MTS	Midwifery Training College	1	1			1	1
	Ketekrachi Hosp.	Healthcare Institution			1	1		
ASHANTI	Kumasi KNUST	Nursing/Midwifery Training College					1	2

REGION	INSTITUTION	FIELD	POSITION					
			HTI Heads	Preceptors	Other Hospital Admin	Staff Unit Heads	Tutors/Lecturers /Faculty	Students
	South Suntreso Hospital	Healthcare Institution		1				2
	Pramso Saint Michael Hospital	Healthcare Institution		1(*m*) 1				
	Kokofu NG/MD	Nursing/Midwifery Training College	1				1	
	Kokofu District Hosp.	Nursing/Midwifery Healthcare Institution			1(*m*)			
TOTALS	Individual Interview Participants		5	1	4	1	1	
	Focus Group Participants			7			5	7

Note. All participants were female except those marked with (*m*). NMTC is Nursing and Midwifery Training College. MTS means Midwifery Training School. N & M means Nursing and Midwifery.

I purposively sampled one head from the selected nursing/midwifery training institutions and one from Nursing/Midwifery in-charge/manager/director/administrator from the primary healthcare facilities and engaged in in-depth individual interviews.

Table 3.4 provides information for the participants in the Northern Zone, which comprises five regions, though only four were selected for this study: Upper West, Upper East, Northern, and Savannah regions.

Table 3.4

Study Participants from the Northern Zone of Ghana

REGION	INSTITUTION	FIELD	POSITION					
			HTI Heads	Preceptors	Other Hospital Admin	Staff Unit Heads	Tutors/Lecturers /Faculty	Students
UPPER WEST	Wa NTC	Nursing Training College	1(*m*)				2	1
	Wa Regional Hosp	Healthcare Institution		2				
	Jirapa N&MTS	Nursing & Midwifery Training College	1(*m*)				2	2
	St Josephs' Hosp	Healthcare Institution		2		2		
UPPER EAST	Bolga N&MTS	Nursing & Midwifery Institution	2(*m*)			1	2 2	2 2
	Bolga Regional Hospital	Healthcare Institution		2	1	1(*m*)		
	Bawku NTC & Presby Hospital	Nursing & Midwifery Healthcare Institution		1			1	1
NORTHERN	Tamale NMTC	Nursing & Midwifery Training College	1	2			2	2
	Tamale Teaching Hospital	Healthcare Institution			1	1		
	UDS School of Nursing & Midwifery	Nursing & Midwifery Training College					1	1
SAVANNAH	Kpembe NMTC	Nursing & Midwifery Training College	1				2	2
	Salaga Govt. Hospital	Healthcare Institution		2		1		
TOTALS	Individual Interview Participants		5		2	4	1	
	Focus Group Participants			9			13	13

Note. Participants were female except those marked with (*m*). NMTC is Nursing and Midwifery Training College.

I grouped the regions into zones/belts, with each zone/belt having three or more separate focus group interviews. I selected lecturers/tutors, preceptors, nurses/midwives' managers, and students in the third and fourth years from selected schools and their primary sites hospitals in

the regions to form each belt. The groups were made up of three to five participants purposively sampled from selected Nursing and Midwifery Training Institutions and primary hospitals. The following section is the situational initial messy map which was performed before the interviews.

Situational Maps

I began this study and subsequent analysis first by developing initial messy map which served as a project map, then an ordered map showing refinement of data from initial messy map, and finally, social world/arena maps. These maps guided the study prior to data collection and analysis. The final version of the maps used for this study, which were derived from these initial maps through continuous refinement, are presented in Chapter IV.

Messy Maps

The fundamental importance of messy maps is that "they intentionally work against the usual simplifications characteristic of scientific work" (Clarke, 2005, p. 100). Situational analysis tries to eliminate outliers at this (or any) stage of a research. These are mind maps of the raw data emerging from the research, and, as such, are a snapshot in time of the process of making meaning.

Figure 3.8 shows initial messy map comprising all issues perceived to be affecting the situation of preceptorship in Ghana. It is the starting point for the situational maps which lays out the groundwork of human and nonhuman element or actors in the situation. It is a starting point for identifying patterns and connections from the literature (e.g., journal articles from databases, developed manual from the MoH), other sources and my experiential knowledge. The maps, according to Clarke (2005), should "capture the messy complexities of the situation in their dense relations and permutations" (p. 100).

Figure 3.8

Initial Messy Map

The initial messy map lays out all issues that I perceived to impact on the preceptorship phenomenon. On this, data were gathered from the researcher's own reflexivity, literature, archival materials, policy documents, and reports from the GNMC and GHS. This gave me a broader view of the issues affecting preceptorship practices in Ghana, though some of the issues

were later not relevant to the study and were removed through continue refinement of data and further development as new messy map and ordered map as shown in the Chapter IV.

Situational analysis opens up data through the provision of comprehensive framework for considering multiple connections and relationship that can influence activities (Clarke, 2005). The network within which interviewees exist become visible and, importantly, exiled components of the network can also become visible through the process. According to Clarke et al. (2015), situational maps and analyses are based on gathering data through interviews, documents, and other sources, such as web sites, to illuminate basic social problems. Situational maps, considered an analytical exercise, can be used to stimulate thinking and to free the researcher from analytic paralysis (Clarke & Star, 2007). Furthermore, situational maps help in articulating arguments or assertions of other elements of a situation.

This section employs situational analysis using the three main maps of situational analysis. The approach is consistent with Clarke's (2005) description of the analytic process of situational analysis working map and mapping is an iterative process in which maps can be revisited in order to expand or modify existing elements as new data is collected. Each of the maps reflects a situated representation of the situation. The messy map will be created first with the literature review laying out all the groundwork for considering all the human and the non-human elements and actors in the situation.

Ordered Maps

Based on the initial messy map, I created an ordered situational map to bring of clarity to and make sense of the data (Figure 3.9). This involved adapting the framework Clarke (2003) suggested.

Figure 3.9

First Ordered Map for Study of Preceptorship Practice in Ghana

Individual Human Elements/Actors	**Nonhuman Elements/Actors**
Administrators, preceptors, nurses, midwives, researcher, Ivy, students	Hospital
Preceptors	Health centers
Nurses	District hospitals
Midwives	Clinics
Researcher (Ivy)	Maternity clinics
Tutors	Reference manual for preceptorship in midwifery
Collective Human Elements/Actors	**Implicators/Salient Actors/Actants**
NMCG	Preceptors
MoH	GRNM Association
GHS	Students
Midwifery schools	Nurses/Midwives
GRNM Association	Expansion of schools
WHO	Lack of adequate supervision
Human Resource for health development	Responsibilities of midwifery schools
Curriculum review committee	Competent base learning
Poor student monitoring	Lack of facilities in some regions (1980s)
Expansion of student population	Mastering basic nursing competence
Lack of support from NMCG	Permission for continuing education
Lack of support from Ministry	Remuneration
Adult learning	Competent base learning
Reduction of preceptor workload	Communication between school, clinical site and preceptor
Students' observation of provision of care	
Adequate support and effective collaboration	Proficiency in clinical and counseling skills
Personal commitment of leaders	support for health training institutions activities
Poor student monitoring	Assist educational institutions
WHO Training programs for nurses	Adoption of tools
Role of tutors, preceptors important	Adoption of methodologies
Students' roles and responsibilities	Practical skills and training as important to preceptors
Student's attitude	
Preceptor support	Coordination of activities
Preceptor selection	Dressing as important in student training
Establishing and maintain preceptor system	Mastering basic nursing competence
Preceptor qualification	
Preceptor criteria selection	
Role of policy maker	
Agreement on clinical and preceptor standards to prepare students for preceptorship	
Adult learning	
Impact of preceptor support	
Preceptor time to meet tutors/students	

Political/Economic Elements

Cost of in-service training
Allowance to students
Preceptor system monitoring
Agreement on clinical and preceptor standards
signing agreement letter
Cooperation issues

Temporal Elements

Reference manual for preceptorship in midwifery, 2013
1980s good collaboration and support from district directors
2005–2008 report
Commitment for a period
1980s good collaboration and support from district directors

Major Issues/Debates

Preceptorship supervision
Formal Policy and guidelines development
Equipment deficit
Cooperation between institutions and facilities
Allowance for precepting
Preceptor distinction

Key Events in the Situation

1980s clinical teaching

Sociocultural/Symbolic Elements

First class attitude
Student's attitude needed
Standard base management approach

Spatial Elements

Emergence and existence of several training schools, UG, KNUST, UCC
Accra

Related Discourses

Lifesaving interventions

Ordered maps involve sorting out elements identified into a particular group or categories. The categories often encompass specific, though permeable, areas of effect. In this landscape, what happens at any level is affected by what happens at any other level to a greater and lesser extent. The focusing tool of situational analysis allows the researcher to purposively change perspective and lens so that some of the most closely enmeshed elements will be described as heading to become visible for sense making and understandable. Clarke (2005) suggested 12 headings for the ordered map, ones which capture and group the elements and actors' individuals, groups, or non-human entities. Examples of such actors are implicated silent elements/actors, discussive construction, temporal elements category, political, economic, and

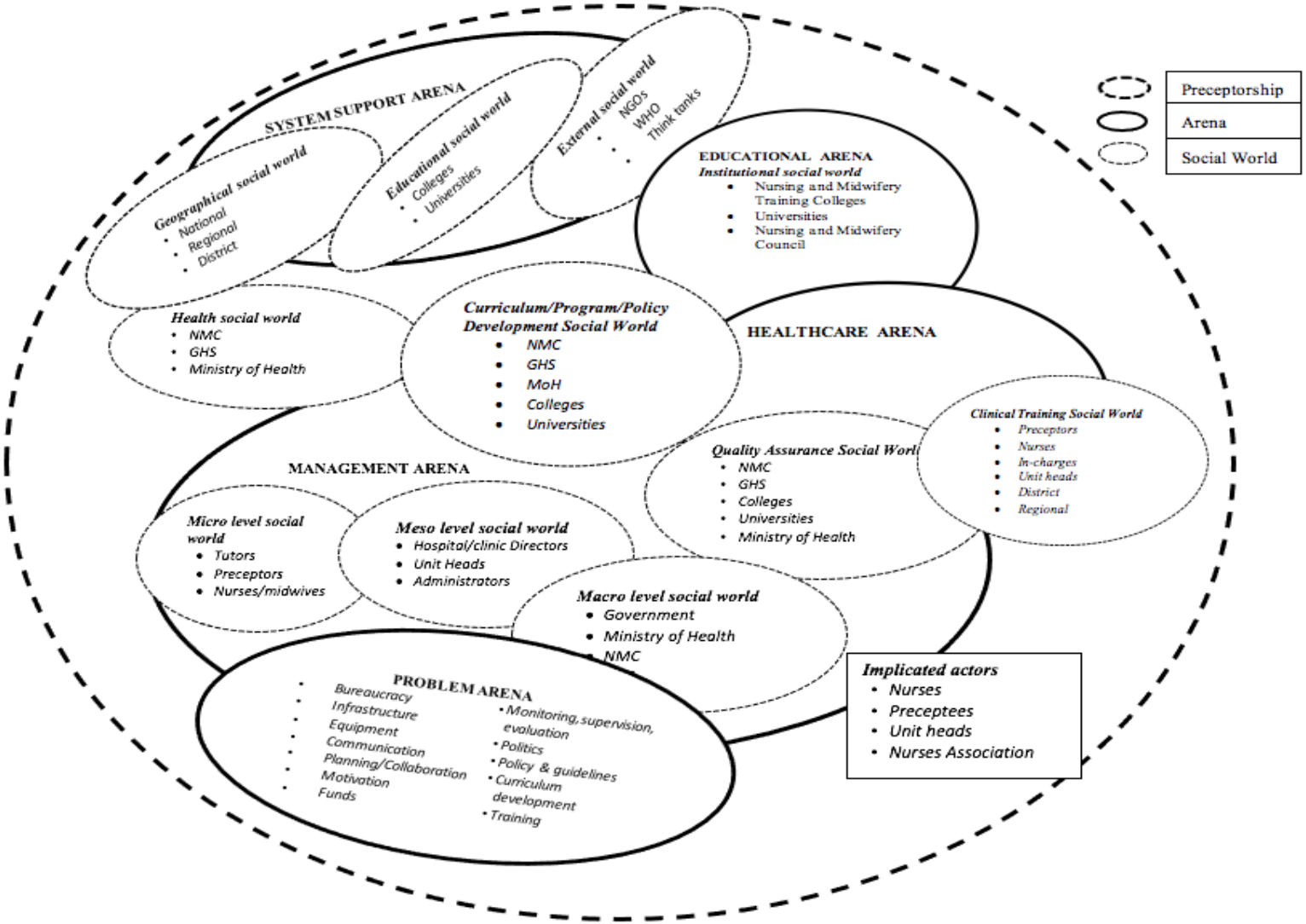
sociocultural elements which facilitate thinking in a broader framework in a situation, among others. Creating the ordered map facilitates the exhibition of all the elements and discourses in the situation which will be grossed over. Developing the ordered map for preceptorship meant that all elements and actors from the messy map are placed within the appropriate category. Developing this map initiated the analytical framework for social worlds/arena. Moreover, the maps have the flexibility to grow and change and can inform theoretical sensitivity and can stimulate additional collection of data.

Social World/Arena Maps

The third category of map that was used to explore the situation was the social world/arena map as shown in Figure 3.10. This map identifies "the various arenas, social worlds, collective actors, discourses, and commitment which they are engaged in the situation" (Clarke et al., 2015, p. 14). It was originally constructed with pencil and paper which helped in focusing the data. Social arenas or larger groups of social worlds were mapped with dotted lines because no distinct boundary separates them. They can overlap since individuals are located in more than one social world at a time. Salazar-Perez and Cannella (2013) suggested such maps "are distinctly postmodern because directionality, boundaries, and traditional forms of scientific negotiation are all challenged" (p. 513). The maps identify "basic social processes that construct and constantly destabilize social worlds' relations and arenas maps" (Clarke et al., 2015, p. 14). Social worlds arenas maps are built by situational analysts to "lay out the collective actors and the arena(s) of commitment and discourse within which they are engaged in ongoing negotiations—meso level interpretations of the situation" (Clarke, 2005, p. 99). High levels of abstractions are provided to "offer interpretations of the broader situation, taking up its social organizational, institutional, and discursive dimensions" (Clarke et al., 2015, p. 214).

Figure 3.10

Social World/Arena Map for Preceptors in Ghana



This map was originally constructed using pencil and paper which helped in focusing on the data and make easy changes with the map before generating a final map using Microsoft Word. Social arenas or larger groups of social worlds were mapped with dotted lines. This is because social world has no true boundary separating them, and they can overlap since individuals are located in more than one social world at a time (Clarke, 2005). Earlier work by Salazar-Perez and Cannella (2013) suggested that social-worlds/arenas maps "are distinctly postmodern because of directionality, boundaries and traditional forms of scientific negotiation are all challenged" (p. 513). These maps identify the "'basic social processes' that construct and constantly destabilize social worlds' relations and arenas maps" (Clarke et al., 2015, p. 14). Social worlds arenas maps are built by situational analysts to "lay out the collective actors and the arena(s) of commitment and discourse within which they are engaged in ongoing negotiations—meso level interpretations of the situation" (Clarke, 2005, p. 99). High levels of abstractions are provided to "offer interpretations of the broader situation, taking up its social organizational, institutional, and discursive dimensions" (Clarke et al., 2015, p. 214).

Having a view of the social spheres/power arenas map interests me as a way of sharing my understanding of the social spheres/arenas that might be revealed in my study in a similar way. The motivation for creating the social world was to identify various tensions expressed and experienced by actors whose workings impact on preceptorship and further how these actors communicate and collaborate. Questions put forward in creating this type of map included what pattern of interaction and commitment exist between actors and salient social world, who is actively involved in the social world and who is not, what kind of environment does preceptorship operate, and which of the environment greatly impact on preceptorship. The map depicts three main arenas which shows the tension between education, health institutions, and communications.

In addition, Figure 3.3 shows five main social worlds which include preceptors, students, number of students per preceptor and tutor/lecturer, resources/logistics, and Ghana registered nurses/midwife's association and nursing and midwifery counsel within which exist both human and non-human actors all which impact on preceptorship.

Positional Maps

Positional maps are created after initial, ordered, and social worlds maps have been prepared, and data is finally saturated. These maps are presented in Chapter IV. They "lay out the major positions taken, and not taken, in the data vis-à-vis particular axes of variation and difference, concern, and controversy around issues in the situation of inquiry" (Clarke, 2005, p. 99). The importance of positional maps is that they give voice to the silent voices. Whilst situational maps and social worlds/arenas maps should enable the researcher to define elements and collectives present in a situation (micro-level or meso-level), positional maps reflect the different points of view taken within it (Mathar, 2008). The challenge Clarke (2005) presented to the researcher was to analyze, not just consider, individual or group human and non-human elements when delineating which positions are taken but to also recognize the paradox of potential contradictions that may occur when positions are articulated, "independently of persons, organizations, social worlds, arenas, non-human actors, and so on [which] allows the researcher to see situated positions better" (Clarke, 2005, p. 127). Indeed, it is claimed that Clarke's emphasis on such contradictions is the most significant factor here (Mathar, 2008) because if the contradictions were not considered, then the situational analysis would merely be oversimplified associations made between individuals or social worlds, as opposed to the researcher being enabled to create spaces between actors and positions.

The importance of considering the most significant positions taken (or not) taken by representing the complete array of discursive positions allows for the heterogeneous nature of "multiple positions and even contradictions within both individuals and collectives to be articulated" (Clarke et al., 2015, p. 14). I found this visual dimension of reviewing other research using positional maps aided my understanding. My aim in creating a positional map was to search for potential issues to situate my current study. In the current study preceptorship occurs within a social environment and affected by both human and non-human factors. A significant part of engaging in a situational analysis study is the examination of those sensitizing concepts that as a researcher, I bring to the study.

Data Collection

Data Collection Tools

A questioning guide was designed to exhaustively cover the objectives of the study. The design made room for probing questions and deemed necessary. I employed an interview guide to encourage participants to share their thoughts, perspectives, and insights about preceptorship practice in nursing/midwifery institutions, schools of nursing/midwifery (universities), with some hospital personnel, GNMC, GHS, and MoH participants in Ghana.

Interviews are widely used tools to gain a detailed picture of a participant's experiences and their inner perceptions, attitudes, and feelings of reality. The unstructured interview involves an in-depth, interactive dialogue between the interviewer and the participants on the phenomenon under the study main issues. A questioning guide was designed for the external stakeholders (MoH, GHS, and GNMC) at the macro level, then develop another one for heads of institutions, Nursing and Midwifery directors, and administrators at the meso level. A questioning guide was also prepared for the ward in-charges, preceptors, staff nurses and midwives, lecturers/tutors, and

preceptees at the micro level as well. Most of the questions were common across the three types of questioning guide. However, there were many differences between them, depending on the roles and functions they perform in the various settings.

Before the research began, letters requesting permission to carry out the research were sent from the Antioch University Institutional Review Board, Nursing and Midwifery Council Institutional Review Committee, and the Ghana Health Service Ethics Review Committee. Approved informed consent documents were prepared for use with the participants and as needed, their institutions. After getting approval to conduct the study and providing relevant documents and confirming their support, I approached participants who voluntarily decided to take part in the study at the time and date to begin the data collection. There were two consent forms: one for in-depth individual interviews and another for focus group interviews. These were provided to each participant.

At the time of interviews, introductions were made by reading the participants the general and consent information. I sought permission from respondents to have the interview recorded, signing of consent form after which the interview began. Data collection was in three phases using in-depth individual interviews, focus group interviews, and voice recordings document search as outlined above under the data collection procedure. Procedure for data collection was as follows:

- **Phase One** A—This was done before interviews began and consisted of document search and examination of archival/historical records and secondary data from various Institutions (GHS, MoH, Nurses and Midwives training institution reports, and informal discussions).
- **Phase One B**—In-depth interviews were conducted from participants at the macro or governmental level.

- **Phase Two—**In-depth interviews were employed for nursing and midwifery institutional heads, organizational directors, and administrative heads.
- **Phase Three**—Focus group interviews were employed for students, preceptors, and tutors /faculty/lecturers and in-depth interviews for few students, preceptors, and tutors /faculty/lecturers.

The study investigated preceptors' issues from three main levels of health system which have a major impact on precepting nursing/midwifery students in the healthcare facilities. These systems are as follows:

- Micro level, which basically comprises those individuals whose activities directly impact on precepting nursing students mainly the students themselves, preceptors, and other healthcare professionals, direct interactions at the lower level.
- Meso level comprising the middle level actors who possess some amount of power to ensure that systems and policies are working and environment conducive for learning and better health outcomes. They include directors, administrators, educators, and care coordinators in an organizations or institutions.
- Macro level are major actors who make policy decisions that affect both at the level of meso and micro. It also has to do with the political, economic, legal, and regulatory frameworks which affects all other levels.

Participants provided answers to a set of questions relating to my research areas only, personal questions were avoided. In order to accurately capture answers given by the participants, a voice recorder as well as zoom recorder were used. A consent form including permission to record was provided to and signed by each participant before the commencement of each interview. The researcher took field notes, and participants assured of privacy and confidentiality

of their information and was not used for any purpose except research and that no individuals were not identified personally.

Informed consent information contained advice to the target participants of the nature of the study. The participants' rights were clarified, and they were informed that their participation is voluntary and that they can choose to leave the interviews at any time. In addition, participants were made to understand that the in-depth interview were audio-recorded and later transcribed. Also, participants were assured of anonymity and that their names were not mentioned or published anywhere. Thus, the researcher coded the responses of the participants, which were kept their responses confidential.

The focus group research involved the invited participants in group discussions that lasted for 45 to 60 minutes. There were between three and seven participants in groups with meetings that had been scheduled at a time best for all.

At some points, participants did not see each other as they covered themselves on Zoom and some saw and heard them as they uncovered on zoom in the focus group interview, hence, anonymity was challenged. However, at the beginning of the discussion, all participants were requested to keep information or what happens in the focus group confidential**.** Written consent was obtained for each of the participants before the commencement of each focus group interview. However, in presenting results, I have de-identified all information so that it cannot be connected back to individual participants.

Notes of issues discussed, along with tape recordings of the discussion sessions, remain kept in a locked, secure location. Participants for focus groups were reached via phone or email and assigned specific code numbers used for zooming interviews. The zoom settings were controlled to hide the participants' faces. Focus group interviews were audio recorded with the

consent of participants. I was able to assure participants that their information would not be used for any purpose except the research described in advance and that no individuals should be identifiable personally. I explained that an observer would take written notes during the discussion to keep track of emerging ideas and questions. The observer was trained on the observation and reporting of the data and signed consent form. The information discussed in the group has been treated as private and confidential and not shared outside the group. Only group data are reported in this dissertation.

Data Transcription and Analysis

Data were transcribed alongside each interview. A professional transcriptionist was hired to transcribe all interviews. I listened to the recordings several times and carefully reviewed the transcripts for all the relevant information.

Data from interviews were recorded, transcribed, along with memos, archival materials, newsletters, formal and informal manual, and websites. Both electronic and hand search were used to access materials from the public domain. The process of constant comparison was used in which data analysis is ongoing and influences data collection.

Data were analyzed using the three main situational analysis forms of mapping: situational maps, social worlds/arenas maps, and positional maps. The purpose of constructing these maps is to get the researcher thinking about the different elements within the situation and the relationships between the elements (Clarke, 2003, 2005, 2014). Social worlds/arenas maps are created for meso-level analysis of the social. Arenas/social worlds within which collective actors, human, and nonhuman elements are engaged among themselves. Positional maps provided a depiction of the differing positions or controversies present within the situation of inquiry. The maps acted as a refinery and gave a broad description of the situation which helped to construct

preceptorship empirically. The maps were consistent with Clarke's (2005) description of analytic processes of situational analysis. Mapping is an iterative process in which maps were revisited in order to expand or modify in existing elements as new data was collected. Each of the maps reflected a situated representation of the situation. The messy map was created first with the literature review laying out all the groundwork for considering all the human and the non-human element and actors in the situation.

Coding

The recorded interviews were initially transcribed manually by breaking down statements line by line into codes and concepts. When analyzing data, the researcher considers the components of "why, where, how, and what happens; inter/actions and emotions; and consequences—of inter/actions and emotions" (Birks & Mills, 2011, p. 94). In situational analysis mapping as used in this dissertation, "initial coding results in messy and intricate diagrams, which evolve into neat and simple diagrams as you move into intermediate and advance coding stages" (Birks & Mills, 2011, p. 100). I relied on one volunteer as part of the coding team who coded interviews independently for comparison with my own codes. This was to put into perspective my innate biases as much as possible.

This process allowed for a "heuristic device that leads the researcher to study each line of data to discern the action it indicates" (Bryant & Charmaz, 2010, p. 410). This is necessary because it is all too easy for researchers to translate what an interviewee said into what they expected to hear. Breaking the transcript up allows for more curiosity, which leaves room for the authentic meaning the interviewee intended. According to Holloway and Schwartz (2018), "the coders pay close attention to the language and structure, intonation, and metaphor embedded in the conversation" in order to avoid hearing only what we wanted or expected to hear (p. 515).

In the course of examining transcripts for pieces of information, codes develop into concepts and concepts become the "categories which describe concepts" (Holloway & Schwartz, 2018, p. 515). Categories are identified with the central ideas which are distilled from the interviews. These groups made it through the furnace of constant comparison and have been emerged from numerous interviews and dialogues. According to Birks and Mills (2011), "Any concept that is relevant will persist, and any that is not will eventually self-extinguish" (p. 174). Over time, while the researcher works with these concepts, a category develops as "a descriptive or explanatory idea, its meaning embedded in a word, label or symbol" (Birks & Mills, 2011, p. 86). Categories which are identified through constant comparisons may later became the building blocks for the situational analysis.

Memo Writing

Writing memos is a common practice when grounded theory research is undertaken (Charmaz, 2006). However, all qualitative approaches can be enhanced using memos. Memoing is not restricted to the analytical phase alone but from the time a study is conceptualized. It helps to provide fine-tuned the research topic and facilitate the development of the study design. Memoing records the natural progression of the study along with any changes in the direction of the study and the context from which they arose. The best approach to memos writing is for each researcher to do what works for them (Charmaz, 2006). Some may use conversational style others not. One may write with pen or paper or record it on computer program. It is a personal choice (Clarke, 2005).

Memoing was performed in this study using electronic format by recording and typing using computer. I mainly utilized analytical memos which provided the opportunity to examine data at great length of abstraction and to explore relationship and explanations contained in the

data. For instance, with analytical memos, I was able to explore codes, concepts, and the situational maps in details through abstractions and examining relationship between and among the data contain in messy maps and positional maps. I performed memoing specifically after the coding session. Thus, memoing was done by focusing on certain ideas and thinking that came to mind after I had completed some codes which I needed more and detail understanding on some concepts and issues. For instance, on the issue of preceptor background, the data collection showed that preceptors are experienced nurses who are charged with the responsibility of providing clinical training to students, but it was noted that at the same time these preceptors also perform their normal duties in the course of clinical training. I noted this in my memo and sought to find out why not having specific people assigned solely to provide clinical training to students. Again, through memoing the concept of motivation of preceptors was further clarified by asking whose responsibility to motivate preceptors. The same applied to supervision by tutors whether it had been effective or not. Thus, I went back to participants to seek better clarification on some issues and concepts.

In relation to messy maps, through memoing, I was able to make sense of unclear elements/concepts within the situation and how they relate with each other and others. For example, through memoing, the concepts of clinical training, academic calendar, and the practicum were clear in how they relate to inter and intra semesters. Thus, the question of how inter and intra semester relates to clinical training, academic calendar, and practicum and how that can impact on preceptorship was answered. From narratives given by participants, the intra semester was understood as a period within the normal semester where students are provided with clinical training normally for a period of a month or few weeks. In all, I was able to develop 24 electronic memos including some which were recorded.

Field Notes

According to Birks and Mills (2011), "Field notes should be made after you conduct interviews to retain details of the physical environment, to record your immediate responses to the interaction and to capture participant non-verbal behaviour that will not be revealed through transcription" (p. 76). Because not all of the context of the interview can be captured through the words themselves (H. Schwartz, personal communication, May 15, 2019), it is advisable to make process comments to get nonverbals into the transcript and onto the data record, such as, "You smiled when you said that; what does that mean?" I undertook field notes on the physical environment of the various places where the data collection occurred using digital camera to capture images of data collection settings.

Constant Comparison

In constant comparison, each interview generated its own codes that was then compared with other sets of codes from other interviews. Codes are "important words or groups of words (usually verbatim quotes from participants) which are themselves used as the label" (Birks & Mills, 2011, p. 10). Coding did not wait for all the other interviews to be completed but began with the receipt of the first transcript and continued throughout. As with interviewees, researchers' experience is always and ever in process, even as they attempt to gain some idea of patterns and important concepts. The initial coding allowed the researcher to see recurring ideas in the data and to align the interviewees' descriptive words to those ideas. The procedure of comparing codes, concepts, and categories was continuous which involved comparing new data and previously collected ones and reassessing codes and focused concepts derived from those codes (Glaser & Strauss, 1967). Categories are aggregates of codes and concepts, but they are not structuring, once found, are considered to be final truths.

Ethics

The research proposal was submitted to the ethical review board at Antioch University using the online submission system. The research proposal was also submitted to the review board at the Ghana Research Ethics Review Committee in Ghana, as well as Ethics Review Committee of the NMCG. Both were approved after going through a rigorous process. The following are the ethical considerations that were considered to ensure for the preservation of dignity, privacy, and safety of the study participants. Also, participants were assured of anonymity and that their names would not be mentioned anywhere in the study or in subsequent publications. Thus, I used codes for participants, which helped keep their responses confidential. The participation was in the form of face to face or and virtual interview in the form of zoom conference, phone call conference, at their own choice of day and time for a period of 25 to 36 minutes for in-depth individual interviews and 45 to 60 minutes for focus group interviews. Consent forms were provided for in-depth individual interviews and focus group interview participants to sign.

Informed consent was sought from the target participants after they read the information on the nature of the study. The participants' rights were clarified, and they were informed that their participation is voluntary and that, they can leave the interviews at any time. In addition, participants informed that both the in-depth individual and focus group interviews would be audio-recorded and later transcribed. In the case of focus group interview participants, some may have been able to see each other and hear what each other stated. Therefore, participants were informed that information shared in the interview should be kept confidential and private. The information should not be shared outside the focus group interview.

The interview began with the introduction and signing of informed consent forms after which I sought permission from participants to have the interview recorded. The signed forms and

initialled information sheets have been stored separately in locked cabinets in a separate location than where the data were stored. Each audiotape and transcript were identified with a number. The researcher alone had access to the codes or identifiers of the participants. All identifiers of study participants were eliminated from the transcript to preserve anonymity of the research participants. I stored the research study materials appropriately under lock and key and virtual document encryption to maintain confidentiality. The data obtained from the study would be stored by the researcher for at least five years after the study has been completed.

There are few risks for participants associated with this research study. Participants were assured that if they became uncomfortable during the interviews or wished to withdraw from the study, they could freely do so without giving reasons. The participants were informed that the withdrawal of participation will not affect their conditions of employment or position. Participants in focus group interviews were counselled or informed that everything said should remain confidential and comments from specific individuals should not be attributed to them in outside conversations.

Research Trustworthiness

Credibility was established using field note taking, prolonged engagement with participants, and member checking. All participants had the opportunity to review transcripts of their interviews for content and accuracy. Dependability was ensured by engaging in careful and extensive journaling and memoing to explain how the data was collected and analyzed. The study also ensured transferability through participant's description of their experiences in detail.

Challenges in Conducting the Study

Every research study comes with its own challenges and in embarking on this research journey, I faced my fair share of challenges, a significant one being obtaining permission letters

from the institutions I needed to study. Though I was a Ghanaian and a former worker at one of the institutions (making me essentially an insider), I was treated like an outsider because I was based in the United States. This led to delays in receiving clearance, which affected when I could begin conducting interviews. Additionally, I faced a delay in receiving clearance from the ethics board, which also delayed the conduct of the interviews. Combined, all these delays had the trickle-down effect of exacerbating the difficulty of completing the project on time.

Another challenge I faced was funding for the project. I had initially been informed that my employer in Ghana would be assisting with the funds; however, when this funding did not materialize, I had to turn to close family members for financial support to take care of the various expenses involved including transport arrangements, accommodation in some of the regions, payment of administrative personnel who assisted me in the collection and organization of data, and refreshments and incentives needed for the study participants, among other miscellaneous expenses.

Given the COVID-19 situation, I was not able to collect all the data in person, using one-on-one interviews. Instead, I had to adopt a virtual approach to collect the data. This in and of itself presented challenges because of the poor internet access and intermittent internet connection for some of the study participants, especially in Ghana's Northern Region. I even had to transition to phone calls and WhatsApp calls. As a result, I was not able to interview some of the key identified participants because they decided to drop out of the study after our frustrating efforts to connect.

Finally, another challenge had to do with securing the cooperation of some of the participants at the regional and national level who seemed hesitant to meet due to the ongoing pandemic. The main problem was obtaining the consent of respondents agree to participate in the

study. What was not anticipated from the beginning of the study was the impact of COVID-19 on data collection. The COVID-19 situation impacted on the study such that I was unable to have a direct or onsite interview with participants which could have made it easier in terms of reaching them and their responsiveness to participate in the study. Thus, given the pandemic, it was difficult getting participants on phone calls as well as their attention. I also experienced data connectivity challenges during Zoom interviews as there was intermittent breaks in networks. Irrespective of these challenges, I managed to adjust the situation by providing extra data to participants and changing interview times as I noticed that some time periods especially evenings were challenged with connectivity problem especially for those in the Northern regions. I also had to extend some of the days of the interview though mutual understanding with participants. Some participants were exceptionally helpful and spoke to their colleagues about which helped increase participation rate.

Financial support was sought from close family members to help in the cost of the project. Mobile data and call credit were given to respondents to motivate them and get their attention to participate in the study. Finally, all COVID-19 protocols such as face mask, hand washing, social distancing, and sanitizing were adhered to. In situations where it becomes difficult for face-to-face interview or focused group, appropriate technology such as phone or virtual (e.g., Zoom) were utilized albeit with some loss of the directness that only in-person discussions can achieve.

CHAPTER IV: DATA ANALYIS WITH SITUATIONAL MAPS

The purpose of this study was to explore the current model of preceptorship practice in Ghana with the aim of identifying the barriers and enablers to effective preceptorship program in Ghana. Specifically, it sought to answer questions on the nature of preceptorship approaches in selected healthcare training institutions in Ghana; the challenges associated with preceptorship practice in the delivery of healthcare in Ghana; the enabling factors influencing preceptorship practice in healthcare delivery in Ghana, and the role of external (NMCG, MoH, GHS & GRNMA) and internal (student nurses, faculty/nurse/midwife educators & preceptors) in the entire preceptorship program.

This chapter presents analysis of data derived from interviews, focus groups discussions, and discourses such as the preceptorship manual from MoH and the Ghana College of Nursing and Midwifery. Clarke's (2005) situational mapping strategies was the analytical technique for the study. Given that this study sought to explore preceptorship practices in Ghana in detail, situational analysis became appropriate and relevant technique to analyze data collected from the study. Situational analysis aids for exploring a phenomenon in detail as it provides a comprehensive framework for working through multiple data, creating connections and relationships which are relevant in understanding of a phenomenon in details. Situational analysis provides unique and clear understanding of a phenomenon using explanatory maps and immerse the researcher into the data and situation of enquiry (Clarke, 2014). The first section of this chapter begins by presenting the various maps that were created from the beginning of data gathering to the final maps utilized for discussions of the study. As such, it begins with messy maps, and continues to ordered maps, relational maps, social worlds maps, and positional maps.

The second section provides an interpretation of the key maps that ended up in the final stage of the study for discussions in the next chapter.

Situational Analysis Maps

This section describes the several kinds of maps that were developed in conducting situational analysis.

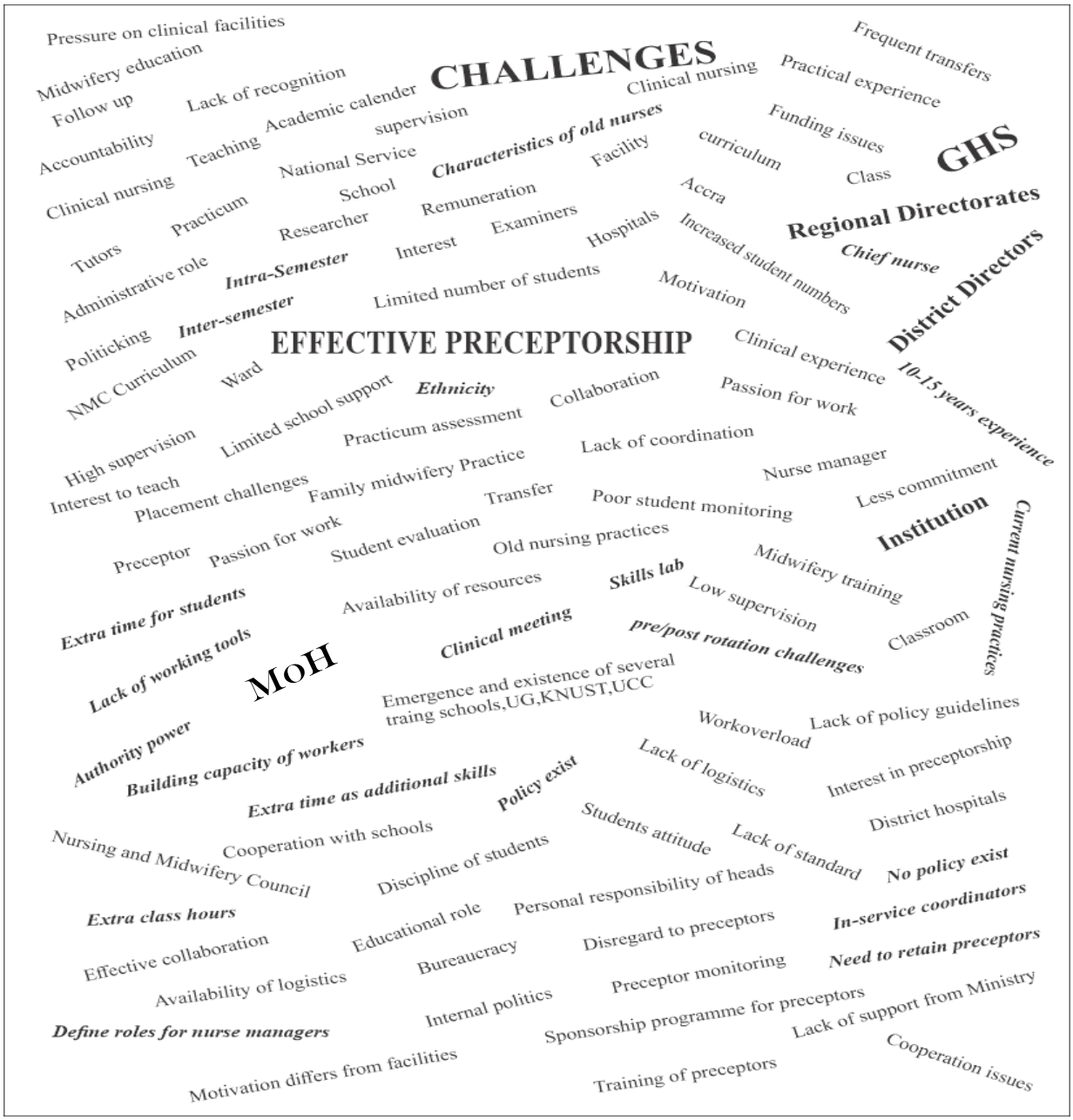
Messy Maps

The initial messy maps were done in preparation for data collection and served as a project map which guided development of subsequent maps. This map was shown in Figure 3.8 in Chapter III and lays out all issues I initially perceived as impacting the phenomenon (nature of preceptorship). The initial messy map was created using manual codes created from all the sources of data (informal discussions, documents, reflexivity, literature, archival materials) gathered at the beginning of the study. This gave me a broader view of the issues affecting preceptorship practices in Ghana though some issues later turned out to be not relevant and were removed in subsequent messy maps.

The issues retained in the initial messy maps indirectly became codes that constituted individual, relational, and discursive elements affecting the situation of inquiry, preceptorship. Five additional main messy maps were created out of the initial messy map through constant refinement of data in the data gathering process. In all, six messy maps were created but only the second (Figure 4.1) and three adapted maps (Figures 4.2, 4.3, 4.4) are presented to show refinement in the data collection process.

Figure 4.1

Second Messy Map



The initial messy map comprises all issues I perceived to be affecting the phenomenon of preceptorship, both human and non-human, discursive elements among others. Though initially, all these were perceived to be relevant to the phenomenon, as I continued with data gathering

through informal and formal interviews as well as focus group discussions, I realized some of the issues were not really relevant, which made me understand that messy map is not static but keep changing in the process of data gathering where some of the issues broadly conceived initially are refined, deleted and new ones may be added to understand and analyze the situation. For instance, in the initial messy map, lifesaving interventions and the American College of Nurse and Midwives' including adult learning were perceived to be relevant to the phenomenon. But as data gathering progressed, I realized they would not be useful as they were not central in respondents' narratives of the phenomenon. Hence, the items were deleted in preparing the second messy map.

Figure 4.2

Messy Map of Preceptorship Challenges

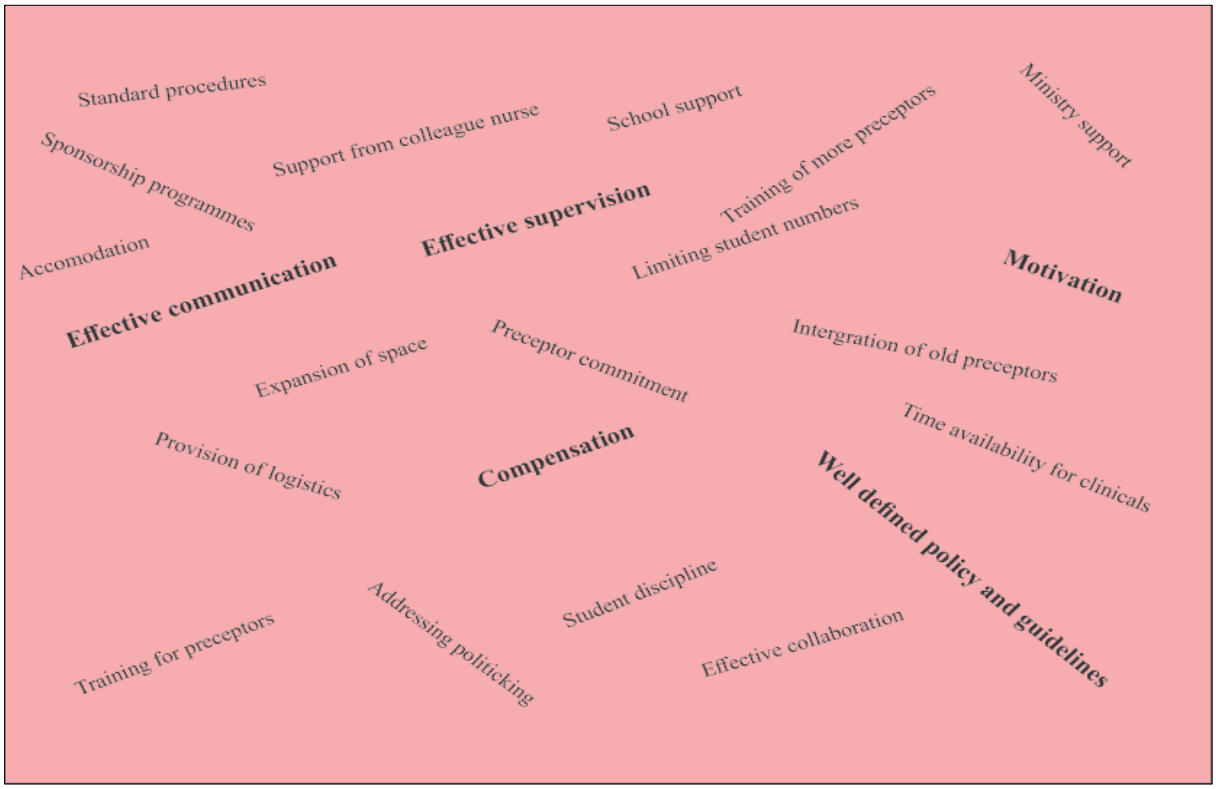
Figure 4.2 shows an additional messy map adapted to explore preceptorship challenges. The bolded words represent the most significant challenging issues within the situation. These

were issues mainly gathered from participants. They included motivation, lack of supervision, increased student numbers, use of outdated procedure manual, lack of ministry support, politicking, lack of coordination, compensation among few others. The issues with a paler font were noted by participants' but were not major issues as compared to the bolded ones.

Figure 4.3 shows messy map adapted to explore enablers of preceptorship. In this, there are five main issues seen as major enablers and which are shown boldface. They included motivation, effective communication and supervision, well defined policy, and guidelines as well as compensation.

Figure 4.3

Messy Map of Preceptorship Enablers



The messy map in Figure 4.4 was adapted to explore students' clinical training in the preceptorship situation. This map reveals 13 main issues which challenge clinical training of

students. Among these issues included students' evaluation, logistics, transportation, limited supervision, standard procedures, training of more preceptors to mention a few.

Figure 4.4

Messy Map of Students' Clinical Training

Ordered Maps

Taking a cue from Clarke (2005), new issues which emerged were added accordingly in the ordered map (Figure 4.5). For instance, inter and intra semester, placement challenges, skills lab, extra class hours, and extra time as additional skills were placed under discursive construction of non-human actants, characteristics of old and new nurses were put under socio-cultural and symbolic elements, policy existing or not was captured under major issues, and debates and authority power were placed within political and economic elements. This led from the messy map to the initial ordered map, which was also amended as newly identified issues were added. Although multiple messy/situational maps are expected in situational mapping as situational

analysis is not static given continuing memoing which results in further gathering of data generating new findings and codes, my study came out with additional messy and ordered

Figure 4.5

Final Ordered Map

Individual Human Elements/Actors
Administrators
Preceptors
Nurses
Midwives
Researcher (Ivy)
Tutors
Students
Heads

Collective Human Elements/Actors
NMCG
Ministry of health
Midwifery schools
NM Association,
WHO
Regional and District Directorates
Curriculum review committee

Discursive Construction of Individuals/Collective Human Actors
Addressing students' accommodation challenges
Nurses have passion to precept
Limited preceptor time to meet students
Poor student monitoring/supervision
Expansion of student population
Lack of support from NMCG
Politicking among dominant actors (GHS, MoH, NMCG, GCNM)
Lack of support from MoH
Providing motivation for preceptors
Reduction of preceptor workload
Providing training for preceptors
Enhancing coordination among dominant actors
MoH should address increased student numbers
Poor student monitoring
UNFPA.JIEPAGO funding and training programs for nurses
Role of tutors, preceptors important
Students' roles and responsibilities
Student's attitude
Preceptor support

Nonhuman Elements/Actors
Hospital
Health centers
District hospitals
Clinics,
Maternity clinics
Reference manual for preceptorship in midwifery, 2013
Gloves
Skills lab
Procedure guidelines
Logbook

Implicators/Salient Actors/Actants
Preceptors
NM Association
Students
Nurses
Ward managers
Tutors

Discursive Construction of Non-Human Actants
Quality and available facilities
Pressure on clinical facilities
Unclear policy and guidelines
Lack of equipment/facilities
Expansion of schools
Lack of standard policy and guidelines
Responsibilities of midwifery schools
Limited skill labs
Limited supervision and monitoring
Lack of recognition
Permission for continuing education
Remuneration
Poor communication and coordination between schools and facilities
Communication between school, clinical site and preceptor
Logistic challenges
Outdated manual
Adoption of technology (WhatsApp)
Bureaucracy

Colleague nurse should address preceptor workload
Limited/lack of support from colleague nurses
School should motivate preceptors
Preceptors should be recognized
GHS prepare policy manual
Agreement on clinical and preceptor standards preparing students for preceptorship
MoH prepare manual
Addressing ethnic sentiment
Government role critical in addressing preceptor challenges
Students' amorous relationship at workplace
Limited students' concentration, attention on social media

Political/Economic Elements
Cost of preceptor training
Accommodation and transportation for students and tutors
Preceptor system monitoring
Agreement on clinical and preceptor standards
Manual ownership
Cooperation among dominant actors
Manual development
Funding of preceptorship manual (MoH, GHS, NMCG, GCNM)
Ethnicity
School should train their own preceptors
School should motivate preceptors

Temporal Elements
Reference manual for preceptorship in midwifery, 2013
1980s good collaboration and support from district directors

Major Issues/Debates
All nurses must precept
Not all nurses must precept

Key Events in The Situation
Old clinical teaching practices
School should train their own preceptors
Facilities should provide basic equipment for clinical training
Clinical supervision responsibility of schools
Provision of policy and guidelines
Provision of logistics
Limited equipment and space for clinical training
Too much errand jobs limit student acquisition of knowledge
Students' exposure to risky and technical assignment

Sociocultural/Symbolic Elements
First class attitude
Student's attitude needed
Students' indiscipline
Ethnic sentiments

Spatial Elements

Related Discourses

Through further memoing and continuing interviews, additional messy maps and ordered map were developed. In doing this, new messy maps (Figures 4.2, 4.3, and 4.4) and ordered maps (Figure 4.5) were created for specific and commonly raised issues which were perception of

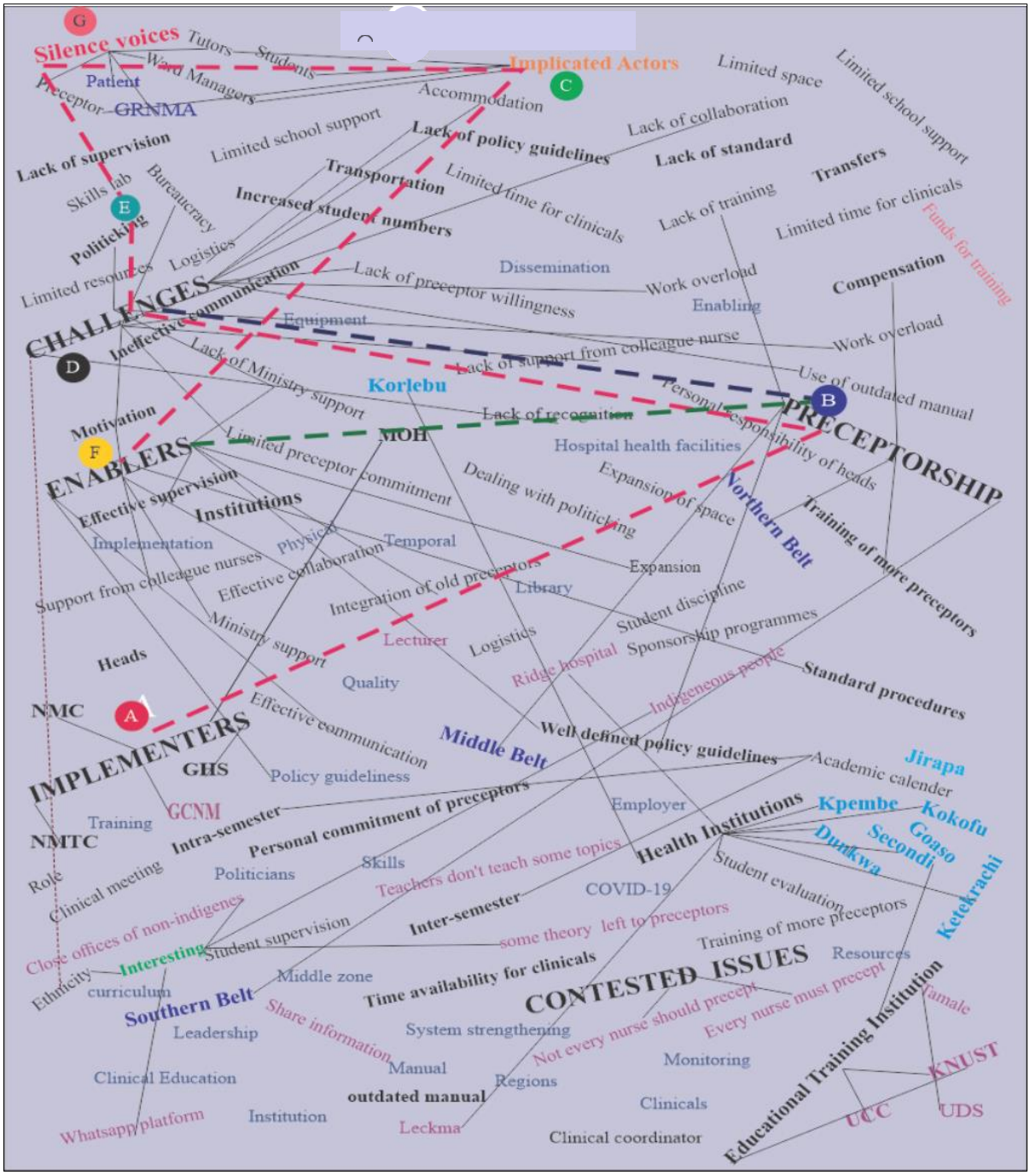
preceptorship challenges, perception of effective preceptorship and students clinical training. This was made possible given that situational analysis is fluid and flexible in approach, hence enabled me to focus on specific issues of relevance to the study. Furthermore, myriads of issues and concepts were raised and noted from participant narratives, but through theoretical sampling, I focused on most issues that were raised and which were highlighted by participants and impact immensely on preceptorship. For example, motivation, accommodation, policy guidelines on preceptorship, clinical training, compensation, supervision, commitment, Monitoring and evaluation, passion for work, effective collaboration, effective training, politicking, communication, transcend, students' discipline among others were most noted narratives from participants. The next step after creating these messy maps and the ordered map was to do relational mapping.

Relational Maps

Figure 4.6 shows the relational mapping derived through memoing to help make sense of elements within the maps. Through this map, key issues or concepts related to each other and greatly impact on the preceptorship situation were identified and linkages created to connect them. This map also led to the development of the social worlds/arenas map.

Figure 4.6

Relational Map



This relationship mapping revealed the key dominant actors (MoH, GHS, NMCG, NMTC) and how they significantly impact the preceptorship dynamics. Looking at the map, Point A depicts the key implementers of the preceptorship policy which is demonstrated by the pink line connected to preceptorship at Point B. These actors at the same time pose major challenge (Point D) to preceptorship given the ongoing politics (Point E) in terms of development of manual and decision making on policy**.** Thus, authority and power politics prevail between and among these dominant actors (MoH, GHS, NMCG) which has trickled down to the meso and micro level. For instance, there is ongoing power politics between GHS and MoH which borders mainly on decision making and implementation of policy guidelines for preceptorship.

At the meso level as well, the quest to secure approval from the regional directorates for student clinicals results in delays and tension between institutions and directorate. The micro level was also not immune to this politicking as some students were noted to disregard preceptors and perceived tutors/lecturers as having high theoretical knowledge creating tension and impacting on clinical training. Politicking also exist among other nurses/midwives and who feel those who precept is given some compensation whiles they have not, hence been unwilling to support them in the process

This has resulted in contradictions and tensions in the clinical setting arena leading to complaints from some students that, they are not supported when they ask of support from some nurses. What was noted from this ongoing politicking was that it has resulted in poor and ineffective communication between and among these actors, hence the delays and lack of standard in developing preceptorship manual, provision of required resources to support clinical training of students and motivation of preceptors.

The greatest effect of all the factors noted in the preceding section was at the micro level where actors at that level suffer the consequences but are unable to speak out or their views not heard or taken into consideration as Points D and C show implicated actors on the map. Again, on the map, both ethnicity and WhatsApp platform which emerged as interesting issues both pose major challenge and effectiveness to preceptorship respectively as shown by the lines connected to challenge and preceptorship. From the map, it can be seen that lack of supervision, politicking, policy guidelines, transportation, increased student numbers, and motivation were major challenges which impact on preceptorship. This is shown through various lines connecting challenges and challenges further connecting to preceptorship on the map. In all, the key focus on the relationship lies on the issues within the challenges and enablers, how they interact and relate and impact on preceptorship as the map depicts.

On the other hand, new issues that emerged from continuing data collection and were deemed relevant to the situation were added to the new messy map. For example, issues such as inter and intra semester clinicals, practicum assessment, placement challenges, disregard to preceptors, extra time as additional skills, ethnicity, authority power, characteristics of old and new nurses, skills lab, extra class hours, policy on preceptor manual exist and not exist among key stakeholders', others were prominent in respondents' narratives and were added to the second messy map as highlighted in blue.

Further, I focused on the primary issues of concern (challenges, enablers, clinical training) of the study and created a messy map for each. This mapping brought focus and clarity on the key issues affecting the situation.

Social Worlds/Arenas Maps

Social worlds/arenas maps are used to explore a situation by locating social action or activity, highlighting groups, departments, units, fields of action, and interaction among different and collective entities. In the context of this study, I developed four main arenas and 15 social worlds. Figure 4.7 shows all the various arenas and worlds within the focal situation. In the analysis of these arenas within the preceptorship situation, the four main arenas were isolated to better explore the tension, challenges, and complexities within them and how these are impacting on preceptorship. It was done to bring clarity and better understand to the ongoing tensions between and among various collective entities.

Figure 4.7

Social Worlds/Arenas Maps

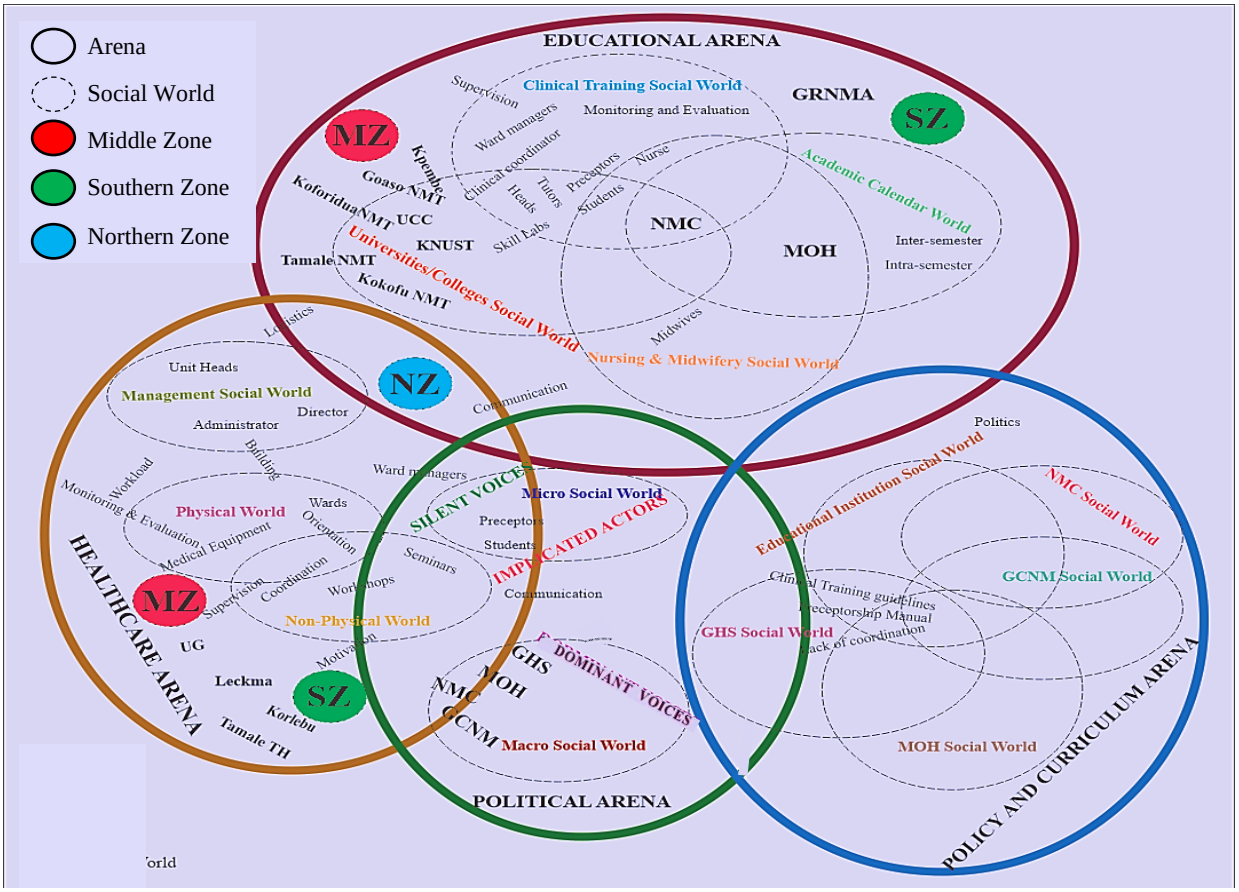


Figure 4.8 shows the educational arena with four main social worlds comprising clinical training, academic calendar, nursing and midwifery council and universities/colleges social worlds. Each of these social worlds has commitments to certain activities which build their interest. Strauss (1978) asserted that social worlds are groups that shared commitments to certain activities by building common ideas about how they can share resources and execute their businesses to achieve their goals. For instance, in the clinical training world, ward managers, preceptors, tutors, and heads are all committed to the activities of monitoring and evaluation as well as supervision of students. Similarly, both nursing and midwifery council and MoH in the academic calendar arena also performed shared function by committing to the activity of designing academic calendar for institutions which is well depicted by the dotted lines crossing over the universities/college's social worlds. The main issue of concern here is how the actors within the institutions interact as linked to clinical training in the entire preceptorship.

Figure 4.8

Social World Map of Educational Arena

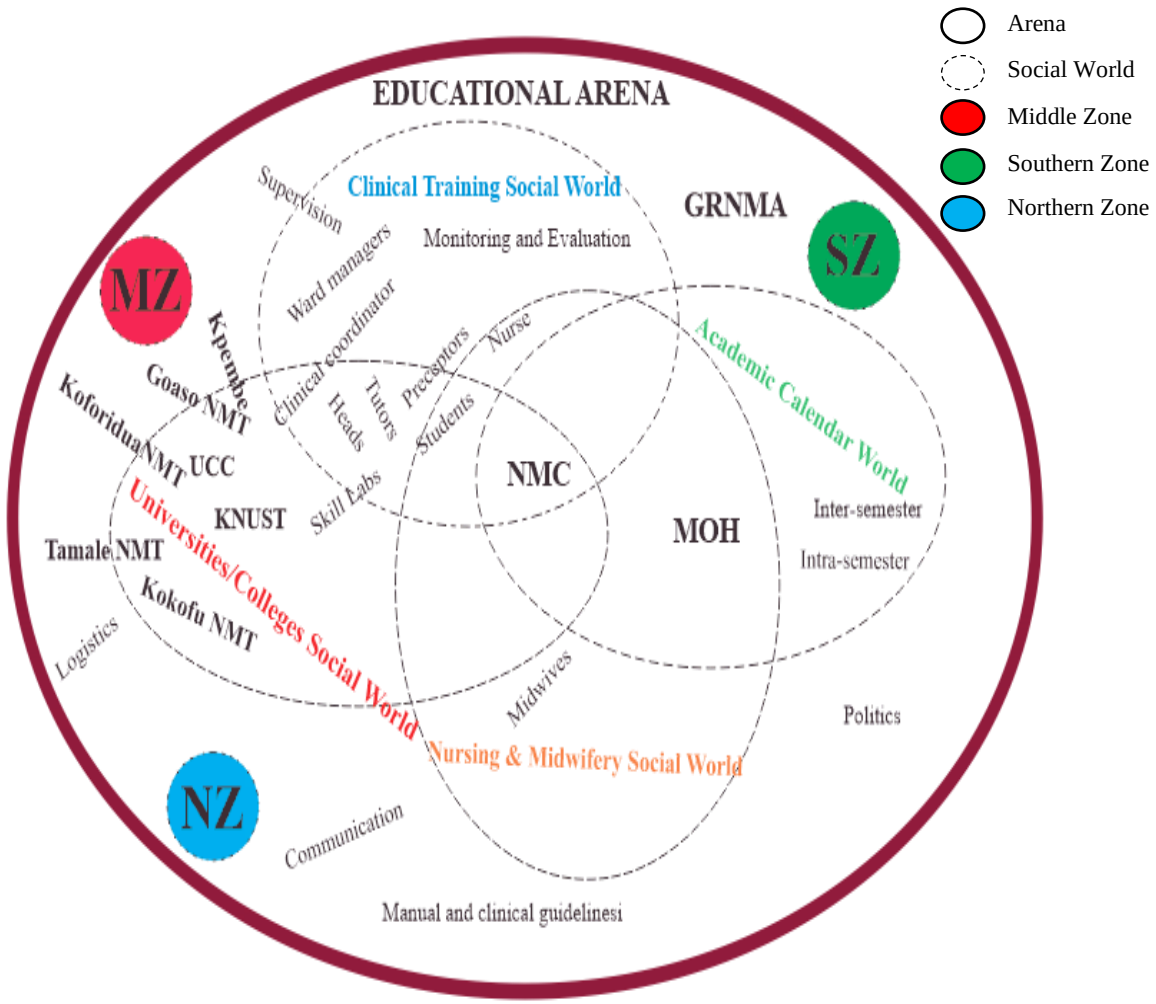
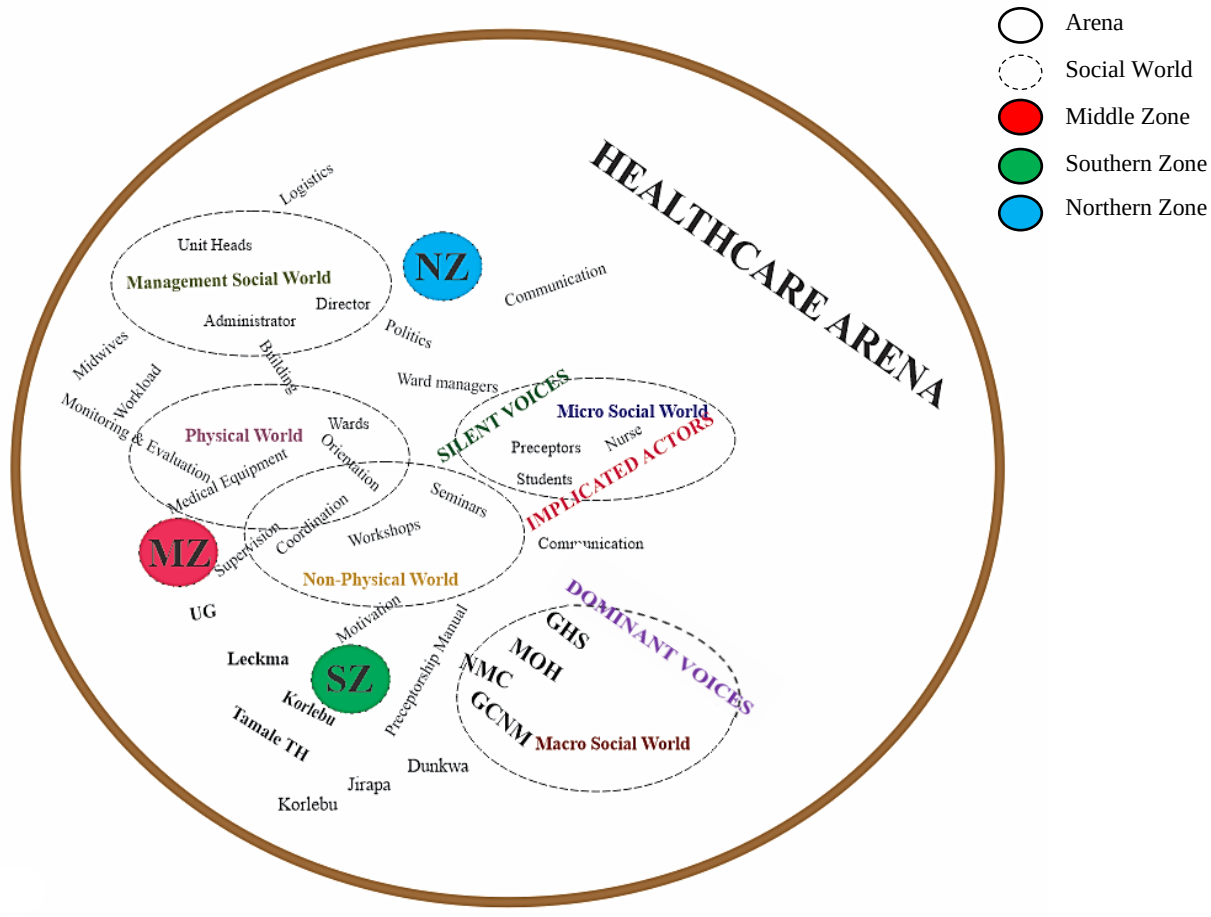


Figure 4.9 shows the healthcare arena comprising five main social worlds with both human and non-human actors interacting within the situation. The management social world comprises of unit heads, administrators and directors who are committed directly or indirectly in ensuring that certain key decisions are taken for work to progress. For instance, these actors in this world ensure that logistics/equipment which are within the physical world are made available at the hospital facility for work to progress. In this way, the supply of medical equipment is provided which aid in clinical training of students. Actors within the management world are also committed

to activities of monitoring and evaluation as well as supervision of medical equipment in the micro social world.

Figure 4.9

Social World Map of Healthcare Arena

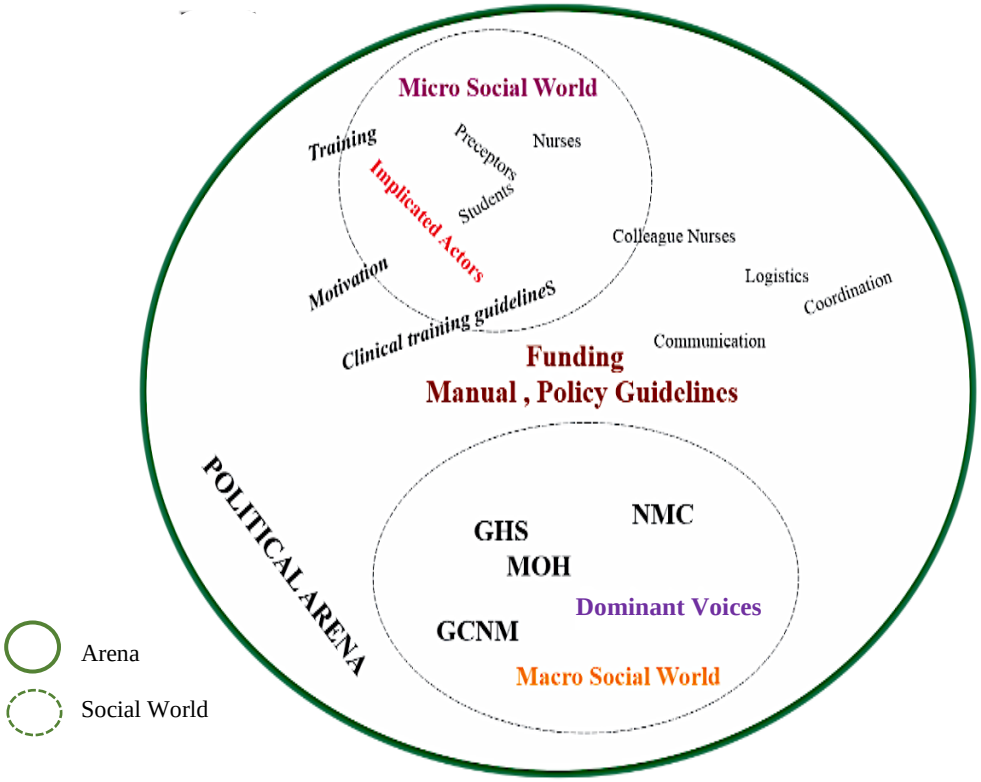


The management social world comprises unit heads, administrators, and directors who are committed directly or indirectly in ensuring that certain key decisions are taken for work to progress. For instance, these actors in this world ensure that logistics/equipment which are within the physical world are made available at the hospital facility for work to progress. In this way, the supply of medical equipment is provided which aid in clinical training of students. Actors within the management world are also committed to activities of monitoring and evaluation as well as

supervision of medical equipment in the micro social world. The map also shows key dominant actors in the macro social world whose commitment and activities greatly impact on the preceptorship situation. For instance, these dominant actors primarily have to work together in the provision of medical equipment, other logistics and motivation in the preceptorship situation. Their failure to work together to perform these activities have resulted in tensions where some actors within the micro arena (preceptors, students) had become implicated and silent (Clarke, 2000, 2005). Figure 4.10 shows the political arena within the situation with two main social worlds (micro and macro).

Figure 4.10

Social World Map of Political Arena



The social world map of the political arena seen in Figure 4.10 comprises key human (preceptors, students) collective (MoH, GCNM, GHS, NMCG, colleague nurses) and non-human

actants (motivation, coordination, manual guidelines, communication, logistics, monitoring, and evaluation). The micro social world which can be related to the macro world in terms of resources and policy guidelines involves three main human actors which are preceptors, students, and colleague nurses and a non-human actant (motivation) within and across the world. This world forms the main focus of the situation under study as they are the primary actors and center of attraction of the preceptorship situation. Thus, the entire preceptorship concerns these actors without which the situation cannot be discussed. The preceptor's main commitment in this world is to provide clinical education or training to the students who are basically the recipient of clinical training. To ensure that the work of the preceptors is efficiently and effectively carried out, they require support from colleague nurses, logistics, motivation, effective communication, coordination, manual, and policy guidelines. Actors in this world believe that they can fulfil their commitment of clinical training when these needs are been provided and received. To actors in this world, these needs are fundamentally the sole responsibility of actors (MoH, GHS, NMCG) within the macro environment.

The key actors in the macro are described by the micro actors as not been effective in their role of providing the needed resources and policy guidelines in the situation of preceptorship. For instance, the need for logistics and policy guidelines are lacking if not limited to aid the primary actors fulfil their commitment in the situation. The key question now is, what is the cause of the ineffectiveness on the part of actors in the macro world in providing these needs in the situation? In answering this question, I entered the macro arena to find out the issues within that world. What was gathered shows that the main issue borders on power politics among these actors who form the dominant voices in the situation. Power politics centers on the development of manual and policy guidelines for preceptorship. There is lack of coordination and cooperation between

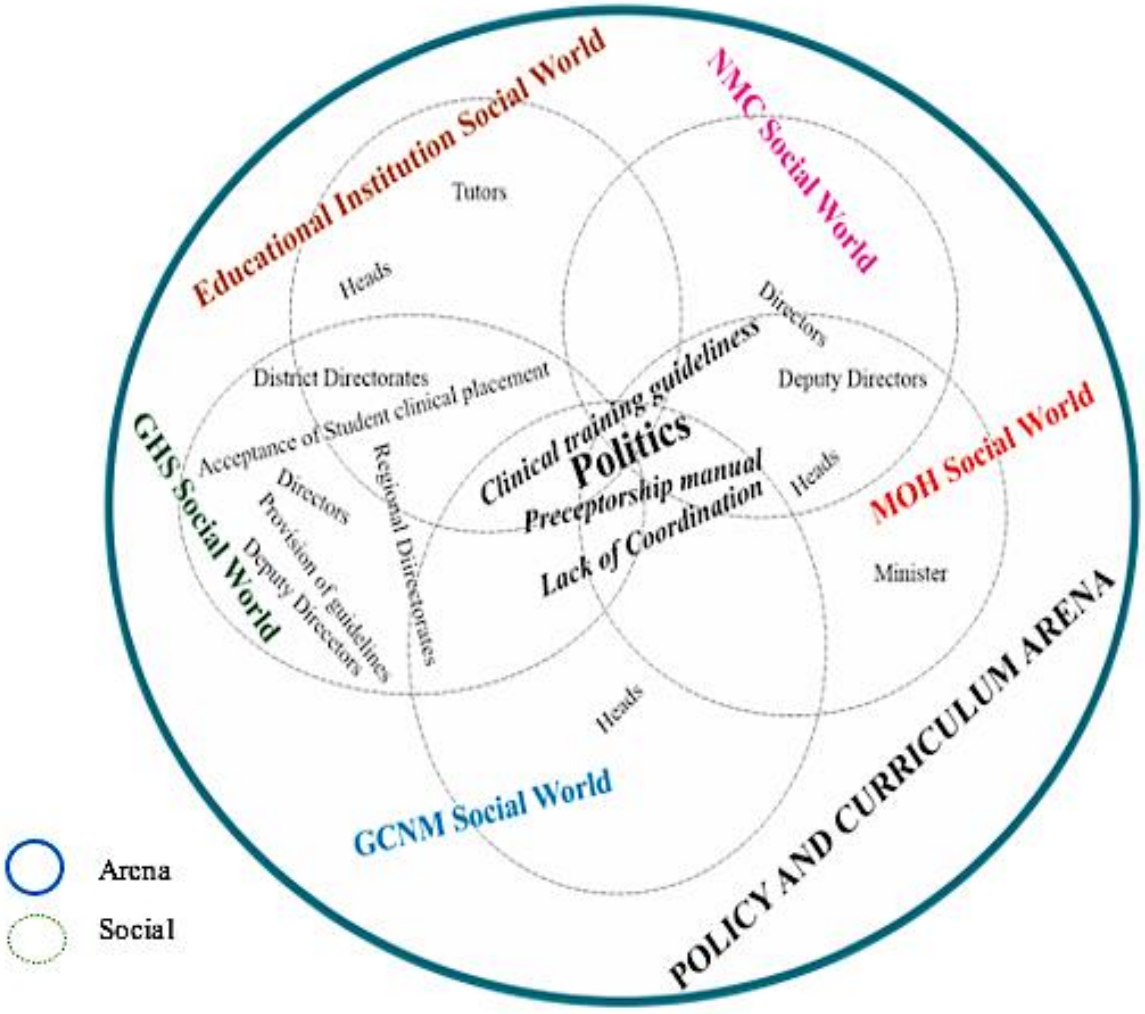
and among these actors in coming out with a generally agreed and standard policy guidelines on preceptorship. Each of these actors directly or indirectly exert certain independence in the context of manual and policy guidelines development. Situations where they have come together for the common good, there is high level of uncooperativeness which results in each trying to develop their own guidelines to guide preceptorship. As the development of the manual and policy guidelines has financial implications, the question of who should provide funding and who should have authority over the manual remains a critical issue and controversy among these actors. Unfortunately, actors in the micro world are less powerful in the ongoing discourse with their voice either not been heard or listened to even though they are present in the situation. Thus, they have become implicated actors/actants and are silent or discursively present in the situation. (Clarke, 1998, 2000, 2005). In other words, these actors in the micro world are bearing the negative consequences of the ongoing politicking with preceptors not getting the need guidelines and direction to be able to provide effective and standing clinical training to the students. The burden now lies on them to find their own resources and materials to teach students which in themselves are not adequate to meet the requirement of effective preceptorship program.

The ongoing macro level politics and its negative effects has resulted in tensions, pressure and challenges at the micro level and interestingly leading to minor politics between students and preceptors and between preceptors and colleague nurses. From the map, the distance between preceptors and colleague nurses is quite apart showing the uncooperative and unsupported nature of colleagues' nurse as a result of the controversy surrounding motivation and remuneration for preceptors. The perception from some colleague nurses is that preceptors receive some benefits from the work which they do not get and must do their job than seeking their support.

The last arena of the social world map presented here is the policy and curriculum arenas (Figure 4.11). It is made up of five main social worlds; educational institution, MoH, GHS, NMCG and GCNM and four non-human actants (politics, clinical training guidelines, preceptorship manual and lack of coordination.

Figure 4.11

Social World Map of Policy and Curriculum Arena



The main focus of this arena is on preceptorship manual and policy guidelines for preceptorship. The commitment of the various worlds is to cooperate and contribute to the development of policy and curriculum for preceptorship program. As the map shows, the main

tension between and among these worlds lies on politics which rest at the center of the arena surrounded by preceptorship manual and clinical training guidelines. The politics have been informed by the fact that the four key social worlds (MoH, GHS, NMCG, and GCNM) described themselves as having some level of autonomy like the case of political arena in development of policy guidelines for preceptorship. This is the more reason why these actors (dominant) in the past have on some occasions developed their own manuals and guidelines for preceptorship without any form of cooperation and coordination between and among each other. Given the ongoing challenges in the entire situation, it is anticipated that these actors may cooperate and coordinate together to come out with a single policy guideline for preceptorship.

Positional Mapping

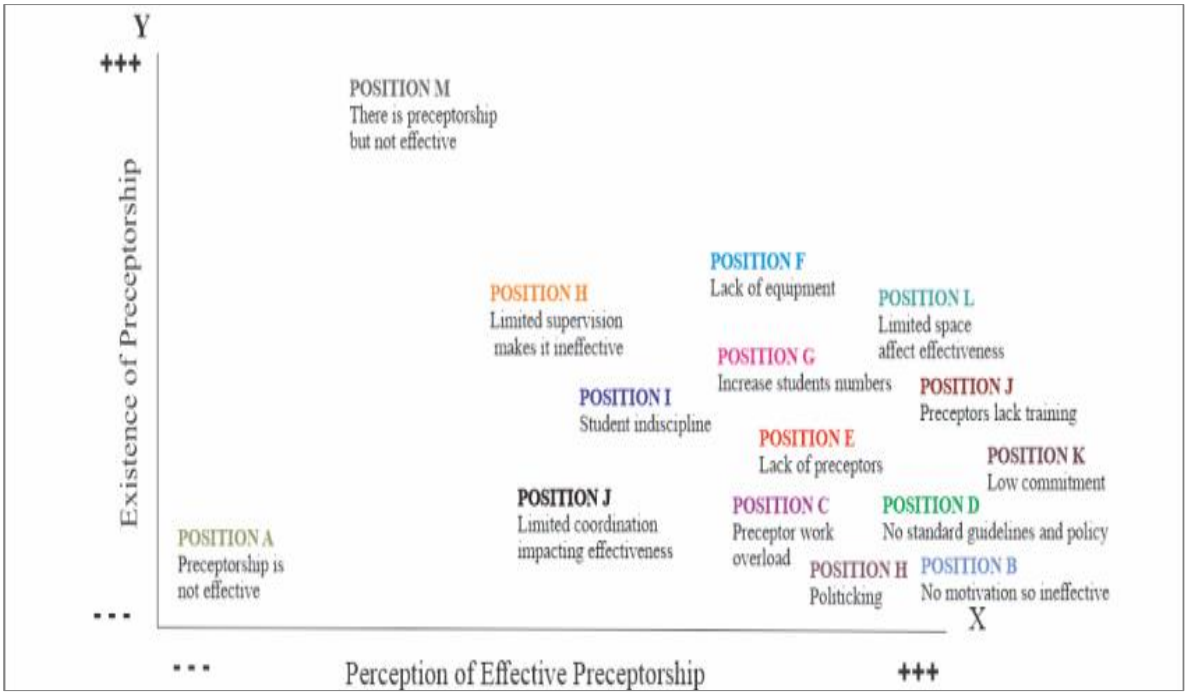
Positional mapping is an iterative process and mainly done in the later part of data collection and analysis (Clarke et al., 2015). In creating a positional map, the researcher plots positions on a graph, grounded in the data collection as relates to identified axes of concern. Plotted positions do not represent any individuals or groups but discursive positions of the issues themselves. Clarke et al. (2015) pointed out that an individual can simultaneously hold multiple positions and even positions that are contradictory. As the researcher get immersed in the data, he/she becomes aware of the nuances and differences between positions that are similar and now determines when the positions are distinct enough to plot a point of separation. Finally, the research labels the maps, look for gaps where positions may be created.

I started the positional maps by noting all the various contested issues, complexities, controversies, contradictions, and discourses that emerged from data collection through interviews and focused groups conducted. Positions were revealed and noted from the beginning of various phases of the interviews and focused group while others were identified after memoing and

following up on memos with further questions in other to gain clarity of the issues. In beginning the positional maps, I first reflected deeply on the main contested issues in the situation of inquiry, ones that were being argued and debated. I then figured out the major dimension or axes of concern to the issues. When this was noted, I started by drawing the two main dimensions on the vertical axis and horizontal axis. The positional map of the preceptorship situation in Ghana (Figure 4.12) depicts the positions taken by various actors within the preceptorship situation on the discursive issues on challenges and enablers. Twenty contested positions emerged (Appendix A) mainly from interviews and focused group discussions. However, only the key issues that specifically addresses the situation would be analyzed.

Figure 4.12

Positional Map 1—Effectiveness of Preceptorship



Positional Map 1 lays out the various positions taken in the discourse with respect to *effectiveness of preceptorship*. The positions are organized according to two axes: existence of preceptorship on the vertical axis and perceived preceptorship effectiveness on the horizontal axis.

The map shows several positions at the middle to lower right. Most positions show highly perceived preceptorship as not effective though somewhat existing (positioned at both lower and middle of the vertical axis) as a result of factors such as limited space (L), lack of preceptor training (J), low commitment (K), no motivation (B). Some students' comments that were shared follow.

> You have been given so many students and you know the facility that you have is not adequate for that number and you are quiet and pick all the students and at the end of the day we are talking about the tutor-student ratio.

Another commented:

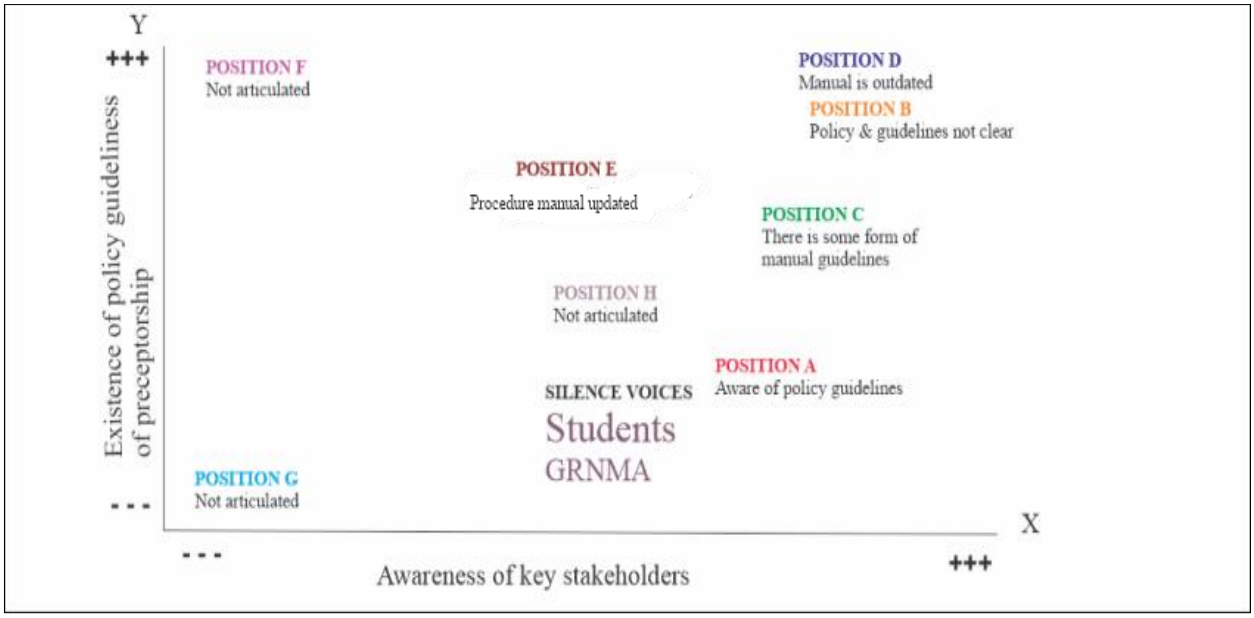
> That preceptor's area is vague, there's nothing, nobody recognizes them, some kill themselves to teach the students, some too don't. So, if you come and my ward is busy, there're about 30 people in labor, we're running up and down, I won't' pay attention to you. But say there is something attached to it, some kind of motivation, some incentive to motivate the staff then when students come and you take them through this and this, this is what is for you, I think people will be interested.

Position M, located at the upper left of the vertical axis and at the lower end of the horizontal axis, shows that preceptorship exists but has not been effective. There is only one exception (A) from this map which shows the perception of preceptorship as not effective and even not existing

Positional Map 2, shown in Figure 4.13, lays out the positions taken on *awareness of policy guidelines*. Four main positions were derived from this discourse with three positions not articulated. It also revealed two silent voices (student and GRNMA).

Figure 4.13

Positional Map 2—Awareness of Policy Guidelines

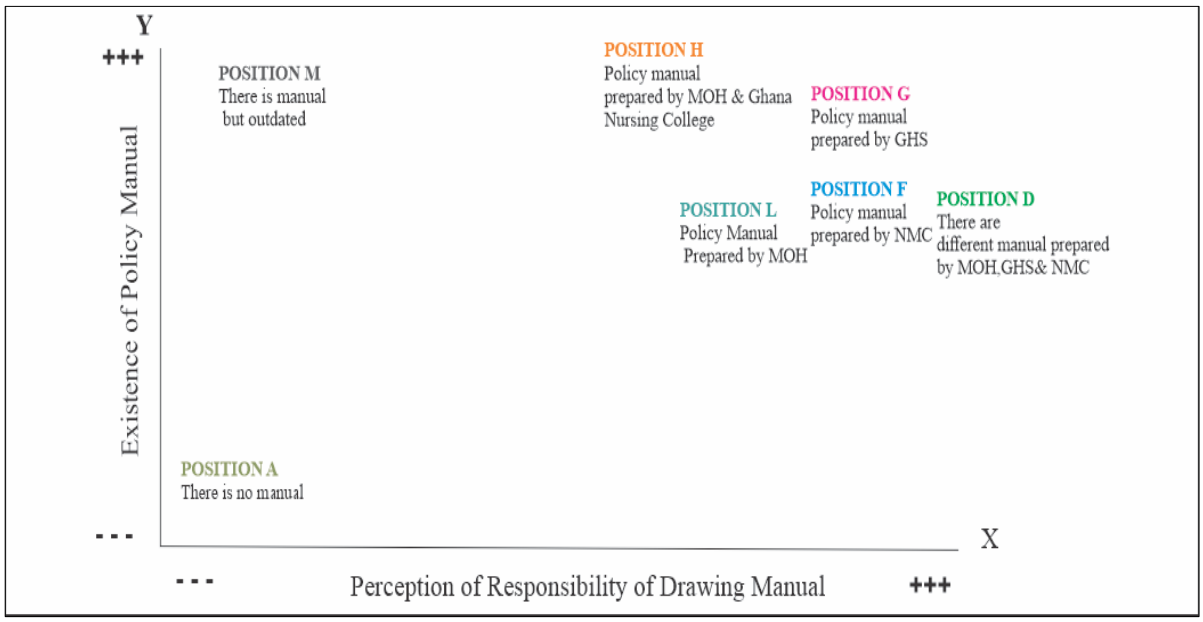


The map also revealed two silent voices-student and GRNMA. Generally, the map showed that procedure manual is seen as outdated and, while policy guidelines do exist (D) these are not clear (B). These issues were missing from students and GRNMA.

Positional Map 3 (Figure 4.14) highlights the discourse on the *existence of policy manual* which was organized on the axes of existence of policy guidelines of preceptorship and perception of responsibility of drawing the manual.

Figure 4.14

Positional Map 3—Existence of Policy Manual



Seven main positions were created with most (D, F, G, and L) settling at the upper right sector of the map. Positions taken show that some kind of policy manual exists. One institutional head stated as follows: "So yes, we have the manual and some policy guidelines contained in it So, my office role is to coordinate and ensure the implementation of the policy and the manual that we have developed." But there is a strong perception (D) that the responsibility of drawing the manual is performed by different actors in the situation such as GHS, MoH, and NMCG. This position reinforces the different views shown as positions F, G, H, and L. A head at NMCG said:

> Usually, it's the NMCG who's supposed to develop the standard practice documents, the manual which every learner should have and then it will be with the facility. That spells out step by step wise, way of doing things or standardized ways of doing things or competences.

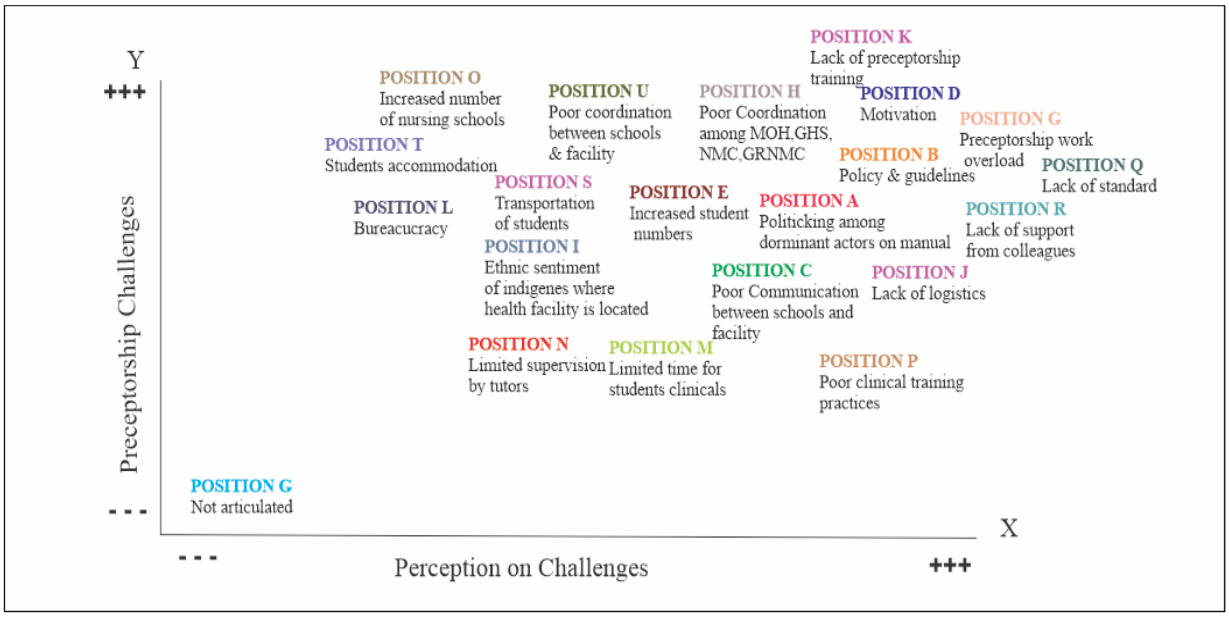
A head at MoH also mentioned, "So, my office role is to coordinate and ensure the implementation of the policy and the manual that we have already developed. And er also disseminate the content of the policy and manual to all institutions." Two other distinctive

positions were that the existence of manual which is outdated but the responsibility of who developed the manual was not known. There was also a position of no manual and responsibility not known.

Positional Map 4 (Figure 4.15) shows the results of discourse on *preceptorship challenges* with the vertical axes taken on preceptorship challenges and horizontal on perception of challenges.

Figure 4.15

Positional Map 4—Preceptorship Challenges



Most of the positions on this map are clustered in the upper right corner and middle part of the map. Given the directions of most of the positions, it is clear that most issues in the various positions were challenges in the preceptorship situation, but the degree to which issues are major or minor, varies. For instance, lack of preceptorship training (K), motivation (D), preceptorship workload (G), policy and guidelines (B), lack of standard were highly perceived as major challenges in the entire preceptorship situation. A nurse manager said this:

> For the challenges, I will touch on motivation and incentives. The work of preceptor dealing with lots of students is a lot and need motivation. People don't want to precept or support them because they are not motivated and even recognized, yes. For nurses who do this preceptorship and mentorship. I think that will motivate them, that will encourage them to do the work as they are supposed to do. We do our best to maintain good relationship with them, but I want to be emphatically clear that there are situations some of them the inner motivation is not there because they want to see something physically.

A head of a MoH unit said:

> We train a few to also go back and train. Ahaa because we don't have funding to do all the dissemination physically. So, the little that we secure from my office, I think that we use it to train them.

A Nursing/Midwifery head of GCNM on the key challenges mentioned:

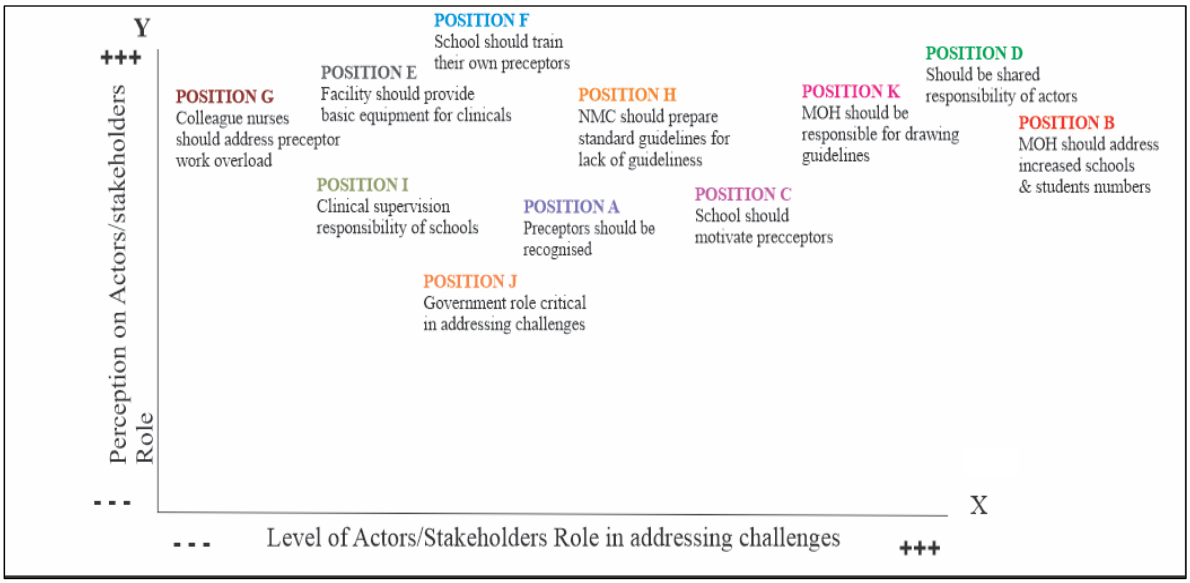
> So, the first thing I can say on challenges is training. We need training on preceptorship because I know that nursing is involving, and so day in day out things change. So, they should be trained at least on the basic things that they need to know and to do to students, that's one of the areas.

Other positions (I and F) were not highly perceived as major challenges in the situation. The major argument emerging from the map is that though lots of challenges exist in the preceptorship situation, some are more critical to address than others, especially on the issue of motivation and policies.

Positional Map 5 (Figure 4.16) outlines the discourse on *addressing preceptorship challenges.* The vertical axis is perception on actors' role and horizontal axis level of the actor's role in addressing the challenges. This discourse was intended to find out how participants perceived stakeholder roles and the level at which those roles are being addressed by these actors.

Figure 4.16

Positional Map 5—Addressing Preceptorship Challenges



As seen in Figure 4.16, participants strongly held that MoH should address the challenges of increased student and school numbers. However, the level at which this is perceived to actually be addressed is quite moderate (B). In terms of drawing guidelines, perception of MoH playing that role was quite high and the level at which this is being performed was high. Position H shows the perception of NMCG to perform the role of providing standard guidelines was quite high; the level at which this role is being provided is moderately high with the position almost reaching the middle of the map. This means that though NMCG is expected to provide such standard guidelines, they are not really doing so to the level of these expectations. Who should motivate preceptors emerged as a key question from the study. From position C, it was moderately perceived that the school should provide motivation to preceptors. A tutor at the Middle Belt expressed this as follows:

> There is no document saying that if you are a preceptor, we should give you credit; if you are a preceptor, we should give you something and maybe the school should be charged to pay something to the preceptors. So that they can also help us together train these children.

Looking at the position on the horizontal axis (level of actors/stakeholders' role in addressing challenges) one can tell that the school is doing quite well in motivating preceptors. Position F takes issues regarding training of preceptors. From this position, training of preceptors was highly perceived to be provided by schools. However, efforts by schools in addressing training challenges have been very minimal as shown by Position F being closer to the negative end. Similarly clinical supervision was to some extend perceived to be done by schools but a look at this position on the map shows that provision has been poor with a movement of this position on the *x*-axis so close to the negative end. A head of a unit in the Southern Zone mentioned:

> I think the single most challenging and difficulty issue has to do with the student size as my colleagues have just echoed. The size is unbearable and uncontrollable. So, we are not able to have effective supervision. So now, what I suggest we do in our quest to achieving, if not achieving hundred percent effective supervision, at least we can bring down the challenges to the barest minimum.

Provision of basic equipment for student clinicals was very key in participants responses. Perspectives on this discourse was perceived high that facilities should provide basic equipment for student clinical training (I) as a head in a middle said:

> But the ministry is saying that we don't have to tell them to bring any gloves or basic equipment, so the facility has to provide them with those things to do their clinical training. So, they don't come with any logistics, but if you are a student and you have your own apparatus, you can use it at the facility and practice with it at home.

Despite this, it was noted that not much effort has been made by facilities in addressing this challenge as shown in the position E being closer to the vertical axis. Positions that were marginally represented in terms of actors' role in addressing the challenges included positions A and J.

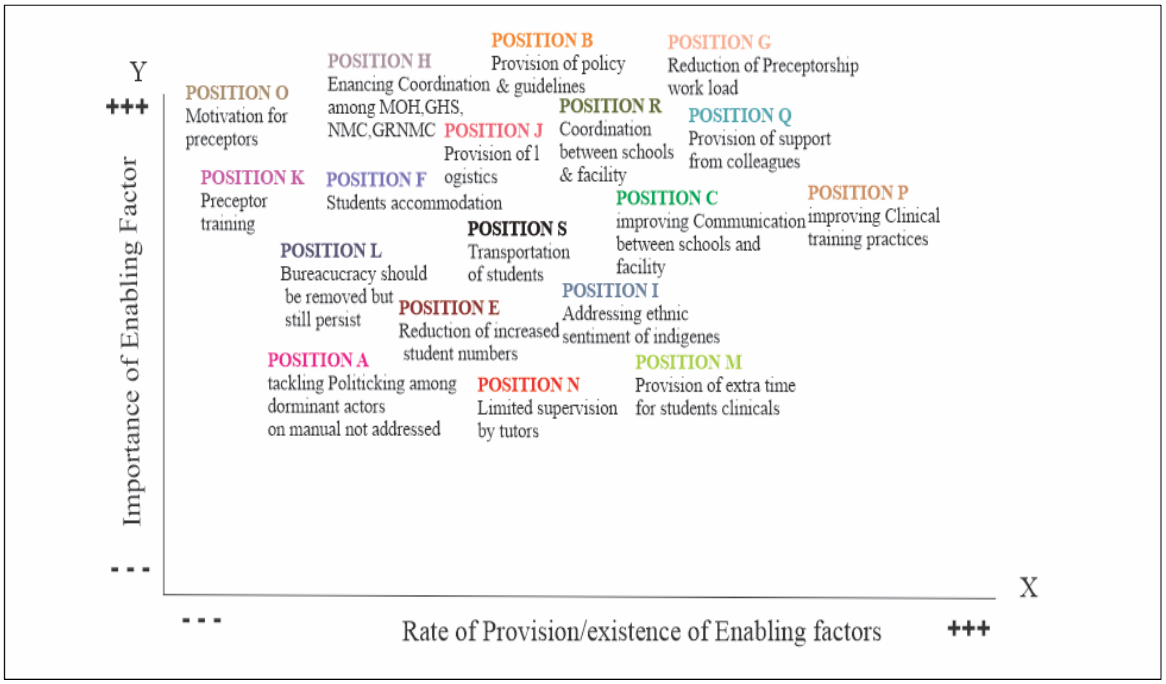
Work overload was strongly perceived to be addressed by colleague nurses who should provide support to preceptors but on the flip side, it was the lowest when compared with other roles performed by other actors as shown by the various role positions in the *x*-axis. What this

implies is that the supportive role of colleague nurses to the preceptor has been very poor if not existing. Despite the various positions and expected roles to be performed by actors, it was however, noted that addressing the preceptorship challenges is a shared responsibility of actors at the micro, meso and macro.

Positional Map 6 (Figure 4.17) illustrates discourses on the *importance of the enabling factors* and the rate at which they are provided.

Figure 4.17

Positional Map 6—Importance of Enabling Factors



From the map it can be seen that motivation of preceptors (O) was a very important enabler but how it had been provided is rated poor. A tutor in a middle belt expressed:

> For me, motivation comes first as a key enabler, but much has not been done which has negatively impacted on preceptorship in Ghana. Preceptors are not motivated, it's just the same as what my colleagues are saying. When we keep sending our students, then they also ask us, what do they get in return. So, they are motivated inwardly, but they are not getting anything from the school. There is nothing, no credit, nothing at all. So, at times too when you call them and then we design a roaster, you see that they'll be giving

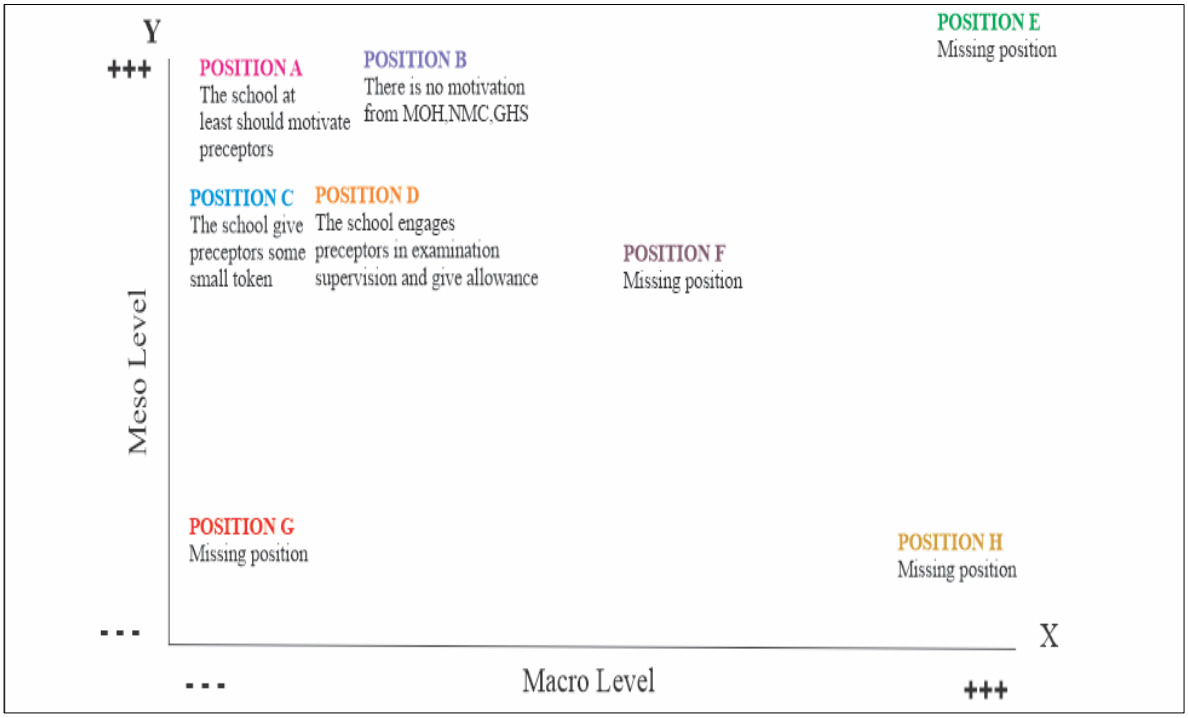
> excuses. I will not come for this duty; I am for that duty. Meaning that they are actually running away from the work that we have planned that we do with them.

Other key enablers include coordination among dominant actors (H) and preceptor training (K). Both are seen to be very high as important enabling factors but poor in terms of present efforts made in providing them in the preceptorship situation in Ghana. Accommodation (F), transportation (S), and bureaucracy (L) were perceived as moderately important but very poor in terms of the extent to which they are been addressed as enabling factor. Further, policy and guidelines (B), reduction of preceptor workload (G), coordination between schools and facilities (I), and support from colleagues (Q) were rated very high as important enabling factors but only moderate in how they are being addressed as key enabling factors. These appeared at the middle of Positional Map 6. In addition, while politicking (A), supervision (N), ethnic issues (I), and provision of extra time (M) were deemed to be important, they were considered low in importance as enabling factors and very low in terms of them been addressed as enabling factors. Position P (improving clinical training practices) was an important enabling factor in preceptorship and at the high end of rate of provision. This showed that efforts towards improving clinical training practices have been high. This is particularly true given the various efforts the dominant actors including some schools are making in training preceptors and provision of guidelines. Finally, communication between schools and facilities was high in importance with a somewhat middle level efforts in terms of its improvement as important enabling factor in preceptorship.

Positional Map 7 (Figure 4.18) displays discourse on *preceptor motivation* and specifically based on how the meso level actors on the vertical axis and macro level actors on the horizontal axis are making effort in addressing them.

Figure 4.18

Positional Map 7—Preceptor Motivation

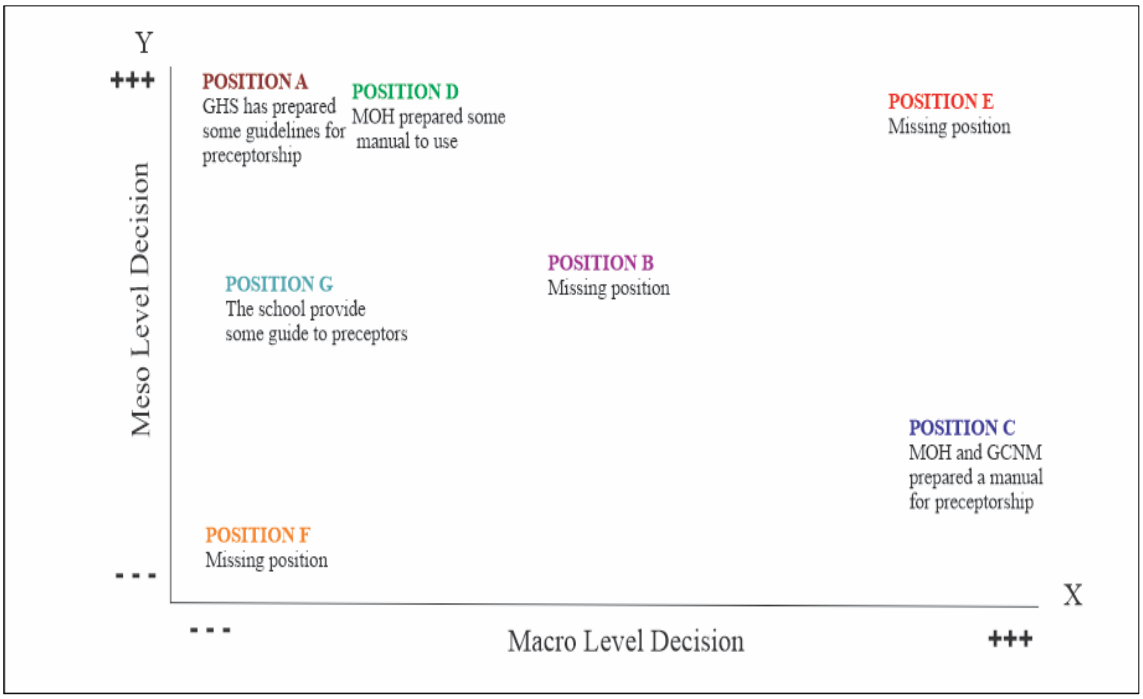


This discourse was very important given the many concerns expressed by participants on motivational challenges and the critical need to address it for effective preceptorship. Position A at the very highest end of the meso level takes the stand that the school should motivate preceptors. Position B, which was also at the very highest end of the meso level, shows that motivation at the meso level is high but lacking at the macro level actors (MoH, GHS, and NMCG). Positions C and D shows that motivation at the meso level is high given efforts in providing token and allowances for preceptors. The remaining positions, E, F, G and H, were all missing.

Positional Map 8 (Figure 4.19) takes on discourses on *policy and manual for preceptorship* with meso level decision on the vertical axis and macro level decision on the horizontal axis.

Figure 4.19

Positional Map 8—Policy and Manual for Preceptorship



Positions A and D shows that macro level decision in preparation of preceptorship manual has been very low especially on GHS preparation of preceptorship guidelines and MoH provision of manual. However, at the high end of the macro level decision, collaborative decision-making I effort by MoH and GCNM was high in terms of these two dominant actors having come together to prepare a manual. Position G shows that at the meso level, moderate decision-making effort has been made by schools in preparing some guide for preceptors. Other positions were missing (E, B, and F).

Training of preceptors was one of the important aspects of the discourse on preceptorship. Positional Map 9 (Figure 4.20) shows responsibility of training preceptors with institutions on the vertical axis and facility on horizontal axis.

Figure 4.20

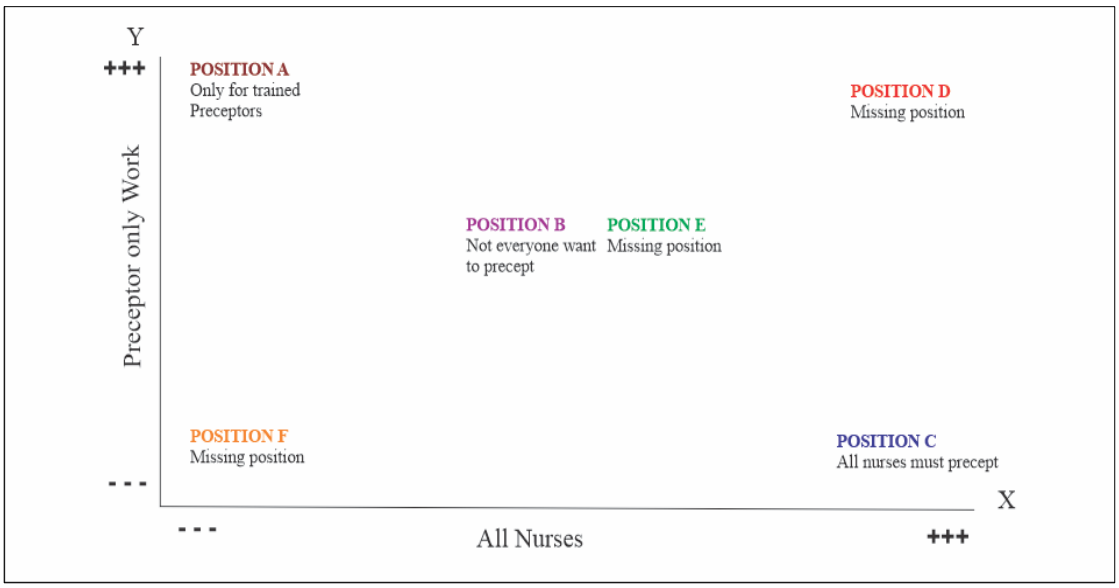
Positional Map 9—Policy and Manual for Preceptorship

Training of preceptors was one of the important aspects of the discourse on preceptorship. Positional Map 9 shows responsibility for training preceptors with institutions on the vertical axis and facility on horizontal axis. The extreme end of the institutions shows position A indicating that responsibility of training preceptors is the highest role of the schools. There is a mid-level position G which however holds that MoH and NMCG should train preceptors.

Another contested discourse was on the work of the preceptor as indicated in Positional Map 10, Figure 4.21. This is represented on the *y*-axis by preceptor only work and on the *x*-axis as all nurses. Position A takes extreme stand that preceptor work should only be for trained preceptors with a mid-level position (B) which provides that not everyone must precept. At the highest end of all nurses' axes show that all nurses must precept I.

Figure 4.21

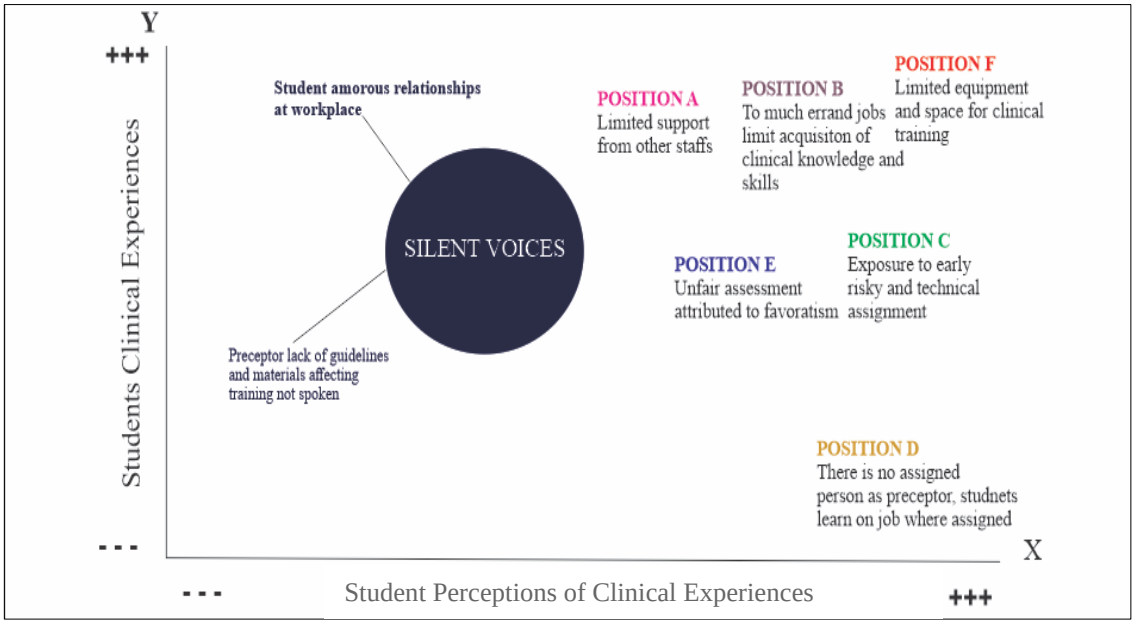
Positional Map 10—Preceptor Work



Positional Map 11 (Figure 4.22) displays discourse on *students' experiences in facility* with students' clinical experiences on vertical axis and student perception of clinical experiences on the horizontal axis.

Figure 4.22

Positional Map 11— Student Experience in Facility



At the very high-end of students' clinical experiences were positions D, C, F, and B. For instance, Position D shows that students experience of clinical training is very poor given that there is no assigned person as preceptor, but students were only left to learn on the job based on unit where they are assigned to work with limited support.

> So, so far based on my attendance for the clinical period from first year to this particular year, I think the preceptors are doing a moderate work. Let's say when it comes to their job concerning students in the ward, because when we go to their ward, most of times we find just a few people giving off their best in teaching us to acquire the basic skills that we need in terms of the practical aspects, most of them don't concentrate on it, because they feel like teachers are in the classroom who are supposed to do that and then they are being paid for being in the classroom

A similarly frequent perception was the limited equipment and space for clinical training (F). For instance, a student mentioned:

> We still encounter a lot of things that go on in the wards. Now, one of them one of them is the in provision of certain procedures. You know you know down North here where unfortunately we don't get, should I say properly equipped hospital facilities.

Another student added:

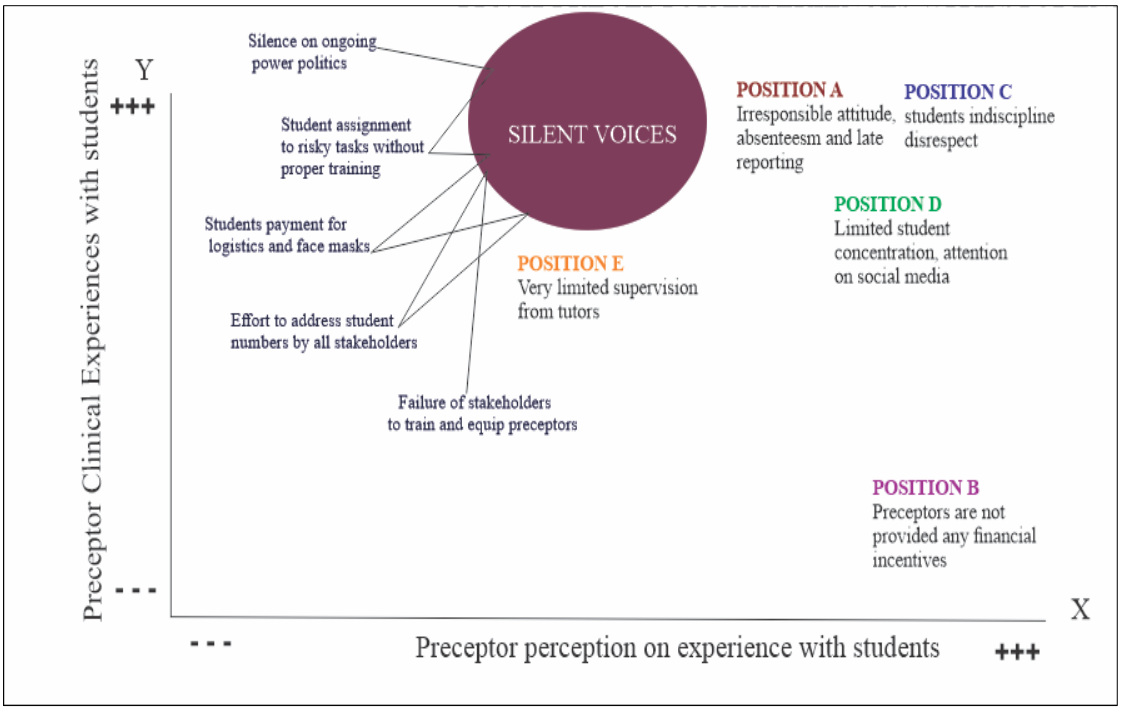
> We don't have the tools to work. So usually, it makes the exposure in a way not so effective during the clinical practice that sometimes if like you're going take vital signs and come back home. I just mentioned earlier aside the X Ray here where we can do bone checkup for maybe accident cases and dislocations and a lot. But we are very, very down when it comes to equipment. So, it makes most of those who undertake their clinical sessions in the northern sector here, actually, don't have the feel of the practical.

Other moderately perceived negative experiences were limited staff support (A), errand jobs (B), and unfair assessment (I). In this discourse, students were silent on unethical issues such as amorous relationships within and outside work which impact negatively on clinical training. They were also silent on the lack of guidelines and materials to be used by preceptors in their clinical training.

Positional Map 12 (Figure 4.23) takes on discourse on preceptor experiences with students indicating preceptor clinical experience with students on the *y*-axis and preceptor perception of experience with students on the *x*-axis.

Figure 4.23

Positional Map 12—Preceptor Experiences with Students



In Positional Map 12 (Figure 4.23), positions A, B, C, and D were displayed at the high end of preceptor perception on experience with students showing lack of lack of financial incentives for preceptors (B), limited student concentration (D), student indiscipline (C), and irresponsible attitude (A). Position E was in a middle location, which shows that there is limited supervision from tutors. Silences identified in this discourse included silence on ongoing power politics, students' assignment to risky tasks not trained, students' payments of logistics and face masks, efforts on addressing increasing students' numbers, failure of stakeholders to train and equip preceptors.

General Observations on Results in Positional Maps

Based on the positions outlined and questions posed, five positional maps were critical for understanding the preceptorship situation. These were positional maps 1, 4, 7, 8, and 9.

Positional Map 1 (Figure 4.12) displayed the effectiveness of preceptorship program which helps bring clarity to the study and set the study into context. Examining these maps, it was clearly established that preceptorship practices in Ghana had not been effective given myriad challenges that confront the situation such as motivation, training, policy on preceptorship and procedure manual, and logistics, among others. Positional Map 4 (Figure 4.15) was very important as it directly addresses one of the key objectives of the study which is challenges of preceptorship. Through this map, I was able to identify myriads of challenges confronting preceptorship and impacting on the situation in Ghana. As noted, some of the key issues included motivation, training, lack of policy manual and procedural guidelines, limited monitoring and supervision, politicking, and lack of logistics to mention but few. Further, Positional Map 7 (Figure 4.18) which examined motivational issues was also key given that throughout the interviews and among all the challenges, motivation was the most commonly and widely spoken challenge. All participants that I interviewed, preceptors, nurses, students, heads, tutors could not talk about challenges without mentioning motivation. They all shared concern of the need to motivate preceptors.

Another key positional map was Positional Map 8 (Figure 4.19), which explored policy and manual for preceptorship which has been a major political issue. Thus, major power politics has been played among dominant actors in respect of this position. This map was deemed important given the negative impact of the politics on the entire preceptorship situation. Positional

Map 9 (Figure 4.20) was also important as it highlighted training of preceptors, which was a key enabler within the preceptorship situation.

Summary of Maps

The situational maps have revealed quite a number of issues within the preceptorship situation as well as key social worlds/arenas where these issues were occurring. From the study, the key social worlds/arenas comprised four main arenas: educational, healthcare, policy and curriculum and political. This shows the tensions within the preceptorship situation and 15 social worlds (clinical training, management, clinical training, universities colleges, academic calendar, nursing, and midwifery, NCM, GCNM, non-physical, physical, macro, micro, educational, institution, MoH, GHS) that overlap arenas shown by dotted lines.

The primary contested views I found ongoing in the various arenas and worlds had to do with issues of motivation, preceptor training, manual development—whether updated and circulated or not—and whether every nurse must precept or not. From the study, the issue of motivation was highly contested with some asserting that this should be provided by the school with others expecting MoH and NMCG to motivate preceptors. Some nurses and faculty shared their words on these issues. One put it this way:

> I'm talking about motivation and preceptors feel that they are doing extra work outside their core mandate by training students, teaching students and all that so they feel that occasionally, either the minister of health or the school should at least motivate them in a way. By either money or work, whichever way, so that they can feel that their extra work that they're doing is noticed and rewarded, yeah.

Another contested view I found was on the issue of whether every nurse must precept or be a preceptor or not. Two schools of thought emerged on this discourse. One school believed that every nurse must be a preceptor or precept arguing that once someone is a nurse, they should automatically know how and be able to teach given their experiences over the years. Other

reasons were also used to buttress this position. A head of an institution and facility interviewed for this dissertation argued:

> I totally agree. That, uh, you know, if we check other professional groups, let's say you, you, let's say the medical profession. Their students go for clinical; everybody is entitled to, and teaching is the main component of preceptorship. So, I feel that preceptorship should not be left to just a few or one or two in a hospital, but everyone because knowledge from one person to the other can change depending on the level of experience. Every nurse is supposed to teach. You see, I don't believe in a nurse who doesn't know anything. Even if the person, the nurse hasn't gone through a professional teaching course, there are some things that you will be able to teach the students on the ward. The student is the novice. This, this person has worked and experience and intuition alone you can't add school to it. So, we advocate for that. In the Bora university all the people will tell you, we advocate for every nurse to teach our students, we don't mind who is teaching. But at least you should know what you are teaching them, but we allow to teach. We are for it; we are for it.

On the other hand, every nurse cannot precept school also believes that not every nurse must or can precept since people have their own right and personality which would not make them wanting or willing to precept. One participant commented:

> Some people, they are ready to teach and on their leisure hours they do some teaching assistant. These are the people I identify and then work with them. so, it is not everybody who will be a preceptor, you can train people but it's not everybody who will be a preceptor. When people go for workshop people come back and they do not do, and they put it in their pocket, they do not teach. Even the report that they bring from work shop it's a problem. They kept giving excuses here and there. To pick a preceptor you need to be careful because you cannot choose anybody to be a preceptor. Some people are gifted in teaching, truly knowledgeable and are ready to teach, they are the people who avail themselves to be trained as preceptors, they find time to teach the students but others not.

Given the two schools of thought, I turned to the literature and the recommended practices of Health Education England (2016), which is the basic standard of preceptorship practice and framework for all healthcare organizations in London to make sense out of the ongoing debate. Duteau (2012) pointed out the criteria for choosing a preceptor and stressed that clinical expertise, willingness to act as a role model, the desire to teach and foster learning, excellent communication skills, and evidence of ongoing teamwork are fundamentally required for one to be a preceptor. Edmond (2001) argued that staff nurses are the best suited to facilitate clinical learning, role

transition, and professional socialization of students and novice practitioners and their ability to do so is well-documented in research (Carlson et al., 2010a, 2010b; Kowalski et al., 2007). However, he added that simply because a nurse is an expert clinician does not mean that he or she will make an expert preceptor.

Preparation is necessary for any role and preceptorship is no different. Health Education England (2016) presented a standard requirement for preceptors stressing that to become a preceptor, one should have completed a structured and formal preceptorship/clinical supervision course. The above supporting data and references reinforced the position that not every nurse must be a precept or can precept. It demands willingness, dedication, sacrifice, commitment, and special training to be able to precept. Given my years of experiences, cognizance of the right of individual and understanding of the above reference points, I was reinforced and compelled to align myself to the position that not every nurse must or can be a preceptor.

New Findings from the Study

This study revealed several new and unique findings related to the study questions and literature on preceptorship and worth to discuss. First was the issue of extra curriculum activities which manifested itself in unethical behaviors of students during clinical training. The data gathered here showed students' engagement in sexual and immoral relationships both within and outside clinical settings. In relation to the study question on challenges of preceptorship, this finding remains a unique challenge impacting on effective preceptorship in Ghana. It also shows that major challenge exists in the management, micro, and educational institution social worlds. Thus, existence of this problem shows that the management social worlds within the healthcare arena is not doing enough in addressing the situation. The directors, the heads, clinical coordinators, and administrators situated within the management social worlds need to intensify

their disciplinary measures to ensure that students in clinical training must uphold the highest level of discipline, commitment, and ethical standards throughout the period.

This study also found the need for strong collaboration and communication between actors within the educational social world such as tutors and heads and management social worlds in the healthcare arena in terms of educating students on discipline and ethical standards during clinical training. This unique finding shows that much needs to be done at the micro social world where this problem persists. It also shows that students who are key actors and implicated within the micro social worlds are the main source of this problem. It is surprising that other key actors within this world like the preceptors, nurses, ward managers, and in-charges who are expected to monitor and supervise these students, are not doing what is required to address the problem. Given the above, it is very important that supervision, monitoring, and discipline which are key enablers of the preceptorship situation should be vital at both clinical and institutional level if preceptorship is to be effective.

Other new findings were about clinical coordinators at hospitals and other institutions. These actors are situated within both the educational and social worlds and in relation to the study question on enabling factors; they are key enablers in addressing the challenges within the entire preceptorship situation. Thus, the study identified two categories of clinical coordinators, which were those at institution and facility. From the study, these actors play a key role in ensuring that clinical training are given needed support to enhance effectiveness. These coordinators ensure that students are supported during skill lab practices, well prepared prior to clinical training, assigned to designated facilities, introduced to preceptors, and given the needed orientation during clinical training. The head of a unit in one facility said:

> Clinical coordinators will introduce prepare the itinerary of the training to the students and take them to the wards to introduce them to the preceptor or ward managers. The clinical

> coordinator when we are going for our clinicals will communicate to the facility and arrange us. I think that the huge number of students there is the need to divide them into smaller groups so that teaching would be amazingly effective. If we are having the 180 at least we can divide like 25 in a group in the skills lab so that the technician can teach students, the skills needed, and they would have a schedule that would be much effective than sending all students to the skills lab to be taught.

Preceptorship in Ghana faces many issues, and it is important that clinical coordinators increase their effort to improve current practice. For instance, with the current situation of poor communication between facilities and institutions coupled with student preceptor challenges, it is important that clinical coordinators collaborate effectively to ensure that students and preceptors benefit substantially from their role.

One new key finding that emerged here was that ethnicity in the context of the study question is a significant challenge to preceptorship. This challenge was found to be occurring at the micro social world in the healthcare arena especially in the Northern Zone. Here, the study found that some group of indigens attacked a facility with the perception that those working there were not from their region and should not be allowed to manage the place. The nurses and unit head who were attacked expressed fear and a limited desire to continue working at the facility. It is important to note that if such incidents continue, many individuals who could be sharing their knowledge and experience would probably leave the facility. If this happened, no longer would students benefit from their rich experience. Furthermore, given that there are presently no preceptors native to the town where the clinical training takes place, no nurse/midwife preceptor would be willing to take up the challenge and risks of working in such an environment. Ultimately, the entire preceptorship or clinical program would be affected, and students would bear the consequences.

Surprisingly, the study found no effort was made towards addressing the incident. This points to a major weakness on the part of actors within the management social world in the

healthcare arena in handling major conflict issues which occur in the arena. A unit head in a facility from the Northern Zone stated, “Some of the people in the township came to attack us because we were not from their tribes or indigens and our offices were locked.”

The value of adopting up-to-date information technology (IT) such as the use of WhatsApp platform and internet technologies, was an important new finding here. This is a key enabler in addressing the research question on challenges. Thus, in this current dispensation, IT, social media, and the internet are playing key roles in global transforming that sector, and it is important that the health sector should leverage this opportunity to resolve some of the myriad challenges among which preceptorship forms a major component. The study noted that facilities are finding new ways of addressing communication, supervision, and monitoring challenges through the use of IT, social media platform such as WhatsApp and live and prerecorded videos. While this development is a step in the right direction, it is important that efforts are made in terms of addressing accessibility and cost issues. It is important to further note that IT could be applied in all the various social worlds/arenas in resolving most of the challenges in the arenas which the study question seeks to identify. In light of this, actors within the micro social world in both the healthcare and educational arena such as preceptors, tutors, unit heads, and ward managers to mention a few needs to be well educated and trained in the use of IT in addressing most of the challenges in the preceptorship situation. A unit heads in one facility reported:

> I have proposed that to link with the universities and create a common platform and whatever we are teaching the student they can sit in their office and we can work together because sometimes they have a lot of students and sometimes leaving their class to come to supervise them is a challenge but when they have this kind of WhatsApp platform we can link up with them have meetings and they can have their presentations they can be there and supervise. We are even working out a project on how to use technology in teaching. So, we are teaching them how to use technology so that sometimes the students will not have to be necessarily present, but they can teach them. So, we taught them, we’ve even developed procedures in the school. Most of the procedures have been video recorded and given to the preceptors so that they can use to teach the students. They also

> are apart from the in-service. We give them materials—the sites can go off so, that they can vary their teaching methods on the ward. Then, any evidence-based articles that we come across, we push it to them because since they are on the ward and don't really have time, we do most of the search we push it to them—so they can be abreast with whatever is going on.

Another new finding here was motivation of preceptors by putting them on school payroll. This was unique effort by an institution towards preceptor motivation. One key research question was about challenges and, given the above, it is important to note that the universities and colleges social worlds are making some effort in addressing the challenge of motivation which is a critical issue in having effective preceptorship. From the study, it was clear that motivation was crucial in preceptorship effectiveness, yet efforts to address this issue have been poor if not entirely lacking leading to very limited interest among nurses to precept. I was very happy when I got to know this from the institution as this has not been heard anywhere in my years of nursing practice. It is important, and I hope that other institutions make this kind of effort to help in the bid of making preceptorship effective in Ghana. A faculty member expressed the following:

> So, the preceptors, you know with our system it's quite difficult to take money and give without the VC's approval so what we do here is that they have been employed as part of faculty/tutors for the university. So, they are on the university's payroll as part-time lecturers. They are part of us; It's just that they are on the wards. So, they have a paid salary and everything. And the VC is aware so every month they pay them.

One other new issue that I gathered from the study was that payment was sometimes required from students to have access to preceptors including payment for some equipment for use during clinical training. This is a serious problem at the micro level social world in the healthcare arena. This was very surprising to me given the fact that students as part of their tuition already pay for this. In interviews with students, a number complained of this development. It is sad to note this but given the current state of preceptorship in Ghana with the fact that motivation has being lacking coupled with increasing student numbers, it becomes possible for such issues to occur. These are silent voices or the underrepresented group that nobody is paying attention to.

Nevertheless, it is important that the institutions most especially attend to this development and address it accordingly. One participant reported**:**

> But before that, there was something going on already in the training institutions. Where, I mean the MT, the basic ones, where I think the training institutions have been sending their students to the facility and the facilities ask them to pay some amount of money to the facilities for their students to be precepted. So, at the moment, what some hospitals are doing, is that because the schools are not motivating the preceptors, what is on record was that some of the hospitals are charging students. I don't want to mention some of the hospital, I know them, but I don't want to mention them. But what I know is that most of the hospitals nowadays are charging students for using their facilities. Some charge each student 20 dollars per student and the school pays 100 dollars per semester, before they will accept student, the school pays for the vacation practicum; they abuse the gloves, that is the PPEs [personal protective equipment]. The protective equipment and so they would want to pay so that they can buy more. So that has been a challenge.

A final new finding concerned exposure of students to risky tasks during clinical training. Standard procedures require students to be well oriented, guided, and supervised during clinical training. However, with the many challenges confronting preceptors in clinical training, I understood that attention given to students by preceptors, ward managers, and colleague nurses have been extremely minimal students, hence, students are not well guided, supervised, monitored, and well oriented during their clinical practices. The net effect is that students are being given tasks and exposed to activities that pose great threats to their health and that of patients. Thus, standard practice is lacking and not adhered to by some preceptors and nurses who are expected to orient, impact knowledge, guide and provide professional training to students. One of the students explained as follows:

> One challenge is assigning any tedious work to students without any assistance, especially doing bed-bathing, bed-bathing you need assistance; I remember my first experience at Metro Hospital, A patient soiled herself and she was a "retro virus infection" [RVI] I did not know and they did not informed me, even though level 200 student nurse and the first time of going to the ward, was asked to change her diaper, I took my glove and everything waiting for the nurse in-charge to come and me because at that cubicle I was the only person there, and the woman is old and has been in that bed for long because she [was] an RVI patient nobody wants to go near her. So, I didn't know when I was going to change the diaper, so I did everything, so I was angry that nobody was coming to assist me, she even had a pressure sore in her back, buttocks, and everything so nobody has attended to

> this woman or what? I was very angry and later on, after cleaning up putting a new diaper, discarded my things and went to the report bort book wrote everything. And I took the patient folder and I realized that the patient was an RVI patient so after that went to the male In-charge that nobody helped me and I was the only person doing turning and the disposable glove got torn and my hand was smeared with fecal matter and the in-charge said, "you're a student that is what you are supposed to do." The in-charge said that "if you are a student, you suffer that".

Given this narrative, it becomes crucial that issues of standard guidelines and supervision which came out as one the key challenges are critically looked at and addressed.

Contradictions, Contentions, and Controversies

The study noted some key contradictions, contentions, and controversies which are impacting on preceptorship in Ghana. First, the preceptorship manual prepared by MoH and GCNM—which the MoH reported having sent soft copies to all schools and clinical sites—was contradictory and contentious as findings showed that only one facility had received it. That this was contested by an institution had not been so as indicated by MoH. Further, the issue of the school training their own preceptors also revealed controversies as to whether by policy they have the mandate to do this and by which avenue they fund the training of the preceptors. It was also contradictory given that GCNM also indicated that they have the mandate to train preceptors. The question to ask is whether it is possible or the best way to go to have different bodies or authorities training preceptors. This I something that needs to be addressed.

One other controversy had to do with the preparation of the preceptorship manual and standard procedures by different bodies within the preceptorship arena, more specifically, the key dominant actors. It was learned in the present study that all the dominant actors had developed, one way or the other, some independent manual and guidelines for preceptorship. The question arose, who is better placed or legally mandated to do this? Is it the MoH, NMCG, or the GCNM?

Another contention and controversy concerned motivation of preceptors. As found in the study, participants views were divergent on motivation of preceptors. They discussed efforts

which some saw as token, made by some institutions and schools in motivating preceptors by putting preceptors on salary and engagement in examination supervision. Others also expressed that MoH and NMCG should play a stronger role motivation of preceptors. In effect, perspectives about the issue of who should motivate preceptors were mixed. The key question in this regard is, should it be the school, students, facility, NMCG or MoH who motivate preceptors?

Finally, there was also controversy on student funding of logistics/equipment for their clinicals such as gloves and payment made to institutions to be able to assign preceptors to students. Given this scenario, I ask whether students must be responsible for funding their clinical training equipment as the study found? These controversies, contentions and contradictions are key issues that need to be reflected on for effective preceptorship practices.

Chapter Summary

The chapter explored and analyzed data using all the situational maps. Table 4.1 summarizes the key findings in relation to the study questions.

Table 4.1

Key Findings in Relation to Study Questions

STUDY QUESTION	KEY FINDINGS
Q1. What is the nature of preceptorship approaches and practice in nursing/midwifery education in Ghana?	• In Ghana, preceptorship is a method of clinical education whereby experienced nurses selected as preceptors train both junior and senior nursing students. • Unlike a formal preceptorship program in some developed countries where the program length is defined as anywhere from 3 weeks to 12 months (Health Education England, 2016), the program length is indefinite in Ghana. • Preceptors are selected by the heads /coordinators and School of Nursing/midwifery of health training institutions in collaboration with nurse managers within the hospitals. • The criteria for preceptor selection include nurses/midwifes' with three years plus of clinical experience, nursing/midwifery degrees, and an interest in teaching/preceptoring/mentoring nurses/midwives. • Preceptors are expected to be formally trained and mentored (Gossaye & Dohrn, 2013; Myrick, 2002, Robinson & Griffiths, 2009) and (Al-Hussami et al., 2011). • Previously in Ghana, preceptors were trained under a formal program led by the MoH in collaboration with other Trainer of trainers NGOs; however, this is no longer the case.
Q2. What are the challenges associated with preceptorship practice in clinical teaching in nursing/midwifery Ghana?	• As a result of the increasing student numbers in HTIs, there is a disproportionately high student to preceptor ratio, which negatively impacts the quality of the training experience students receive (Dennis-Antwi, 2011; Udlis, 2008). • Because of a lack of collaboration between external stakeholders due to politicking, there is no proper structure in place for the preceptorship program in Ghana, which results in myriad trickle-down effects such as insufficient preceptor preparation, confusion regarding who is responsible for providing things such as logistics, and a lack of incentives/motivation for preceptors, among others. • Not sufficient guidance and supervision (Kaviani & Stillwell, 2000). • Inadequate formal preparation of preceptors (Al-Hussami et al., 2011). • Low motivation levels (Goss, 2015; Hautala et al., 2007; Watson et al., 2012;).

STUDY QUESTION	KEY FINDINGS
Q3. What are the enabling factors influencing preceptorship practice in clinical teaching in nursing/midwifery Ghana?	• Robust training and education program (Al-Hussami et al., 2011; Asirifi et al., 2013; Duteau, 2012). • Rewards, Support, and commitment to preceptor role (Hyrkas & Shoemaker, 2007). • Strong collaboration between institutions and macro actors (Asirifi et al., 2013). • Inconsistent use of standard procedures (Asirifi et al., 2013). • There should be conscious effort by MoH to raise funding was deemed essential for training, development of manual, logistics, monitoring, supervision.
Q4. What is the role of stakeholders (external/internal) in the implementation of preceptorship in Ghana?	• External stakeholders include MoH, GHS, NMC Ghana, within the system. • Internal stakeholders include the heads faculty members/tutors, students of the health training institutions, nursing/midwifery directors/administrators' managers, preceptors staff nurses and midwives within the hospitals and clinics within the health. • External stakeholders like the MoH and the GHS are responsible for developing policies, providing funding and supporting (program guidance, curriculum, training etc.) necessary for the proper implementation of preceptorship in Ghana, as well as collaborating with each other to ensure accountability—Strong collaboration between institution and macro actors (Asirifi et al., 2013). • Internal stakeholders like the heads of HTIs and nurse/midwifery managers are responsible for following available guidance from the external stakeholders, while faculty/tutors and are responsible for monitoring/supervision and students learning, respectively as opine by (Nabolsi et al. 2012). • Monitoring and evaluation (Boyer, 2008; Patton, 2010). • Equipment/Logistics (Burns & Northcutt, 2009; Hautala, 2007). • Standard procedures required (Asirifi et al., 2013) MoH and GHS is responsible for funding. • For MoH, GHS and NMC, Ghana and GCNM, there is currently no formal training (Al-Hussami et al., 2011; Asirifi et al., 2013). Duteau (2012) stated that the organization should provide formal training and update program for preceptors. • NMC of Ghana is a Regulatory body for the Nursing and Midwifery professions, it also a statutory body to ensuring the utmost standards and training of nursing and Midwifery practitioners.

This study revealed issues and challenges at the micro, meso, and macro levels of the preceptorship situation. The study results also revealed some silenced voices for multiple reasons. An important example was assignment of multiple tasks to novice students without proper guidance from their preceptor/ward managers. Due to their increasing numbers, students faced difficulties in accessing basic safety supplies (masks, sanitizers, etc.). The preceptors were not willing to talk about and address these issues. In addition, there were concerns related to unethical behavior, inappropriate relationships during clinical training, and inadequacy of preceptor training that were not heard.

CHAPTER V: DISCUSSIONS AND IMPLICATIONS

In this chapter, I will discuss the results of findings and relate them to the pertinent literature. Thereafter, I will highlight the limitations of the study and consider its implications for research, practice, and policy. I will focus the discussions on the key issues emerging from the study which I noted are critical to the broader framework of the preceptorship situation under study. First, I will discuss preceptorship challenges and then proceed to consider enabling factors. Next, the major debates and contentions which form potential issues surrounding the situation. I will highlight the main silent voices, new findings from the study, relates findings to the two main theories and finally look at study limitations and implications for research and practice.

Challenges

In this inquiry into preceptorship challenges, I identified six main key themes which were highlighted by almost all the respondents in individual interviews and focus group discussions within all three regions. The challenges were motivation, manual and policy guidelines, power politics, logistics/resources, communication, collaboration and cooperation, supervision, monitoring and evaluation as well as training.

Motivation

Motivation emerged as an issue challenging the situation under study. As noted, from the beginning of the data gathering and development of situational maps, motivation runs through from the beginning of developing messy map, to ordered map, social world/arena maps, and positional maps. For instance, from the positional maps, it was seen that motivation was highly perceived as though it had the lowest rate of provision as compared to training. Further, respondents in all the three zones comprising heads/directors/administrators, preceptors, faculties/tutors, and some nurses could not talk of anything without mentioning motivation in their

responses to the challenges of preceptorship. They explained that preceptors are not motivated to help them perform their duties well by showing commitment to the work. According to them, this was a major reason for the limited interest in precepting.

My findings resonate with Chore's (2018) study on the implementation of preceptorship standards and clinical skills development among nursing students at Jinja School of Nursing and Midwifery which revealed that lack of extra remuneration undermines effective preceptorship programming. Further, findings here corroborate Hautala et al. (2007) and Watson et al.'s (2012) observations that lack of motivation, adequate support, and appreciation are major barriers to effective preceptorship. A study by Goss (2015) on building a preceptor support system noted that inadequate appreciation of preceptor contributions and lack of some form of external reward system remain barriers that adversely affect preceptorship.

Preceptorship has been seen as a major bridge between theory and practice (Myrick & Yonge, 2005) and a way to facilitate role transition from student to graduate nurse role for most nursing students (Heath & Australia Department of Health and Ageing, 2002). However, to make this achievable, there is a critical need to address one major aspect of its effectiveness: the motivation of preceptors. Preceptor motivation needs to be increased as nursing schools increasingly depend on the availability of preceptors for students (Pringle et al., 2004). This puts enormous added pressure on preceptors. The heightened demand for preceptor training has resulted in increased workload for preceptors as they attempt to manage the high number of students under their supervision. Fair compensation for preceptor efforts would increase motivation and commitment to their critical role in training.

Asirifi et al. (2013) stressed that regular education on preceptorship through workshops, is key to improving the effectiveness of preceptorship. Landmark et al. (2003) also stressed that the

success of clinical teaching is dependent upon the ability of the organization to create a supportive framework that ensure that the necessary resources and required time are given to students. A phenomenological study by Valizadeh et al. (2016) also adds that that for effective and successful preceptorship; there is the need for preceptors to be adequately prepared through formal training to acquire relevant skills to be able to deliver quality teaching to student nurses (Chang et al., 2015; Whitehead et al., 2016). While these points are relevant to the issue of motivation, the challenge becomes how to create a supportive framework ensuring that resources and required time are available to students, given that the very people needed to train them—the preceptors—are neither well motivated nor have their expectations met. To Chang et al. (2015) and others, if after adequately preparing preceptors to deliver quality teaching to students, if their motivational needs are not attended to, how will they provide the quality teaching the student nurses? Evidence in the literature has also shown that preceptors perform better when they are educated through a preceptorship program (Al-Hussami et al., 2011). The current study, while recognizing the need for education and training, suggested that motivation greatly impacts the preceptors' fulfillment of this critical educational role.

My study shows that financial reward facilitates preceptorship effectiveness by increasing motivation. One major issue is who and what should motivate preceptors? Although this study established motivation as a major challenge, effort have been made by some institutions to increase motivation by providing additional compensation to preceptors for their supervision of students' examinations. But these efforts are not enough as only a handful of institutions are making the effort. A critical look at preceptor motivation, as from the present study, also shows that motivational issues cannot be solved at the government or other macro level institutions although some participants expressed that the MoH should motivate preceptors. This study has

shown that efforts to motivate come from the meso level or institutional level of influence. To sum up, given preceptors' critical prominence, to enhance effectiveness there is the need for attention to be paid to their motivational needs by all relevant stakeholders like the MoH, institutions, or individual health facilities.

Outdated Procedure Manual, Lack of Preceptorship Manual, and Limited Access to Manual

The study reported an outdated procedure manual as one of the key challenges. This procedure manual is a standard for schools and facilities to follow during students' clinical training. The guidelines in the manual describe what students need to be taught and used by preceptors in teaching clinicals. The responsibility for developing this procedure manual rests with NMCG, which this study has shown has allowed the manual to become out of date. Thus, the NMCG has failed to fulfill their responsibility. Schools and the facilities are unable to rely on the manual as it has not incorporated the more recent guidelines to meet international standards. Consequently, some schools and preceptors are now performing the key role of comparing the procedure manual with international standards and updating those procedures that have changed to help meet such standards. Unfortunately, as concluded in this study, access to even the existing manual was limited to only two schools. Fundamentally preceptorship manuals provide standard practices to guide preceptorship including the overall concept of preceptorship and its significance in the education of the midwife.

In other words, standard practice is guided by the objectives behind preceptorship, the roles expected of preceptors and preceptees, the support and development that should be extended to preceptors and preceptees, as well as the organizational commitment required to make the program successful. For instance, Health Education England (2016) developed a framework for best practices for preceptorship, which, after extensive engagement of stakeholders from all fields

of professional practice and healthcare, has incorporated the aforementioned elements. These elements have become the basic standard of preceptorship practice and framework for all healthcare organizations in London. This manual provides specific guidelines for preceptorship programs and remains an important resource.

The present study confirmed that while some form of preceptorship manual exists, it is outdated, and most institutions and facilities lacked access to the manual. As a result, diverse procedures and standard practices have been developed by different key stakeholders especially GHS, GCNM, and MoH. This only adds to the confusion. In a study undertaken in Iranian teaching hospitals, Valizadeh et al. (2016) found that lack of clear goals, objectives, and guidelines of the preceptorship program resulted in inconsistencies, uncertainty, and confusion among preceptors and new nurses. In turn, these issues resulted in the preceptorship program not achieving its intended results. It also implies that different approaches have to be used in precepting students.

Results from the current study corroborate Asirifi et al.'s (2013) findings that the standard practice of the preceptorship model is lacking because there is no shared knowledge between nursing schools and health service in Ghana. Valizadeh et al. (2016) discovered that lack of clear goals, objectives, and guidelines were major barriers to preceptorship. Other authors have suggested that preceptorship should have clear objectives, expectations, and guidelines to make it effective and achieve its desired goals (Enrico & Chapman, 2011; Madhavanpraphakaran, et al., 2014; Marks-Maran et al., 2013; Muir et al., 2013). Goss (2015) shared similar views and call on the development and implementation of policies and guidelines at both local and national levels to better inform the program.

From this study, it appears that the development of standard guidelines will only be possible if the dominant actors (MoH, GHS, NMCG, GCNM) are able to cooperate effectively. Asirifi et al. (2013) concluded that clinical teaching is heavily influenced by stakeholders such as the MoH and NMCG. In the existing system, power is skewed towards stakeholders like the GHS, the NMCG, MoH, and the nursing/midwifery training institutions. These stakeholders hold more power because of their size and authority in the form of legal mandates and government support. Thus, in order to make any sort of significant progress, there is the need for strong collaboration among these groups (Asirifi et al., 2017). The participant expressed further that there is no common understanding between nursing/midwifery schools and the GHS for the proper implementation of the preceptorship model in Ghana. This presents a serious problem as it results in an extremely inconsistent level of quality among new nurses. It is strongly recommended based on the findings of this study that preceptorship should be redefine by NMC, GHS/MoH, in partnership with educational institutions and representatives from health care agencies

Additionally, it is imperative that the existing manual is updated to meet current development in preceptorship and distributed for easy accessibility to all relevant stakeholders (institution and facilities). The findings here align with Asirifi et al. (2013) who concluded that the current preceptorship program in Ghana has no formal structure and lacks clarity. It is therefore no surprise that the entire system is confronted with huge discrepancies between the number of students to be trained and the number of preceptors and lecturers to do this training.

Logistics and Resources

Logistic and resource constraints limit learning opportunities for nursing and midwifery students, preceptors, and heads of institutions from across the three zones. Students reported not able to secure or rent accommodation for their inter-semester clinicals, limited or no funds for transportation, and long distances to clinical sites as students experienced that as challenges. Additionally, limited funding contributed to practical difficulties for nursing/midwifery students due to insufficient clinical teachers/preceptors or learning resources. Asirifi et al. (2013) and Dube and Jooste (2006) found that limited resources for clinical teaching are often perceived as having negative effects on learning. Further, Kilam and Carter's (2010) systematic literature review of qualitative and quantitative studies and clinical teaching evaluation reports identified the major challenges that nursing students from urban communities experienced. They found budget cuts led to the most serious logistical and resource problems that students identified as posing challenges.

From the study it was seen that logistics greatly affected students' clinical experience as they reported that they had to provide gloves, hand sanitizers, face masks, cotton wool, gauze et cetera before they were granted access to the health facilities. Limited equipment and space for clinical conference and demonstration was also a challenge. In addition, the schools, and sometimes the students, often pay the hospitals for allowing the students to undertake their clinical practice. Moreover, preceptors have none or limited access to preceptor and procedure manuals. Luhanga et al. (2010a) stated that provision of educational materials is key for a successful preceptorship program.

An additional barrier to achieving effective preceptorship is inadequate infrastructure (Burns & Northcutt, 2009; Hautala et al., 2007). Inadequate infrastructure was identified in this study in terms of the need for more skill labs, hospitals, and space within the hospital to help meet

increasing student numbers and make access to equipment and training easy and comfortable. This would help meet the increasing student number to make access to equipment and training easy and comfortable.

Shortage of Health Workforce

In this study, both human and non-human resources were seen as key in impacting on preceptorship. For instance, the need for more human resources (preceptors) was deemed as very important in addressing the huge and increasing student numbers. Kemper (2007) reinforced this point in noting that the ratio of students to nurse educators was too high to allow for effective student supervision in clinical practice, signaling the need for preceptors. Again, in recognition of the key role of preceptors and challenge of nurse's shortage, MoH, together with GHS, implemented a policy to increase the number of nurses by increasing intake of students between 2007 and 2011. Yet this did not yield many positive results due to the substantial increases in student numbers without corresponding increase in preceptors and tutors/faculty members (Asirifi et al., 2017).

These findings related to human and non-human resources challenges to preceptorship are consistent with other studies. Chore's (2018) study on the implementation of preceptorship standards and clinical skills development among nursing students at Jinja School of Nursing and Midwifery, concluded that inadequate preceptors, inadequate staffing, limited competent tutor and the growing number of students, undermines preceptor performance, and creates barriers to an effective preceptorship program (Burns & Northcutt, 2009; Hautala et al., 2007).

Robinson and Griffiths (2009) looked at resources from the non-physical point of view and argued for investing in development of preceptorship programs, training courses for preceptors, and work management that safeguards time for preceptees and preceptors to work together. The

present study's findings also pointed to the need for stakeholders to pay particular attention in addressing these challenges. Positional Map 5 (Figure 4.16) of this study shows that basic equipment for use in student clinical training should be provided by the facility and training of preceptors by key stakeholders such as NMCG.

Communication, Collaboration, and Cooperation

Other key challenges which emerged from the present study concerned communication, collaboration, and cooperation. As noted, preceptorship must involve multiple players to be effective and successful. It cannot be successful without the involvement of the health facility where clinical training takes place. Conversely, the health facilities cannot precept without the institutions. Furthermore, providing training to students requires some guidelines and policies for preceptors to perform their role effectively. In all these networks of interdependencies, communication and collaboration are essential tools for preceptorship effectiveness.

Collaborative preceptorship in which preceptors, faculty, and students combine efforts is important in helping students achieve their clinical education goals (Asirifi, 2011; Asirifi et al., 2013, 2017). Henderson et al. (2006) expressed that there should be collaboration and communication between educators and managers to provide a supportive environment for preceptors. In the present study, communication and collaboration were found to be major challenges for assuring quality preceptorship in Ghana. Collaboration, cooperation, and communication generally encompass preceptors and students, preceptors and institutions, preceptors and colleagues, institutions and facilities, and facilities with GHS, NMCG, MoH, and GCNM. The study found that some form and degree of collaboration, cooperation, and communication exist but have not been very effective especially among the dominant actors (MoH, NMCG, GHS).

From Positional Map 4, position H (Figure 4.15), poor coordination among these actors was perceived as high among the challenges of preceptorship. These dominant actors are required to give policy direction and standard guidelines to facilities and institutions, but power politics has resulted in them not effectively collaborating to provide the needed standard for preceptorship. Also, communication between some institutions and facilities has been very poor given that some of the institutions do not give enough information to facilities about their students coming for clinical training and thus impacting the preparations necessary for accommodating such students. The resulting effect has been that either the students are not received by facilities, or they are received but are not properly supervised by preceptors.

Furthermore, cooperation and coordination that preceptors should have with colleagues were poor; hence, students' support from other nurses at the clinical training was limited. The perception has been that preceptors are being given adequate rewards and should do their work without relying on other professionals. This has become more of a political issue in terms of who gets what and who should do what. The long distance between the preceptor and colleague nurse—as seen in political arena of the social world map—vividly explains the uncooperative attitude of some colleague nurse towards preceptors in student clinical training settings. In addition, as seen on Positional Map 4 (Preceptorship Challenges; Figure 4.15), that lack of support from colleague nurses is highly perceived as a major challenge to preceptorship. This calls for a collaborative effort by colleague nurses/midwives in the clinical setting to help in clinical training of students. It also shows the need to address motivational issues to increase interest and the number of preceptors to help in clinical training of student nurses.

The present study also provided insight that some form of collaboration occurred among the key dominant actors (GCNM, MoH, NMCG); however, there was a serious issue of power

politics about who should prepare the manual and who should own it. While GCNM felt that they were the implementers and should thus be allowed to develop the manual, the mother body (MoH) refused given the fact that they have secured the funding and must work on the manual. The matter was challenged and argued until finally, GCNM gave in and decided to support MoH without having to be the main originator of the manual.

Results from the present study reflect the views of Henderson et al. (2006) that there should be a collaboration between educators and managers to provide a supportive environment for preceptors. They stressed that managers must be prepared to put organizational structures in place to support preceptors. Corlett (2000) highlighted lack of collaboration between clinical areas and educational institutions as a key challenge to preceptorship. Reeves (2008) agreed that stakeholder collaboration was essential, asserting the need for a good and strong relationship between educational institutions and clinical placement providers. According to Reeves, the clinical facilities, preceptors, training institutions and students, all have a major role to play if students are to achieve the benefits of clinical education. Additionally, other studies (Lawal et al., 2015; McSharry & Lathlean, 2017) have also reported challenges such as ineffective communication between nursing/midwifery educational institutions, faculty members and clinical preceptors, and a lack of adequate feedback for students after their practical sessions as major challenges to effective preceptorship.

Politics—Impact on Preceptorship

The present study revealed politics as a key challenge to preceptorship. The effects of politics occurred at all the levels (micro, meso, and macro) but was most evident at the macro level among the dominant actors (MoH, NMCG, GHS, GCNM). The politics at the meso and macro levels fundamentally centered on development of preceptorship manual and procedures for

preceptorship. The question was, who is responsible for developing preceptorship manual and who has the power and influence to make certain key decisions? At the macro level, politics centered primarily on who should provide funding to develop the manual and train preceptors and who should take ownership of having developed the manual. GCNM claimed it was their responsibility to do so and not MoH's. It was seen in the present study that GCNM was challenged with funding issues and was unable to perform this mandate. On the other hand, because the MoH had the ability to secure funding for the development of the preceptorship manual and training for preceptors, it did not want to allow GCNM to take responsibility for developing the manual and training preceptors because they (MoH) had secured funding.

Thus, given the ongoing politics, the entire preceptorship program in Ghana lacks standard procedures and the updated manuals needed to guide preceptors, institutions, and facilities. As a result, different procedures and guidelines are being employed by different schools and facilities leading to confusion, differential treatment, and variable approaches to student clinical training. The present study found that these dominant actors have not done much in terms of cooperating and collaboration in harmonizing the entire preceptorship program in Ghana. Hence, the issue of updating the manual and guidelines has become a major controversy as discussed above. While some believe that the manual has been updated, others are unaware and disagree. Again, access to the manual has been limited—only one institution indicated having received it. At the micro level, the power politics has to do with motivation and who should precept. Colleague nurses believe that preceptors have been adequately remunerated and should just do their job. As a result of this perception, some nurses were reluctant to support their colleague preceptors. Several studies (Alspach, 2000; Burns & Northcutt, 2009; Hautala et al., 2007) had also reported politics as a major barrier to effective preceptorship.

Other issues that emerged from the present study but were not key challenges hindering preceptorship included training, funding, monitoring evaluation and supervision, increased student numbers, accommodation, limited time for clinicals, students' attitudes, and transportation.

Enabling Factors for Preceptorship

As part of the key objectives of the study, I inquired about the factors that enabled preceptorship to be effective. Enabling is the term used to describe such factors. Findings presented below on enabling factors are as follows: training and education; collaboration and communication; monitoring, supervision, and evaluation; motivation; and a supportive environment including preceptor support, use of standard procedures, and creating guidelines for the provision of resources/logistics.

Training and Education

One of the keys enabling factors was training and education of preceptors. Just like any other professional, preceptors require training to perform their duties effectively. This study found that limited training of preceptorship accounted for many of the challenges confronting preceptorship in Ghana.

The importance of training, as found in the present study, is well recognized by the key actors, hence, its inclusion in the five-year strategic plan of nursing and midwifery in Ghana and deliberate efforts being made by GCNM, NMCG, GHS, and MoH to enhance preceptors' skills and enrich their expertise. Having the desire for training and education was not enough and not the end of the story: a conscious effort to raise funds or seek funding was deemed essential since training and education of preceptors depended significantly on financial resources, which this study also determined had been a major challenge accounting for limited numbers of preceptors.

A phenomenological study by Valizadeh et al. (2016) supports the view that for effectiveness and success, preceptors have to be adequately prepared through formal training to acquire relevant skills and to be able to deliver quality teaching to student nurses (Chang et al., 2015; Whitehead et al., 2016). Evidence in the literature shows that preceptors perform better when they are educated through a preceptorship program. Al-Hussami et al. (2011) conducted a study with the purpose of implementing and evaluating a preceptor training program among nurses. Their results showed that participants' knowledge on preceptorship improved significantly after a formal preceptorship education. As critical enablers of preceptorship, it is very important that training and education of preceptors are given high priority and that adequate funding is made available for these efforts if preceptorship in Ghana is to be effective.

Collaboration and Communication

Collaboration and communication remain key in the entire preceptorship program as noted in other studies on preceptorship. In the current study, collaboration and communication were seen as major challenges across all levels of the preceptorship situation (micro, meso, and macro). There were communication challenges between and among schools and facilities and limited collaboration between NMCG, GHS, GCNM, and MoH. Findings from the study called for the need for collaboration at all levels to make the program effective.

Chore (2018) asserted that for effective preceptorship, there is the need to have the right environment one with strong stakeholder collaborations and competent preceptors to guide learner's access to learning resources and management support. Thus, educational institutions have a major role to play in ensuring an effective and successful preceptorship program. Reeves (2008) also called for stakeholders to collaborate, asserting that there is a need for a good and strong relationship between educational institutions and clinical placement providers. Clinical

facilities, preceptors, and training institutions all have a major role to play if students are to achieve the benefits of clinical education.

Monitoring, Supervision, and Evaluation

The present study identified monitoring and evaluation as a key challenge and an enabler of effective preceptorship. It was seen that tutors who are expected to supervise students during their clinical training had not been effective in performing this role given the challenges of proximity, motivation, transportation, and/or apathy. A tutor in Ghana's Middle Zone shared the following:

> So, in my school, previously we used to go to all the clinical sites and monitor but at a point, because of challenges with extrinsic motivation, it became a challenge going to the distant places. But of course, if, let's say on vacation I live in Kumasi and there are a cluster of hospitals around where I live, like Suntreso, Komfo Anokye, Atonsu Agogo Hospital, KNUST Hospital, definitely I don't need a fuel before I'll drive there because on my normal day-to-day activity, I may pass around these areas and as a tutor, voluntarily or out of the intrinsic motivation, I will go there and supervise. But the challenge will be those who will be going on to distant places. Because I don't have the means, because there's nowhere stated on my salary that I should use this as fuel for this traveling to let's say Nalerugu to go and supervise during vacation practicum, it is not there.

Given this situation, it was difficult for preceptors who are already get limited support and work under stressful conditions to address students' indiscipline during clinical training. Even though some try to report negative student attitudes or conduct to their schools or coordinators, nothing much happens in terms of improving student discipline. Having tutors onsite in supervisory roles during clinical training goes a long way towards improving student focus and discipline. Evaluation should not be used as the only tool to make students aware and focus on clinical training; adequate supervision and monitoring is also critical. This is especially the case given some complaints and comments made by students that some of the students are rated highly because they are liked by certain preceptors. Boyer (2008) and Patton (2010) asserted the ability of preceptors to self-reflect and be honest, organized, and objective in evaluation and in their

general concern for preceptees, all of which are essential enabling factors for successful preceptorship.

The present study further noted that monitoring and supervision are only performed by tutors, preceptors and sometimes heads at the micro level but not seen to be a responsibility of actors at the macro level, especially by GHS and NMCG. These were only seen in this study as decision makers and policy developers, and it was not known whether the monitoring or supervision of the preceptorship program was within their remit. Either way, it is also important that the major actors within the preceptorship situation perform some monitoring and supervision of facilities and institutions to ensure that the policy they have developed has been implemented effectively and yielded positive results. In other words, monitoring and evaluation should not be an exclusive preserve of micro level actors but meso and macro level actors all should all play integral roles in order to have an effective preceptorship in Ghana. According to the MoH (Ghana Ministry of Health, 2015), weak systems and structures have resulted in poor monitoring, supervision, and evaluation of preceptorship program. As programs and institutions strengthen, the enablers of monitoring, supervision, and evaluation, the effectiveness of preceptorship will significantly improve.

Motivation

One of the most important enablers of effective preceptorship was motivation. As noted in previous discussions on challenges, motivation plays a major role and is like the life blood for preceptors. This helps to explain why preceptors number are low and they are not willing to give their best. It is also why many tutors showed limited commitment to supervise students. From this study, motivation seems to permeate across all the challenges and exacerbate other issues. Other issues are exacerbated due to problems of motivation. For instance, lack of motivation for

preceptors and tutors has led to limited interest from nurses in taking up these roles. In turn, this has affected preceptor numbers, which negatively affects the provision of effective supervision and monitoring. A tutor in a Southern Zone made the following comments:

> Motivation of preceptors and tutors is very important and key for effective preceptorship. For instance, previously, if a tutor has to travel all the way to, from let's say, Dunkwa on Offin all the way to, let's say, Ejura in the Ashanti Region or Atebubu or Techiman and the tutor will drive to that place and come back, go for supervision and not even a fuel allowance or nothing at all. Then obviously, next time when you're sending that same tutor to go for that supervision, the tutor might not get the resources to go. So, it is not as if tutors are not willing to go for the supervision. The challenge we have has to be with the extrinsic motivation. The intrinsic motivation is there, that is, you want to go and do it. But if extrinsically, there's no fuel, there's no means to go for the supervision then it becomes a challenge. I remember in the early days, I once went to a clinical site as far as Kasei, close to Atebubu, from Dunkwa. And then when I went, I realized the preceptors were doing a very good job there, but they were also insisting that at least when we send our students there, they take them through practicals, stay there for eight maximum weeks and we don't give them anything at all. They become demotivated. So, it is not only tutor motivation—the preceptors on the ward must also be motivated.

This study showed that motivation should not rely exclusively on institutions. There must be a deliberate policy whereby all preceptors are motivated. Letizia and Jennrich (1998) argued that factors such as clinical expertise and motivation are critical factors that will enable one to be a successful preceptor.

Supportive Environment

A supportive environment came up as one of the keys enabling factors of preceptorship. Given the workload, increasing number of students and the complexities of the preceptorship environment, the study called for the need for an enabling environment that is supportive for preceptorship to thrive. Supportive environment mainly centered on the support given to the preceptor, students, institutions, facilities, and any resources needed to make the program effective. As the study revealed, the preceptorship situation had not received the needed support in terms of logistics, training, motivation, supervision, and monitoring. Actors at all levels of the preceptorship spectrum must play their role in supporting the program. According to Chen et al.

(2011), a supportive and fostering environment is required to overcome the barriers of preceptorship and ensure an effective program. Kaviani and Stillwell (2000) reinforced this point that preceptors require the support of their co-workers, nurse educators and the organization to make preceptorship effective.

The literature also revealed that one element of a supportive working environment was having colleagues acknowledge each other as preceptors (Bourbonnais & Kerr, 2007). Williamson et al. (2010) posited three main constructs as major enablers of effective student clinical teaching. The first construct is *cognitive support* which refers to clinical judgment and facilitating techniques used by preceptors to enhance students' thinking processes. Cognitive support also makes them confident and competent practitioners. The research found that not much is achieved if students are confronted with too many challenges such as inadequate supervision, guidance, and discipline among others. This fails the cognitive support test, Williamson et al.'s first construct.

The second construct is *emotional support* which includes items such as personal attention to students, interest from preceptors, and guidance regarding student learning. This study found that these aspects were not well achieved. As noted from preceding findings, relationship, and attention to students during their clinicals had been poor. Students complained of limited attention to them by preceptors and colleague nurses as well as poor communication and guidance during their clinicals. Adelman-Mullally et al. (2013) asserted that a positive interpersonal relationship between preceptors and students, helped students by giving them confidence and autonomy.

The last construct is *system support* which encompasses items from both the system and tangible support. These include orientation given to students on the physical environment and routines, standards enforcement, opportunities to learn negotiation and thereby meet student outcomes and facilitate professional socialization (Marks-Maran et al., 2013; Rebholz &

Baumgartner, 2015). In this regard, some effort had been made in that student undergo an orientation process and are briefed on the clinical training exercise both at the school and at the facility levels.

Linkages of Findings to Additional Theories

In addition to the linkages highlighted in the literature in the preceding section, there are two areas of theory on which the findings of this dissertation bear significance: the systems theory and expert nursing theory of Benner (1984). I now discuss these linkages between my findings and these theories.

Systems Theory

Systems theory highlights the need to consider the social, technical, and managerial components of a system to achieve goals and objectives. Thus, according to systems theory, there exist social, technical, and managerial systems that are critical components of a system (Emery & Trist, 1960). According to Coffey (2010), a systems approach to leadership is defined as a holistic approach to leadership and organizational development. It can be used by any leader at any organizational level to optimize an organization (or part of it) and, thus, to create sustainable high performance in conditions of high complexity and uncertainty. Emery and Trist (1960) framed organizations as socio-technical systems, underlining the two main components of the firm seen as a system: a social component (people), and a technical component (technology and machines). The social system requires a change in organizational culture (values, norms, attitudes, roles expectations) and communication (quality of relationship between and among individuals, reward structure, behavioral patterns).

The technical system emphasizes tools and machinery to transform inputs into outputs. In the case of preceptorship, inputs consist of students and faculty characteristics (needs,

expectations, and interest), financial resources effectively used, facilities (classrooms, instructional equipment), programs, curriculum, courses, schedules, support services (transportation, food, recreation), measurements of output (assignments, examinations), evaluation of the programs (students, preceptors), and achievement of output (skill development, competency).

The managerial system entails formal design, division of responsibilities, and administrative activities (planning, organizing, directing, coordinating). Systems theory holds that when the entire system is examined holistically taking into consideration all components, issues, and actors within the system, the effectiveness of the system will be better achieved.

This study found major gaps in all three (sub)systems within the overall system. For instance, in regard to the social aspect, the current preceptorship system is challenged by the inadequate communication between institution and facilities and between the micro, meso, and macro levels. Poor student attitudes, unclear preceptor roles expectation, emanating from lack of standard guidelines, and indiscipline are among other key challenges.

Regarding the technical component of the system, the study revealed lack of logistics, limited space for clinical training, transportation challenges, poor supervision and evaluation, lack of collaboration, and motivation as some of the key challenges affecting the entire preceptorship program in Ghana. The managerial component is also marred with politics negatively affecting planning and coordination and cooperation of preceptorship programs and activities. The systems theory lens allows a holistic perspective on the connections among systems and subsystems of preceptorship that are usually seen only in isolation. Others such as Jordon et al. (2010) have likewise stressed that to understand health care organizations and professions, they should be seen as complex adaptive systems. A complex systems perspective identifies leadership as an emergent

process rather than residing in just one person. This view implies distributed leadership that does not reside with any particular person but in an interactive dynamic within which any person will participate as a leader or a follower at various times and for different purposes (Lichtenstein et al., 2006). Relating this to my findings, this means that the heads of the HTIs at the meso level can leverage their position to collaborate with their counterparts at the various health facilities in order to collectively negotiate at the macro level for the items necessary for the preceptorship program to be a success. Additionally, this perspective also suggests that system actors like students, lecturers, and preceptors need to take charge in bringing forth their ideas on how to improve the preceptorship program.

Benner's Novice to Expert Nursing Theory

Benner's (1984) nursing theory identified five levels of experience: novice, advanced beginner, competent, proficient, and expert. These five levels or stages identify the acquisition of knowledge and skill through nursing experience and portray the steady progression from novice nurse to expert nurse, as each stage builds upon the previous one (DeSandre, 2014; Dracup & Bryan-Brown, 2004; Koontz et al., 2010). Exploring the various stages of the theory, I realized that I could relate the study findings more to the first and the last stage of the theory given the key actors (preceptee as novice and preceptor as expert) which the study is centered on.

In the current study, novices (referred to here as *student/preceptee*) find themselves in a network of complex and challenging environment as seen in the social arena map. The novice is situated within multiple arenas (educational, healthcare, and political arenas) where many controversies and politics are occurring. As this study showed, these three arenas have not done much in terms of shaping and developing the novice to acquire the necessary skills, discipline, knowledge, and experience to be effective and efficient future preceptors or professional nurses.

In the educational arena, the novice benefits in terms of the classroom teachings and the intra semester skills lab where they are given hands on experience. However, several challenges persist: availability of needed equipment/logistics for skills labs and space to accommodate the huge and ever-increasing student numbers both at the school and clinical settings.

Similarly, within the healthcare arena, the novice benefits in terms of the clinical training they receive from preceptors, but the challenges greatly exceed the benefits. For instance, there are issues of limited supervision, space, equipment, risk exposure, limited training materials, limited support, accommodation challenges, financial burdens, and transportation challenges among others. All these are critical issues impacting negatively on the novice. The net effect has included indiscipline, limited knowledge, and low interest on the novice.

The political arena with its ongoing politics among the dominant actors has also resulted in delays in the development and updating of preceptorship to guide students. It has also resulted in limited training of preceptors and preceptors not being up to speed on current developments in the field, causing them to pass on outdated and inadequate information to students.

Given the above, I conclude from this the study that the first level of Benner's (1984) theory, the novice level, which needs preceptors and other actors to understand, help train, educate, and guide novice (students) to acquire the requisite knowledge and critical thinking skills to be able to make informed clinical decisions, has not been achieved. According to Hnatiuk (2012), the novice nurse takes on a new or unfamiliar role and generally has no practical experience in which to relate to patient outcomes. Novices tend to be nursing students and use rule and fact governed logic to base their actions and are limited and inflexible when it comes to considering the context of a situation. Novices have limited confidence, critical thinking, and clinical judgment, and are therefore unable to use discretionary judgment since they have

difficulty seeing the big picture, are task-oriented, and tend to rely on memorizing rather than critical understanding (Downey, 1993; Hnatiuk, 2012). Given these characteristics of novices, it is important that preceptors and all relevant actors who play a key role in shaping novices reflect and increase their effort in helping them develop their full potential as professional nurses.

From Benner's (1984) second level, the expert nurses referred in this study as preceptors have extensive experience, demonstrate clinical reasoning, anticipate the unexpected, and can make holistic decisions, as they have an intuitive grasp of the situation; they understand what is needed and why (Koontz et al., 2010). According to Dracup and Bryan-Brown (2004), expert nurses do not get caught up in the technical aspects that a novice might. They use critical thinking and judgment to adapt care to the unique condition of each patient. The teaching focus for the expert nurse lies in finding new challenges and professional development.

Relating this to the current study, preceptors who were expert nurses and occupy the second level of Benner's (1984) theory, had the necessary technical skills and experience, and demonstrated their ability to impart knowledge to the novice. However, the ongoing challenges for preceptors such as the outdated manual, lack of standard guidelines, low motivation, limited equipment, politicking, lack of training, and lack of cooperation inhibit their efforts and effectiveness. Nevertheless, there is the need for expert nurses/preceptors to look beyond the challenges and find alternative ways of developing themselves without relying on external source.

Limitations of the Study

In general, there were four limitations affecting this study: researcher positionality, the large geographic scope, the impact of COVID-19 restrictions, and time constraints.

The first limitation had to do with acknowledging and dealing with researcher bias. As an experienced nurse and top management actor of the healthcare arena, I experienced some

emotional stress as the issues emerged and, on occasion, I felt the need to stop conversations with participants and compose myself while allowing the interviewee to (re)establish the direction of the conversation. Further, I was an insider (a Ghanaian) but was treated like an outsider and this delayed getting clearance to conduct the interviews.

The second limitation was the large geographic scope of the study. Eleven of the 16 regions of Ghana were included, a breadth that, in retrospect, strained study resources, including researcher time. This made it difficult to collect data and to identify all relevant participants. Thus, the study could not cover all the regions of Ghana. However, engaging some people who had recently left a particular region, or who had served in a particular region for a long time before transfer or retirement, helped to address the challenge of not been able to access some regions. Further, the fact that most of the regions were covered reinforced the strength of the study.

The third limitation had to do with the COVID-19 pandemic. I had to travel to collect the data but given the COVID-19 situation, I was not able to collect all the data in-person using one-on-one interviews with participants. I had to complement data collection using video conferencing. To use this approach, I had to rely on the internet which was quiet challenging given intermittent internet breaks or drops, especially for participants in the Northern Zone and hard-to-reach areas where internet access is difficult. At a point, I had to transition to phone and WhatsApp. As a result, due to uncertain internet connectivity, I was not able to interview some key identified participants who could have added depth to the study.

The fourth limitation has to do with the time frame to complete and submit the work. As a result of simply not having sufficient time, I could not raise and capture all issues, but I made every attempt to summarize most of these less thoroughly studied issues.

Implications for Future Research

Given these four key limitations, findings from the study provide pointers to several productive avenues for continued research on preceptorship. For instance, future research could explore how technology could be used to address the myriad challenges confronting preceptorship, most especially in the context of supervision, monitoring and evaluation, training and education of preceptors, and increased student number. Future research could also explore the impact of geographical differences on preceptorship using a comparative approach across regions.

Further, given the politics among several of the key dominant actors in the preceptorship situation, there is an opportunity to conduct future research on the roles of these dominant or macro level actors in preceptorship in Ghana. This could aid in revealing and clarifying their respective roles given that in the current study I have noted role ambiguity and conflicts among these actors as negatively impacting preceptorship.

The current study has also identified motivation of preceptors as a major challenge to effective preceptorship. Diverse views emerged on who should motivate preceptors. Some respondents argued that the educational institution should be responsible for motivating preceptors while others pointed to facilities, MoH, or NMCG. There is a need for future research to probe and increase understanding of motivation of preceptors. This is needed to increase understanding of motives and to help address the conundrum of having preceptors who were initially keen but burn out and often abandon this vital role. It would also be useful for future research to probe alternative means for motivating preceptors.

Another key focus of future research would be to explore the reasons for and the impact of increased number of students' population given limited facilities. This work could focus on how this high number could be managed or addressed to make preceptorship effective. Monitoring and supervision seems to be lacking in student clinical training. As seen in the present study, not much

has been done by institutions in monitoring and supervision of students resulting in students' indiscipline and poor attitudes. This points to the need for future research to investigate in detail how students are monitored and supervised during clinical training.

In summary, the current study has raised awareness of the multifaceted nature of the enablers and challenges of preceptorship as a health policy in Ghana. It has revealed both universal and idiosyncratic factors in terms of the politics, silences, contentions, and controversies which impact preceptorship. The findings underscore the importance of using a contextual and systemic approach when conceptualizing and operationalizing the challenges and enablers of preceptorship practices in Ghana and indeed when contemplating the pathways of ensuring the effectiveness of preceptorship in Ghana.

Implications for Practice

The current study has several implications for improving preceptorship practice in Ghana. The study demonstrated that clinical training is essential in the development and preparation of student nurses if they are to become effective nursing professionals. To achieve this, clinical facilities need to be expanded to accommodate the ever-increasing number of nursing students in Ghana. There is also the need to have sufficient clinical equipment for those numbers. Clinical training of students will not be effective with inadequate resources. This study further showed that clinical training of students is highly dependent on skilled and well-trained preceptors. As well, the study concluded that, given the poor attitudes seen among too many students during clinical training, it is important that a rigorous code of conduct be in place to guide students during clinical training. The main policy makers and implementers of nurse training must come together to develop such a code and monitor adherence to it. When a strong code is in place, it is important to enforce discipline and take disciplinary action if students break the rules.

The study also has practical implications for improving communication and collaboration among schools, facilities, and macro level actors in pursuit of effective preceptorship. From this study, it is clear that the practice of preceptorship should be devoid of politics. Politics among macro level actors clearly had immense effects on preceptorship practice resulting, for example, in delays in development of a standard manual.

Another practical implication of the study is that not all nurses should be selected for preceptorship training or chosen to precept. It is important that those selected must be selfless and keen to precept. Having such people would be helped by having student clinical training undertaken by those who are more than willing to precept students. However, there is still the need to motivate them to remain more committed to the job. Another key implication of the study for practice is the need for monitoring and supervision of the entire clinical training process. This means that institutions must increase efforts in monitoring and supervision of students during clinical training since this is a key enabler in achieving effective preceptorship. Institutions should appoint tutors and coordinators who are more willing, passionate, and committed to take up this key role than is currently the case. It is also important that they are given the necessary support in performing this role.

Recommendations

Based on this study, I make the following recommendations:

- There should be strong collaboration and improvement in communication across all levels (micro, meso, and macro) of stakeholders in the preceptorship situation,

especially among schools (nurse and midwifery training colleges, NMTC) and facilities.

- The NMTC should budget for students' clinical supervision (logistics, preceptors/clinical instructors).
- The schools need to provide for stipend for preceptors/mentors.
- The NMCG or GCNM should institute short training programs for preceptors or mentors and award certificates, then continuously update.
- An organizational support network for preceptors should be created.
- Tutors/Lecturers/Faculty should be mandated to work in the clinical area at least once a week or twice in a month to upgrade their clinical practices, in order to incorporate it in their theoretical teaching.
- The clinical instructor (tutor/lecturer/faculty) should monitor and support student experiences on a daily basis in order to meet clinical objectives.
- The training institutions should create curriculum review evaluation committee so as to give bi-annual or five-year feedback to the NMCG to help review curriculum on time.
- NMCG should have curriculum expert committee in place.
- Adoption of IT such as the use of WhatsApp platform (or other messaging applications) and computing technologies could be utilized in validating students' logging in. Presently, IT and the internet are playing huge roles in global transformation, and it is important that the health sector and training institutions leverage this opportunity. Using these resources, they could resolve issues by creating practical simulation labs where students can go through different procedures on computers before going to the clinical area.

- NMTC should have a well-equipped skills lab to provide support for students' clinical training in schools. Extra days, specifically on the weekend, could be used to provide additional training for students.
- Preceptors/clinical instructors/mentors should be part of the schools' payroll
- The preceptors or clinical instructors should organize post clinical conferences to reflect on the practice and procedure.
- All nurses and midwifery training college students should have to go through both intra and inter semester clinicals.
- NMCG or GCNM should open their doors to Ghanaians from the diaspora, who are in the health arena and can share evidence-based expertise to help boost the training and the health delivery system in general.

Conclusion

This study employed situational analysis (Clarke, 2005) to explore the state of preceptorship programs in Ghana. Situational maps, social world maps, and positional maps were all used in analyzing the data gathered from participants. Findings from the study revealed that several challenges persist in the preceptorship program in Ghana, negatively impacting program effectiveness. The most prominent challenges were the politics among the dominant actors (MoH, GHS, NMCG, and GCNM) and the low motivation of preceptors.

It is clear from the study that motivating preceptors should not only be the exclusive preserve of a single institution, but that all relevant entities, particularly the key dominant actors, should be involved. This is especially important given the critical need for more preceptors to be trained to enhance and meet the increasing number of students and in the limited resource constraint environment.

Another key challenge was the lack of standard guidelines for the preceptorship program arising mainly from limited cooperation, politicking, and poor coordination among the dominant actors. These actors are key decision makers and should work together in the development of policy and standard guidelines. However, the study found that cooperation and coordination have been limited and, therefore, there is disharmony. Each actor has its own authority and guidelines, making it difficult for institutions and facilities to know what procedures to follow during clinical training. Given this scenario, institutions and facilities rely on their own information and guidelines which has led to conflict and misunderstandings. In addition, lack of resources/logistics greatly challenge the preceptorship program in Ghana. Resources such as medical equipment for clinical training, space, additional clinical training facilities, skills labs, and finances, have been very limited. Other significant challenges identified in this study include ever-increasing student numbers, transportation, monitoring and supervision, limited training, and accommodation.

Regarding enablers, the study showed that much needs to be done to address the major challenges. Dynamics at the micro, meso, and macro levels significantly impact preceptorship situation in Ghana. In comparative terms, much effort is seen at the micro and meso level with minimal effort at the macro level particularly on motivation, logistics, accommodation, and standardizing guidelines. Given their powers and roles, the dominant actors at the macro level must increase efforts in terms of policy, guidelines, resources, and training. These actors make key decisions about some of the contested issues for preceptorship to be effective in Ghana. This requires that all the key players establish and maintain effective cooperation, coordination, and commitment.

Several commonalities were revealed in challenges and enablers of preceptorship across all three regions of Ghana. The most common challenges are motivation, training, inadequate

resources, standard guidelines, and increased student numbers. Transportation and accommodation were also identified as distinct challenges and prevalent particularly in both the Northern and Southern Zones compared to the Middle Zone.

This study showed major gaps in reference to Berner's (1984) theory, specifically in reference to her novice and expert levels. These two levels are marred with numerous issues which had impacted negatively on preceptorship. Similarly, gaps were seen through the application of systems theory in this study. Social, managerial, and technical components, as used in systems theory, were all found to be weak and impacting negatively on preceptorship. The study demonstrated and reinforced the relevance of the systems theory and brought into focus the interdependent nature of the various components of the preceptorship system in Ghana. The systems approach revealed how each subsystem impacts overall system goals. The study has shown how all actors in the preceptorship situation contribute and impact the system and each other and how insufficient effort and role at the macro level has negatively affected the preceptorship situation and trickled down to impact the periphery.

The study also showed that situational analysis, with its use of three types of analytical maps, provided a useful framework for developing an in-depth understanding and explanation of complex situation such as preceptorship. The study concluded that much needs to be done in the preceptorship situation in Ghana and that this should be a concern of all actors at the micro, meso, and macro various levels. However, there is a critical need for the dominant actors to take the lead by working in harmony and thereby bring focus and quality to the entire preceptorship program in Ghana.

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Appendix A: Workplan Timeline

		TIMELINE 2020/2021									
ACTIVITY	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Proposal Defense	**X**										
Phase One **Ethical review and approval by IRB Antioch University and GHS ERC** **Contacting Institutions/Organizations for Collection of Archival, Public (Formal and Informal) and Secondary Data, SA- Messy & Ordered Mapping for Nonhuman Data**		**X**			**X**	**X** **X** **X**					
Recruitment of Participants					**X**	**X**					
Phase Two **Data Collection (Interviews at the Macro Level) Transcription, Situational Analysis- Messy, Ordered** **Social World/Arena, & Positional Mapping**					**X**	**X**	**X** **X**	**X**			
Phase Three **Data Collection (Interviews at the Meso and Micro level) Transcription, Situational Analysis- Messy, Ordered, Social World/Arena & Positional Mapping**							**X**	**X** **X**	**X**		
Data Analysis of Findings								**X**	**X**		
Final Report Writing and Recommendations									**X**	**X**	
Final Defense											**X**

Appendix B: Research Budget

SRL. NO.	ACTIVITIES	UNIT PRICE WITH DESCRIPTION Gh5.85.00 = $1.00	TOTAL AMOUNT In DOLLARS	TOTAL AMOUNT GH Cedis
1.	Air fare	$1,700 x 1=$1,700x5.85	$1,700.00	Gh9,945.00
2.	Training Research Assistants	$20x5.85= Gh117.00 x 2days x =Gh234 x 2persons =Gh468.00	$80.00	Gh468.00
3	Transcription	$18x5.85=Gh105 x 40 parts =Gh4,200	$720.00	Gh4,200.00
4	Printing- Toner & A4 sheets	$145 x 5.85 =Gh 848.00	$145.00	Gh848.00
5	NVivo Software	$125.00 x 2 years = 250x5.85	$250.00	Gh1,462.50
6	Digital Voice Recorder	$85.00 x 5.85	$85.00	Gh497.25
7	Communication with Participants	$7 x5.85=Gh41x50= Gh2,050.00	$350.00	Gh2,050.00
8	COVID-19: 2 boxes nose masks, 50 Small Bottles of Hand Sanitizers wash	$100 x 5.85=Gh585.00 Approx. Gh585.00	$100.00	Gh585.00
9	Dissemination Workshop	$10 x 5.85 = 58.50 x 30	$300.00	Gh1,755.00
10	-T & T - Ghana Ethics Research Committee Administrative Cost + Miscellaneous	$300 x 5.85= Gh1, 755.00 $200.00x5.85=1,170.00	$300.00 $200.00	Gh1,755.00 Gh1,170.00
11.	Total		$4,230.00	Gh24,735.75
	TOTAL AMOUNT =		**$4,230.00**	**Gh24,735.75**

Appendix C: Permission Letter from Ghana Ministry of Health

In case of reply to the number
And the date of this
Letter should be quoted

MINISTRY OF HEALTH
P O BOX MB-44 ACCRA

18 TH JANUARY 2021

My Ref. MoH/NMD/180121
Tel No [redacted] **REPUBLIC OF GHANA**
Digital Address: GA0294396

PHDLC IRB Committee
Antioch University 900 Dayton St,
Yellow Springs OHIO, 45387, USA

Dear Sir/Madam

PERMISSION LETTER: MS IVY E. SACKEY

I am glad to inform you that, Ms. Ivy E. Sackey, Graduate Student of Leadership and Change Program at Antioch University, Ohio in the United States of America has the permission to conduct her research dissertation titled "**Preceptorship Practice in Healthcare Institutions in Ghana: Situational Analysis**". Ms. Sackey has indicated she will be gathering information for her research dissertation in the month of January and February 2021. In this regard, I will be very grateful if she would be granted permission to collect her data in Ghana. Her plan is to conduct non-human data collection and interviews within a time frame of five weeks. Ms. Sackey's on-site research activities start in the fourth week of January and will be done by February ending.

The benefits of the research are twofold. First, it will identify bottlenecks in the practice of preceptorship, and the findings of this research will inform regulators and policymakers in Ghana to review policy guidelines that may improve the nursing/midwifery profession. Secondly, it will help sharpen the skills of students' nurses and midwives and aid in superior Maternal/neonatal healthcare delivery in Ghana.
Ms. Sackey has agreed to provide to the ethical committee of the Ghana Health Service a copy of the Antioch University approved IRB report. She will seek consent before she interviews participants in the health facilities, training institutions and organizations in conformity with our ethical requirements. Ms. Sackey has agreed not to enter offices unless otherwise permitted. She has also agreed to provide to the ethical committee a copy of the Antioch University approved IRB report.
If there are any questions, please contact my office on +[redacted]
Thank you.

Yours sincerely

DR. BARNABAS K. YEBOAH
DIRECTOR, NURSING AND MIDWIFERY
Cc: Ms. Ivy E. Sackey

Appendix D: IRB Ethics Application

ANTIOCH UNIVERSITY
GRADUATE SCHOOL OF LEADERSHIP AND CHANGE

900 Dayton Street | Yellow Springs, OH 45387 |

January 25, 2021

Dear Ms. Sackey,

As Chair of the Institutional Review Board (IRB) for 'Antioch University Ph.D., I am letting you know that the committee has reviewed your Ethics Application. Based on the information presented in your Ethics Application, your study has been approved and your data collection is approved to begin.

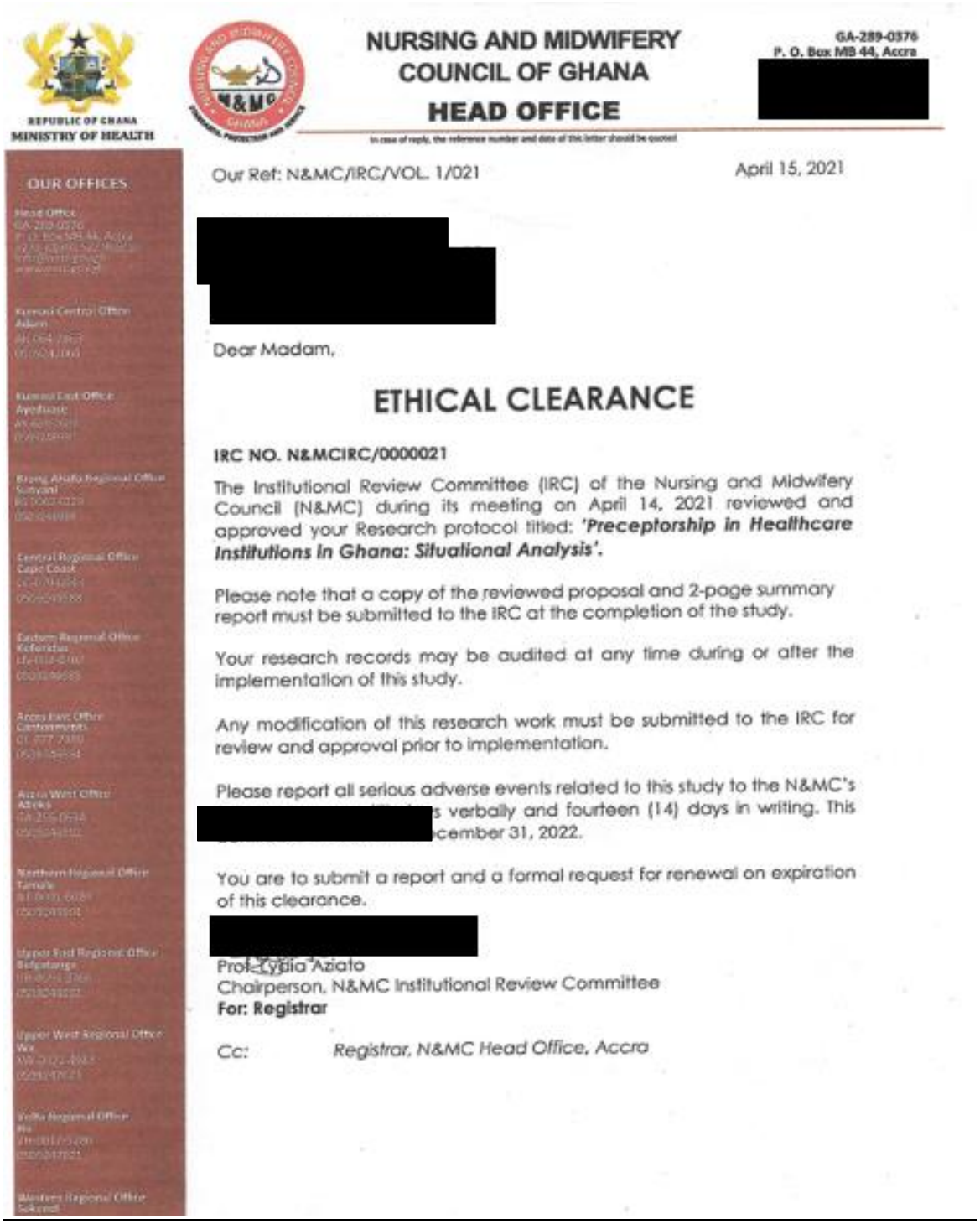
Any changes in the protocol(s) for this study must be formally requested by submitting a request for amendment from the IRB committee. Any adverse event, should one occur during this study, must be reported immediately to the IRB committee. Please review the IRB forms available for these exceptional circumstances.

Sincerely,

[redacted]

Lisa Kreeger, PhD
Chair, Institutional Review Board
[redacted]

Appendix E: Ethical Clearance Statements from NMCG and Ghana Health Service Ethics Research Committee



REPUBLIC OF GHANA
MINISTRY OF HEALTH

NURSING AND MIDWIFERY COUNCIL OF GHANA
HEAD OFFICE

GA-289-0376
P. O. Box MB 44, Accra
[redacted]

In case of reply, the reference number and date of this letter should be quoted

OUR OFFICES

Head Office
GA-289-0376
P. O. Box MB 44, Accra
[redacted]

Kumasi Central Office
Adum
[redacted]

Kumasi East Office
Ayeduase
[redacted]

Brong Ahafo Regional Office
Sunyani
[redacted]

Central Regional Office
Cape Coast
[redacted]

Eastern Regional Office
Koforidua
[redacted]

Accra East Office
Cantonments
[redacted]

Accra West Office
Abeka
[redacted]

Northern Regional Office
Tamale
[redacted]

Upper East Regional Office
Bolgatanga
[redacted]

Upper West Regional Office
Wa
[redacted]

Volta Regional Office
Ho
[redacted]

Western Regional Office
Sekondi

Our Ref: N&MC/IRC/VOL. 1/021

April 15, 2021

[redacted]

Dear Madam,

ETHICAL CLEARANCE

IRC NO. N&MCIRC/0000021

The Institutional Review Committee (IRC) of the Nursing and Midwifery Council (N&MC) during its meeting on April 14, 2021 reviewed and approved your Research protocol titled: ***'Preceptorship in Healthcare Institutions in Ghana: Situational Analysis'.***

Please note that a copy of the reviewed proposal and 2-page summary report must be submitted to the IRC at the completion of the study.

Your research records may be audited at any time during or after the implementation of this study.

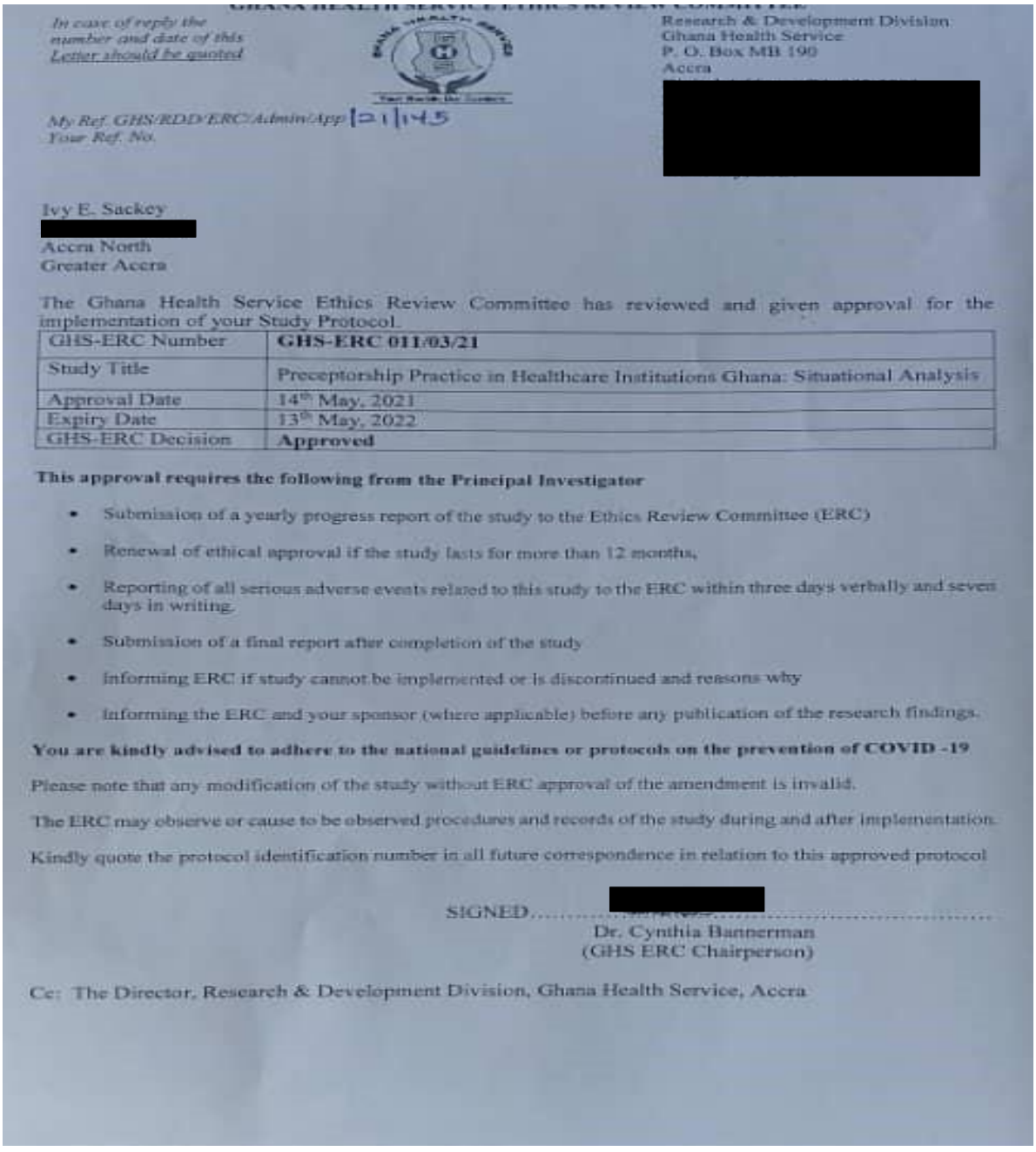
Any modification of this research work must be submitted to the IRC for review and approval prior to implementation.

Please report all serious adverse events related to this study to the N&MC's [redacted]s verbally and fourteen (14) days in writing. This [redacted]cember 31, 2022.

You are to submit a report and a formal request for renewal on expiration of this clearance.

[redacted]
Prof. Lydia Aziato
Chairperson, N&MC Institutional Review Committee
For: Registrar

Cc: *Registrar, N&MC Head Office, Accra*



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
[redacted]

My Ref. GHS/RDD/ERC/Admin/App 21145
Your Ref. No.

Ivy E. Sackey
[redacted]
Accra North
Greater Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 011/03/21**
Study Title	Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis
Approval Date	14th May, 2021
Expiry Date	13th May, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED [redacted]
Dr. Cynthia Bannerman
(GHS ERC Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix F: Copyright Permissions

In case of reply the number and the date of this letter should be quoted.

Ghana Health Service
Private Mail Bag
Ministries
Accra-Ghana

GPS Address: GA-143-4609

T[redacted]
Fa
Email: [redacted]

My Ref. No: GHS/DGS/5.2

Your Ref. No.:
.....

8th July, 2021

MS. IVY E. SACKEY
[redacted]

RE: PERMISSION ON COPYRIGHT: MS IVY E.SACKEY

Reference is made to your letter dated 23rd June, 2021 on the above subject matter.

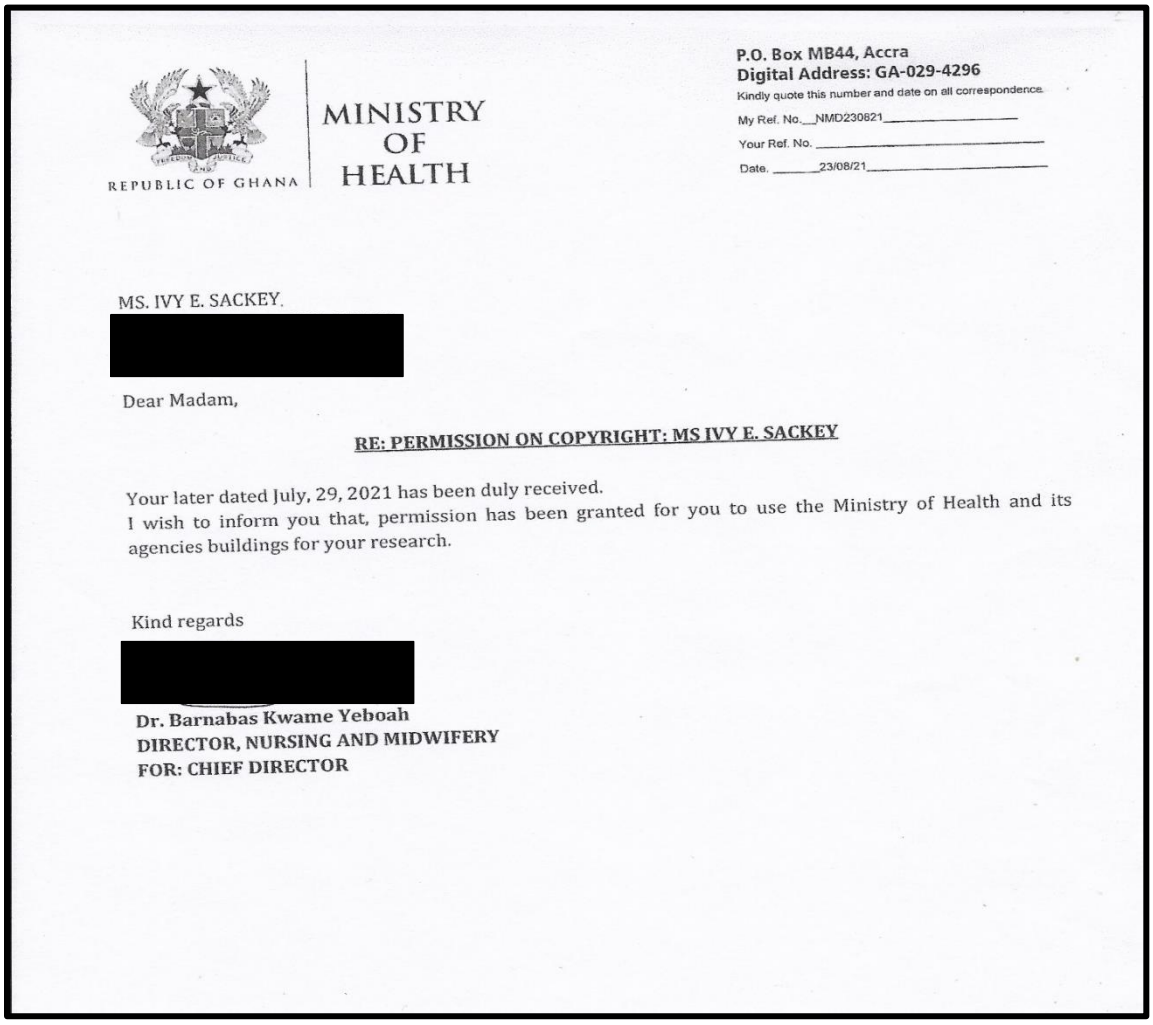
The Ghana Health Service has given approval to your request for the use of the animagi/ picture of its hospital and hospital buildings to be inserted in your research dissertation titled 'Preceptorship Practice in Healthcare Institutions in Ghana: Situational Analysis.

Accept our best wishes.

[redacted]

DR. PATRICK KUMA-ABOAGYE
DIRECTOR GENERAL

Permission to use pictures of the Ghana Ministry of Health Buildings



REPUBLIC OF GHANA

MINISTRY OF HEALTH

P.O. Box MB44, Accra
Digital Address: GA-029-4296
Kindly quote this number and date on all correspondence.
My Ref. No. NMD230821
Your Ref. No.
Date. 23/08/21

MS. IVY E. SACKEY.
[redacted]

Dear Madam,

RE: PERMISSION ON COPYRIGHT: MS IVY E. SACKEY

Your later dated July, 29, 2021 has been duly received.
I wish to inform you that, permission has been granted for you to use the Ministry of Health and its agencies buildings for your research.

Kind regards

[redacted]

Dr. Barnabas Kwame Yeboah
DIRECTOR, NURSING AND MIDWIFERY
FOR: CHIEF DIRECTOR

[redacted]

MINISTRY OF HEALTH

REPUBLIC OF GHANA

KOKOFU NURSING TRAINING COLLEGE

P.O BOX 27 KOKOFU-ASHANTI

[redacted]

In case of reply our ref. no and the date of this letter should be quoted

OUR REF YOUR REF

10/09/2021

[redacted]

Dear Madam,

PERMISSION ON THE USE OF THE TRAID

I am Mrs. Beatrice Williams currently the Principal of Kokofu Nursing and Midwifery Training College in the Ashanti Region of Ghana. I write to give my permission to Mg Ivy E. Sackey to use the 'Traid'a concept I developed to explain the actors in the preceptorship system in Ghana.

Thank you.

[redacted]

Mrs. Beatrice Williams
Principal

Appendix G: Participant Information Sheet

INDIVIDUAL IN-DEPTH INTERVIEW

Name of Principal Investigator: Ivy E. Sackey

Name of Organization: Antioch University PhD in Leadership and Change Program

Name of Project: "Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis"

You will be given a copy of the full Consent Form

Study Title: Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis

Introduction

I am Ivy E. Sackey, a PhD candidate in the Graduate School of Leadership and Change at Antioch University, USA. As part of this degree, I am completing a project to explore preceptorship in selected nursing/midwifery and healthcare institutions in Ghana to gain visibility into the various preceptorship program. I will give you information about the study and invite you to be part of this research. You may talk to anyone you feel comfortable talking with about the research and take time to reflect on whether you want to participate or not. You may ask questions at any time. You are being asked to join a research study. This form gives participants information about the study and your part in the study. Please read it carefully and understands what is expected of you to make an informed decision. The participants involve are internal and external stakeholders. Internal stakeholders comprise participants from the training institution, health facility, Ghana Registered Nurses, Midwives Association, Ghana College of Nurses, and Midwives. On the other hand, external stakeholders comprise the Nursing and Midwifery Council (NMCG) and Ministry of Health (MoH)—Ghana Health Service (GHS).

Background and Purpose of the Research

The purpose of this project is to examine the nature of effective preceptorship practice in the Ghanaian context. This information may help you understand preceptorship practice better as it is an essential aspect of nursing/midwifery practice.

The findings will provide the opportunity for novice nurses or student nurses/midwives to learn and acquire the needed skills to make them more confident, effective, and efficient in their professional role as nurses/midwives. The importance of precepting new nurses and student nurses/midwives in the preceptorship program is incredibly significant to the practice. Additionally, this research will inform regulators and policymakers in Ghana to formulate policy guidelines that can lead to a more robust overall preceptorship program. It will further sharpen the

students' nurses' and midwife's skills and aid in special and Neonatal/Maternal and general healthcare delivery.

Nature of Research

This research is a qualitative study which will employ instrument such as in-depth interview, focus group and observations with participants.

What will I be asked to do?

This research will involve your participation in a face to face or virtual interview in the form of zoom conference, phone call conference, at your own choice of day and time for a period of 30 to 45 minutes, where the choice of place/venue of interview will depend on you. Before the interview, I will seek your consent. Each of these interviews will be audio recorded with your permission. As a participant, I will hide your identity to take care of any potential risk of revealing confidential information. In this respect, I will add no names and other credentials to your responses and will use pseudonyms. Likewise, publication or any portion of this work will not include your identity. These recordings, and any other information that may connect you to the study, will be kept in a locked, secure location.

Additionally, it is possible that I may contact you to participate in a group focus group. At that time, you will have the opportunity to consent or decline participation.

Why am I being invited to participate in this study?

You will be invited to participate in this research because you qualify within the study set criteria as not all health professionals in the healthcare system will be used. Only the following constituents will be utilized: registered nurses and midwives who precept students on the ward and writes reports, such as staff nurses, nursing officers, principal nursing officers and deputy directors of nursing/midwifery, heads of departments/units, and administrators/directors in the clinical areas. Members in these groups should have worked through the ranks for several years (at least three years and above); For those within the nursing/midwifery, members should have had experience in preceptorship. For preceptees, I will select only third and fourth-year students of selected nursing/midwifery colleges and universities in Ghana. I will choose these categories: lecturers/tutors who handle students clinicals, directors and heads in-charge of nursing/midwifery schools, curriculum developers of NMCG, members of Ghana college of Nurses and Midwives, Ghana registered nurses and midwife's association and the nursing/midwifery personnel responsible for policies in the MoH/GHS.

You should not consider participation in this research if you do not belong to any of the categories above.

Voluntary Participation

Your participation in this study is entirely voluntary. You may choose not to participate. I will not penalize you for your decision not to participate or anything of your contributions during the study.

If you agree to this interview, you are giving your information consent to be included in this research findings. I will put information from all responses together in one document. I will include in presentations and publications: Your position in the hospital as Nursing/Midwifery Administrator/Director/lecturer/tutor/head of a training institution/organization/department head/unit/Preceptor/Ward In-charge/student will not be affected by this decision or your participation. You may withdraw from this study at any time. If an interview has already taken place, will not use the information you provided will not be used in the research study.

Risks

No study is entirely risk-free. However, I do not anticipate that you will be exposed to harm or distress during this study. Risks to subjects are minimized: By using procedures that are consistent with sound research design and that do not unnecessarily expose participants to risk, you may stop being in the study at any time if you become uncomfortable. If you experience any discomfort resulting from your participation, employee assistance counselors will be available to you as a resource.

Benefits

There will be direct benefit by participating in the study, and the participants will benefit by increasing their understanding and improve preceptorship practice in Ghana. Participation may help others.

Cost

I will not provide any monetary incentive to take part in this research project.

Compensation

There is **no payment for participation,** however you will be reimbursed if you incur travel expenses.

Confidentiality

All information will be de-identified, so that it cannot be connected back to you. Will replace real name be with a false name in the write-up of this project, and only the primary researcher will have access to the list connecting your name to the pseudonym. Issues discussed, along with tape recordings of the discussion sessions, will be kept in a secure, locked location.

Future Publication

The primary researcher, Ivy E. Sackey, reserves the right to include any results of this study in future scholarly presentations and publications. All information will be de-identified before publication.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and you may withdraw from the study at any time without your job being affected.

Who to Contact

If you have any questions, you may ask them now or later. If you have problems later, you may contact Ivy E. Sackey, Email: [redacted].

If you have any ethical concerns about this study, contact Dr. Lisa Kreeger, Chair, Institutional Review Board, Antioch University PhD in Leadership and Change, Email: [redacted].

If you have any ethical issues, you may contact ERC Administrator Nana Abena Apatu, on [redacted]

Or NMCG Deputy Director Administrator Mercy Avogo, [redacted]

DO YOU WISH TO BE IN THIS STUDY?

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

DO YOU WISH TO BE AUDIOTAPED IN THIS STUDY?

I voluntarily agree to let the researcher audiotape me for this study. I agree to allow the use of my recordings as described in this form.

I confirm that the participant will be given an opportunity to ask questions about the study, and all the questions asked by the participant will be answered correctly and to the best of my ability. I confirm that the individual will not be coerced into giving consent, and consent will be given freely and voluntarily.

Appendix H: Consent Form for Individual Interviews and Focus Group Interviews

CONSENT FORM

STUDY TITLE: "Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis."

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (English language). I fully understand the contents and any potential implications as well as my right to change my mind (i.e., withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant…….

Participants' Signature ……...OR Thumb Print……

Date:

INVESTIGATOR

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name…….

Signature ……

Date…….

Appendix I: Participant Information Sheet for Focus Group Interviews

PARTICIPANT INFORMATION SHEET: FOCUS GROUP INTERVIEW

Name of Principal Investigator: Ivy E. Sackey

Name of Organization: Antioch University PhD in Leadership and Change Program

Name of Project: "Preceptorship Practice in Healthcare Institutions Ghana:

Situational Analysis"

You will be given a copy of the full Consent Form

Introduction

I am Ivy E. Sackey, a PhD candidate in the Graduate School of Leadership and Change at Antioch University, USA. As part of this degree, I am completing a project to explore preceptorship in selected nursing/midwifery and healthcare institutions in Ghana to gain visibility into the various preceptorship program.

I will give you information about the study and invite you to be part of this research. You may talk to anyone you feel comfortable talking with about the research and take time to reflect on whether you want to participate or not. You may ask questions at any time.

Purpose of the Research

The purpose of this project is to examine the nature of effective preceptorship practice in the Ghanaian context. This information may help you understand preceptorship practice better as it is an essential aspect of nursing/midwifery practice. The findings will provide the opportunity for novice nurses or student nurses/midwives to learn and acquire the needed skills to make them more confident, effective, and efficient in their professional role as nurses/midwives. The importance of precepting new nurses and student nurses/midwives in the preceptorship program is incredibly significant to the practice. Additionally, this research will inform regulators and policymakers in Ghana to formulate policy guidelines that can lead to a more robust overall preceptorship program. It will further sharpen the students' nurses' and midwife's skills and aid in special and Neonatal/Maternal healthcare delivery.

What will I be asked to do?

This research will involve your participation in a focus group. Participation in the focus group will last for 30 - 45 minutes. It will be scheduled at a time that is best for most participants.

The focus group will be audio recorded. Because this is a group activity, I cannot fully hide your identity to take care of any potential risk of revealing confidential information. However, at the beginning of the focus group all participants will be encouraged to hold any aspect of the focus group as confidential.

Publication of any portion of this work will not include your identity. Focus group recordings, and any other information that may connect you to the study, will be kept in a locked, secure location.

Why am I being invited to participate in this study?

You will be invited to participate in this research because you qualify within the study set criteria as not all health professionals in the healthcare system will be used. Only the following constituents will be utilized: registered nurses and midwives who precept students on the ward and writes reports, such as staff nurses, nursing officers, principal nursing officers and deputy directors of nursing/midwifery, heads of departments/units, and administrators/directors in the clinical areas. Members in these groups should have worked through the ranks for several years (at least three years and above); For those within the nursing/midwifery, members should have had experience in preceptorship. For preceptees, I will select only third and fourth-year students of selected nursing/midwifery colleges and universities in Ghana. I will choose these categories: lecturers/tutors who handle students clinicals, directors and heads in-charge of nursing/midwifery schools, curriculum developers of NMCG, members of Ghana college of Nurses and Midwives, Ghana registered nurses and midwife's association and the nursing/midwifery personnel responsible for policies in the MoH/GHS.

You should not consider participation in this research if you do not belong to any of the categories above.

Voluntary Participation

Your participation in this study is entirely voluntary. You may choose not to participate. You will not be penalized for your decision not to participate or anything of your contributions during the study.

If you agree to this focus group, you are giving your information consent to be included in this research findings. I will put information from all responses together in one document. I will include in presentations and publications: Your position in the hospital/training institution/organization/as Head of department/unit/Preceptor/Ward In-charge/Administrator/Director/lecturer/will not be affected by this decision or your participation. You may withdraw from this study at any time.

Risks

No study is entirely risk-free. However, I do not anticipate that you will be exposed to harm or distress during this study. Risks to subjects are minimized: By using procedures that are consistent with sound research design and that do not unnecessarily expose participants to risk, you may stop being in the study at any time if you become uncomfortable. If you experience any discomfort resulting from your participation, employee assistance counselors will be available to you as a resource.

Benefits

There will be direct benefit by participating in the study, and the participants will benefit by increasing their understanding and improve preceptorship practice in Ghana. Participation may help others.

Reimbursements

I will not provide any monetary incentive to take part in this research project.

Confidentiality

Because this is a group activity, since participants will see each other and hear what each other will say in the focus group interview hence anonymity will be a challenge. however, at the beginning of the discussion, all Participants will be requested to keep information or what happens in the focus group confidential. However, in publications all information will be de-identified, so that it cannot be connected back to you. Will replace real name be with a false name in the write-up of this project, and only the primary researcher will have access to the list connecting your name to the pseudonym. Issues discussed, along with tape recordings of the discussion sessions, will be kept in a secure, locked location.

Future Publication

The primary researcher, Ivy E. Sackey, reserves the right to include any results of this study in future scholarly presentations and publications. All information will be de-identified before publication.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and you may withdraw from the study at any time without your job being affected.

Who to Contact

If you have any questions, you may ask them now or later. If you have problems later, you may contact Ivy E. Sackey, Email: [redacted]
If you have any ethical concerns about this study, contact Dr. Lisa Kreeger, Chair, Institutional Review Board, Antioch University PhD in Leadership and Change, Email: [redacted].

If you have any ethical issues, you may contact ERC Administrator Nana Abena Apatu, on 0503539896, [redacted]
Or NMCG Deputy Director Administrator Mercy Avogo, [redacted]
This proposal has been reviewed and approved by the Antioch Institutional Review Board (IRB), which is a committee whose task it is to make sure that research participants are protected. If you wish to find out more about the IRB, contact Dr. Lisa Kreeger.
DO YOU WISH TO BE IN THIS STUDY?
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

DO YOU WISH TO BE AUDIOTAPED IN THIS STUDY?
I voluntarily agree to let the researcher audiotape me for this study. I agree to allow the use of my recordings as described in this form.
I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Appendix J: Data Collection Tool/Instrument

This interview guide and focus group interviews will be conducted by the researcher. To share your thoughts, perspectives, and insights about Preceptorship practice in nursing/midwifery education in Ghana. Interviews are widely used tools to gain a detailed picture of a participant's experiences and their inner perceptions, attitudes, and feelings of reality. Unstructured interview involves in-depth, interactive dialogue between the interviewer and the participants on key issues about the phenomenon under study. There are three phases to be outlined in the Data Collection and Instrument Session:

Phase One

This phase consisted of document search and examination of archival, public, and secondary data from various Institutions (Ghana Nurses' and Midwives' Council, Ghana Health Service, Ministry of Health, Individual Interview/Focus Group Interview Guides.

Note: Will contact institutions and organizations through phone and e-mail. The participants will receive the information sheets and will sign informed consent. The interviewer will use an open-ended approach.

Opening Question:

Please tell me about your role and/or your interest in clinical Nursing/Midwifery education.

From your perspective, what are the most important issues in Nursing/Midwifery education today?

Topics to probe if not raised by participants:

a. What are your thoughts on the clinical component of nursing/midwifery education? Are changes needed?

b. Can you tell me how clinical training is implemented in the various Nursing/Midwifery educational institutions and healthcare facilities (prompt, are there any standard procedures, process and programs design, how are they design, monitored, and evaluated in the curriculum)

c. Can you share some of the challenges in the program and how they can be addressed?

d. What in your opinion are some of the factors that can help make the program effective?

e. Can you explain the typical interventions your institution has put in place for effective precepting of students?

f. What are the things needed to make the clinical teaching viable?

Phase Two Interview Guide for Institutions

Ghana College of Nurses' Midwives
Ghana Registered Nurses'/Midwives Association
Nurse Administrators/Directors in Clinical Health Institutions
Heads/In Charges of Nursing/Midwifery Training Institutions

Note: These participants will receive the information sheet and will sign informed consents. The interviewer will use an open-ended approach.

Opening Question:

Please tell me about your experiences in teaching, supervising in precepting students for their clinical practice.

Topics to probe if not raised by participants:

a. Can you share or explain how the facilities conduct preceptorship of Nursing/Midwifery students?

b. What procedures are involved, are programs specifically design for them and how, is there collaboration with institutions?

c. What procedures are involved, are programs specifically design for them and how, is there collaboration with institutions?

d. Tell me some of the challenges of the program?

e. In your opinion what factors do you think can help in effective running of clinical training of nursing/midwifery students?

Thank you for your participation.

Appendix K: Phase Three Interview Guides for In-Depth Individual Interview and Focus Group Interviews

Note: Preceptors, Staff Nurses/midwives with 3 years Experience Supervising Students Faculty/lecturers/Tutors/Student nurses/midwives, Graduate/Undergraduate Students (Year 3 and 4), Nurse/Midwifery Administrators/Directors in Clinical Health Institutions
The participants will receive the information sheet and will sign informed consents. The interviewer will use an open-ended approach.

Opening Question

What has your experience been in preceptorship?

1. Topics to probe if they are not introduced:

a. What in your opinion can be done to make the program effective?

b. Can you share with me what precepting nursing students is about?

c. Can you tell me how your institution precept or conduct its clinical training of students (prompt; the procedures, is there collaboration with health institutions and how, is there any program design specifically for the students?)

d. What are some of the challenges in the clinical training?

e. How do preceptors provide feedback, communicate, assess, evaluate?

as part of everyday interactions with their preceptees?

f. How does the new preceptor receive practical training and suggestions?

g. How often do preceptors receive an update?

h. How many clinical hours are students supposed to do in total, and what is the duration per shift at the clinical site?

I. How many students should be handled by a preceptor?

j. Are there issues that you would like to add?

Thank you for your participation.

Appendix L: Recruitment Flyers and Notice

RECRUITMENT FLYERS and NOTICES

PHASE ONE FLYER

Phase One:
Flyers:
To contact various Institutions/organizations **(**Ghana Nurses' and Midwives' Council, Ghana Health Service, Ministry of Health, School of Nursing/Midwifery, Hospitals Archival, public, (formal and informal documents) and secondary data

Phase Two:
Flyers: Meso Level
Advertising individual/focus group interviews for:
Ghana Nurses' and Midwives' Council, Ghana Health Service, Ministry of Health,
Ghana College of Nurses' Midwives
Ghana Registered Nurses'/Midwives Association
Nurse/Midwifery Administrators/Directors, In-Charges/Managers/Nurse/Midwife's Preceptors in Health Facilities, or Institutions
Heads of Nursing/Midwifery Training Institutions
Universities -Schools of Nursing/Midwifery Institutions
Phase Three: Have Two Groups

Phase Three:
Flyers: for micro level
Advertising individual/focus group interviews for:
Preceptors, Staff Nurses/midwives with 3 years Experience Supervising Students
Faculty/lecturers/Tutors/Student nurses/midwives, Graduate/Undergraduate
Students (Year 3 and 4), Nurse/Midwifery Administrators/Directors in Clinical Health Institutions

PHASE ONE RECRUITMENT NOTICE

Research Study Seeking: Archival, public, and secondary data from various Institutions and organizations (Ghana Nursing and Midwifery Council, Ghana Health Service, Ministry of Health, School of nursing, Training Institutions, organizations, and Hospitals.

Who am I?
I am a PhD student in Antioch University, PhD in Leadership and Change Program

My research is titled "Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis". I am inviting different groups of people who have an interest in nursing/midwifery education to participate in my study. You are receiving this message so that you will be aware of my study before the interview.

For what?

To share your thoughts on preceptorship practice in nursing/midwifery education in Ghana.

When and where?

You will receive request via email. The information received will be put together to provide a summary of the current strengths and weaknesses in the preceptor practice experiences. Various institutions (Ghana Nursing and Midwifery Council, Ghana Health Service, Ministry of Health) will be contacted for Archival, Public and Secondary Information.

Please contact me at [redacted] if you would like more information.

Investigator
Ivy E. Sackey

Supervisor
Dr. Aqeel Tirmizi,

Supervisor
Dr. Elizabeth Holloway

[redacted]

Phone: [redacted]

Supervisor
Dr. Mary Asirifi MN, RN`

Dr. David Mensah

[redacted]

Recruitment Notice for Phase Two

Research Study Seeking- Data at the Macro-level- Ghana Nursing and Midwifery Council, Ghana Health Service, Ministry of Health.

Who am I?

I am a PhD student in Antioch University, PhD in Leadership and Change Program

My research is titled "Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis."

I am inviting different groups of people interested in nursing/midwifery education to participate in my study.

For what?

To share your thoughts about Preceptorship practice in nursing/midwifery education in Ghana. As preceptor, Staff Nurses with Experience in supervising students, clinicians, and Nurse Administrators/Directors in Hospitals, you are invited to be in a focus group interview to talk about clinical teaching and learning in Ghana. A focus group is a small group of 3 to 7 people

who were part of a group interviewed. If you are concerned about being in a group interview but are interested in participating, please let me know. It may be possible to arrange an individual interview.

When and where?

The individual interview or focus group interview was conducted at a convenient time and place (via zoom safety and logistics became an issue) for around 30 to 45 minutes.

Please contact me at [redacted] for more information or to express interest in being part of the study.

Investigator: Supervisor Supervisors

Ivy E. Sackey Dr. Aqeel Tirmizi, Dr. Elizabeth Holloway

[redacted]

Supervisor

Dr. Mary Asirifi MN, RN` Dr. David Mensah

[redacted]

RECRUITMENT NOTICE FOR PHASE THREE

Research Study Seeking- Heads/Leaders of Organizations Institutions: **Meso level**—School of nursing, training institutions, organizations, and hospitals, Ghana College of Nurses' Midwives, Ghana Registered Nurses/Midwives Association.

Micro level- Preceptors, Staff Nurses/midwives with 3 years' experience supervising students, Faculty/lecturers/Tutors/Student nurses/midwives, (Years 3 and 4), Nurse/Midwifery Administrators/Directors in Clinical Health Institutions and Heads/In Charges of Nursing/Midwifery Training Institutions

Who am I?

I am a Ph. D student at Antioch University, PhD in Leadership and Change Program

My research is titled "Preceptorship Practice in Healthcare Institutions Ghana: Situational Analysis". I am inviting different groups of people interested in nursing/midwifery education to participate in my study.

For what? To share your thoughts, perspectives, and insights about Preceptorship practice in

nursing education in Ghana.

You are invited to be in a focus group interview to talk about Ghana's clinical teaching and learning. A focus group is a small group of up to 3 to 12 people who will be part of a group interview. If you are concerned about being in a group interview but are interested in participating, please let me know. It may be possible to arrange an individual consultation. There will be separate focus group interviews for graduate students and faculty members.

When and where?

The interview or focus group interview will be conducted at a convenient time and place (maybe via zoom when safety and logistics become an issue) for around 30 to 45 minutes.

Please contact me at [redacted] for more information or to express interest in being part of the study.

Investigator: Ivy E. Sackey

Supervisor Dr. Aqeel Tirmizi, [redacted]

Supervisor Dr. Elizabeth Holloway [redacted]

Supervisor Dr. Mary Asirifi MN, RN [redacted]

Dr. David Mensah [redacted]

Appendix M: Interview Schedule

INTERVIEW SCHEDULE

ACTIVITIES	TIMELINE
In-depth Interview (in-depth individual interview) with Ghana Health Service Director of Nursing	4/15/2021
in-depth individual interview with Ministry of Health (MoH)-Head for Nsg & Midwifery- Health Training Institutions	4/17/2021
in-depth individual interview with MoH- Director for Nsg & Midwifery	4/19/2021
in-depth individual interview with President of GRNMA - Accra	4/18/2021
in-depth individual interview for Head of NMTC Kokofu	4/20/2021
in-depth individual interview Nursing & Midwifery Council - Ghana	6/4/2021
in-depth individual interview Ghana College of Nurses & Midwives	6/3/2021
SOUTHERN ZONE	
in-depth individual interview Deputy Director of Nursing& Midwifery Services (DNMS) Leckma Hosp, Accra	4/22/2021
Focus Group Interview (FGI) Southern belt—Tutors	4/23/2021
Focus Group Interview (FGI) Southern belt—Preceptors	4/23/2021
Focus Group Interview (FGI) Southern belt—Students	4/24/2021
in-depth individual interview for Deputy Head of NMTC Koforidua	4/24/2021
in-depth individual interview for NMTC Preceptor, Korle-Bu	4/25/2021
in-depth individual interview NMTC Korle-Bu Clinical Coordinator	4/25/2021
in-depth individual interview for DDNMS— (Clinical Coordinator) Ridge Regional Hosp. Accra	4/26/2021
in-depth individual interview for Clinical Coordinator of Municipal Hosp - Koforidua	4/26/2021
in-depth individual interview for Sekondi NMTC Deputy Head	4/27/2021
in-depth individual interview for DDNMS -Head for nursing/midwifery Sekondi Afia Nkwanta Regional Hospital	4/28/2021
in-depth individual interview for Korle-bu NMTC Deputy Head -Accra	4/29/2021
in-depth individual interview for UCC Student	6/15/2021
in-depth individual interview for UCC—School of Nursing/Midwifery Clinical Coordinator -Cape Coast	6/6/2021
MIDDLE ZONE -	
Focus Group Interview (FGI) for Middle belt Students	5/1/2021
Focus Group Interview (FGI) for Middle belt Preceptors	5/1/2021
Focus Group Interview (FGI) for Middle belt Tutors	5/2/2021
in-depth individual interview municipal hospital Nurse Manager Asunafo North	5/2/2021
in-depth individual interview Kete-Karachi NM Head- Municipal Hospital-Primary	5/3/2021
in-depth individual interview for Lecturer (School of Nursing/Midwifery) KNUST	5/3/2021
Focus Group Interview for KNUST N/M Students	5/4/2021
in-depth individual interview for Head of NMTC Dunkwa	5/5/2021
in-depth individual interview for DDNS & Unit Head of Dunkwa Municipal Hospital (2)	5/5/2021
in-depth individual interview NMTC Head Kete-Krachie	5/6/2021
in-depth individual interview for Head District Hospital Kokofu	5/6/2021

ACTIVITIES	TIMELINE
Focus Group Interview for Suntreso Hospital and St Michael Hosp. Pramso, Kumasi.	5/7/2021
in-depth individual interview for Clinical Coordinator St Michael Hospital	5/7/021
in-depth individual interview for NMTC Clinical Coordinator Kokofu	5/8/2021
NORTHERN ZONE	
in-depth individual interview for UDS School of Nursing/Midwifery Student - Tamale	6/11/2021
in-depth individual interview for Tamale Central Hospital	6/7/2021
in-depth individual interview for Lecturer (School of Nursing/Midwifery) UDS - Tamale	5/8/2021
in-depth individual interview for Bolga Midwifery Training School (MTS) Head	5/9/2021
in-depth individual interview Regional Hosp. DDNS Bolga Head	5/9/2021
in-depth individual interview Bolga Regional Hosp. Unit Head	6/9/2021
in-depth individual interview Bolga NTC Head	5/10/21
in-depth individual interview for Wa Nursing Training College (NTC) - Head	5/10/2021
in-depth individual interview for Jirapa Unit Head (2)	5/17/2021
in-depth individual interview for Kpembe Nursing & Midwifery Training College (NMTC) Head	5/11/2021
FGI for Northern and Savanah Students	5/11/2021
FGI for Northern and Savanah Tutors	5/12/2021
FGI for Northern and Savanah Preceptors	5/12/2021
FGI for Upper West & East Preceptors,	5/13/2021
FGI for Upper West Tutors	5/13/2021
FGI for Upper West Students	5/14/2021
FGI for Upper East Tutors	5/15/2021
FGI for Upper East Students	5/15/2021
in-depth individual interview for Tamale NMTC Deputy Head	5/16/2021
in-depth individual interview for Tamale Teaching Hospital DDNS—Clinical Coordinator	6/08/2021

SUMMARY

# Of In-depth individual interview interviews	44
# Of Focus Group Interviews	16
Total	55

There were also two informal discussions with Two Retired Nurse/Midwife educators.

Appendix N: Memos, Themes, and Codes

MEMOS, THEMES AND CODES THAT EMERGED FROM INTERVIEWS AND FOCUSED GROUP DISCUSSIONS USING NVIVO SOFTWARE

MEMOS

1. ***Preparation of first year students***
Preparation of first year is very important in clinical training. But the question is how are they prepared? Number of periods for first year's compared to other year levels

2. ***Role differentiation***
The roles of academic coordinator, supervisor and tutors seem duplicated.
How does the role of academic coordinator defer form supervisor and tutors (teachers)?
How does performing dual role as supervisor and at the same time teacher affect you as a person? and how does it also impact of students' clinical teaching?
Cannot be a specific person assigned to that role and assist the preceptor?
Is it a case that all teachers are supervisors? or is it a policy that all teachers must supervise their student when they go for clinical training or practicum?

3. Tutors' supervision and follow ups

Noted that tutors follow up and supervise students, but it is noted follow ups are not effective.
It is important to better explore and understand better on this. Main issues of concern are when tutors follow up students in clinical settings, do they also write their own report or observations different from what the preceptors will write? If not, will doing that help in terms of ensuring effective supervision and accurate report. Since sometimes students complain and feel that they have not been given the right report on their clinical training and
feel preceptor didn't like him/her. Has there being cases of controversy between students and preceptors in terms of their assessment report by preceptors? Is there a situation where supervisor go back to ask further questions about students clinical training after they have return from clinical practice in order to ascertain the true picture of the report by preceptors?
Do supervisors also do further discussions with preceptors after students have completed them clinicals? How effective is tutors' supervision of students in clinical training? Do they really an active role in supervision? Since preceptors complain tutors do not check up on students

Preceptors complain tutors don't visit facility to check on students. How has this been addressed by heads of institutions.

4. Role of in-charge and preceptor

How do you differentiate the role of in-charge and that of the preceptor?

5. Intra Semester Training

Intra semester training is essential approach of enhancing students clinical training.

Is the intra semester training part of NMCG policy or training institutions' arrangement? And is it consistent in all other schools? Are the number of weeks for the inter family midwifery practice specifically stipulated in the NMCG requirement policy? Is it same for those offering general nursing?

The intra semester clinical training, duration not specific. One month or three weeks? Why cannot there be specific duration.

6. System of communication/Authorization

Systems of communication is a major problem in clinical training.

Approval from regional health directorate before facilities accept students for clinicals? Cannot there be a straightforward and direct communication through formal letter to facilities for acceptance to help resolve unnecessary delays.

7. Preceptorship challenges differ and base on where it is been conducted.

How can preceptorship challenge be location specific? Are there different systems of practice or arrangement in different location? How can location impact on preceptorship practice?

8. Motivation of Preceptors

How can part of student's school fees be use as motivation for preceptor whiles they pay for clinical training/practicum. In which other ways can preceptors be motivated and how do NGOs come to support preceptorship.

Is there any specific policy by NMCG to motivate preceptors other than engagement in practical examination before giving them allowance? What effort has been done on this in terms of discussions with NMCG to motivate preceptors for the main work they do in student clinical training.

Should motivation be NMCG role? Training institution role or healthcare facility role?

Don't you think having specific people assigning to do preceptorship work would help address this motivational issue since that becomes their main work now instead of them

performing dual roles and calling for motivation?

There is no standard way of motivating preceptors. Depends on facility and school. Major problem in addressing retention since people will be willing to go to facilities where they are more motivated than others

9. Preceptor independency

Why can't we have specific people as preceptors instead of having one person performing dual roles as a nurse/midwife and a preceptor? Has there been any effort in terms of discussions on this? Is it stipulated in NMCG curriculum that students will be taught by preceptors? If so, how do they define the preceptor and what expectation is contain therein for preceptors? Are issues of motivation address in the curriculum or any policy of NMCG?

10. Intervention for effective students training

For effective training of students, students are group into 10 and assign tutors to them with specific clinical topics to teach at the skills lab before moving to clinical site. Are the 10 groups the required number or standard by policy or specific to individual schools?

Skills lab provides additional support to students clinical training in schools. How resourceful is the skill labs? Are all other institutions having skill labs? Who funds the skills lab? Extra days specifically weekend use to provide additional training for students.

11. Preceptor student ratio

Preceptors can precept eight–10 students and must have between 10–15 years of experience. Is it a standard policy? And if is so, is it been adhered to by all institutions? If not adhered to, what is the problem?

Is there a specific policy of the number of students preceptors should train?

12. Rule's enforcement and discipline

Strict enforcement of rules between school and facility in terms of students' permission to go somewhere during training.

.

13. Students clinical training guidelines

Preceptors rely on objectives set for student before coming to the site. Is there a situation where what has been given to them is limited or need additional knowledge to better build them. Is there a situation where they are given additional knowledge apart from the objectives

set for them. Do you think the school should set those objectives or collaborate with the facility.

14. Students' perception of what is learnt in school and facility

Students' perception about what they learn school as fiction. Also think that their teachers are better and know more than preceptors when they are having their clinical teaching. So difficulty for them to assimilate what they are being thought. Student's not willing to learn during clinical training.

There are controversies between students and preceptors. Students feel what they have on paper is better than what to be thought. Preceptors lack patient to train students. Students not ready to learn.

15. Accommodation challenges to students clinical training

Change of accommodation arrangement for students on clinical. No proper coordination and arrangement to have students' house in one place unlike previous times. Hospital and school no longer make arrangement for students' accommodation in most cases. Students have to come from their own houses and if far make their own arrangement. Can it be a matter of policy to have students house in one area for effective coordination and supervision?

Distance to work major challenge for students coming far. Results in late arrival and stress on them.

16. Lack of preceptors

Lack of preceptors in some facilities. People not willing to take up the responsibility of precepting. Training institutions have to identify or find their own preceptors. Should that be the case? Some preceptors also demand something from institutions before they agree to precept. So, who is responsible in providing preceptors for students' clinical training? Persistence transfer of preceptors affecting student clinical training. Preceptors easily get transferred and are not reliable. Can't there be a policy to have permanent and specific people

assigned for preceptor work to help address this challenge of retention.?

17. Memos from informal discussions and manuals

17.1 Communication

Lack of coordination major challenge in clinical training of students. There is major gap in

communication between the facilities/clinical site and training/technical institutions. In this case, whose responsibility to address the challenges.

17.2 Authority

GHS decided to draw MoU for the school and regional directorate to sign in order to address clinical training challenges, was it backed by policy? Do they have the right to take such decision in terms drafting MoU without the knowledge of Ministry of health?

Nurse manger, clinical coordinator, and preceptors all support in the clinical training process. where is the boundary of their respective roles? How do each contribute to preceptorship practice?

17.3 Managing new nurses

There exist difficulties in managing new nurses. There are no guidelines for nurse managers to train new nurses. They are unable to discipline or sanction new nurses during the process of mentorship. They are unable to talk about new nurses when they are not doing things right. Need for policy document on discipline and sanctions specifically for new nurses.

17.4 Skill Lab

Is the skill lab training a standardize practice in all the training schools? Is the duration same across board?

17.5 Motivation

Preceptors need to be motivated and motivation a major challenge. Motivation depends on facility as some facilities have proper system in place in motivating preceptors. (Kokofu in the middle belt)

1*7.6 Conflicts and politics*

There are conflicts occurring in all the three levels (micro, meso, and macro). Power politics, authority conflict between MoH and GHS, facility and GHS, students, and preceptors.

17.7 Increased student's population

Student numbers major problem, what effort has been made by institutions in addressing the increasing students'numbers and the proliferation of number of training schools.

17.8 Anger and Frustration

CODES

The main codes that commonly emerged from the various interviews across the different zones using the NVivo software included the following:

1. Students
2. Skills
3. Quality
4. Resources
5. Teaching
6. Tutor
7. Training
8. Manual
9. Policy guidelines
10. Politics
11. Ministry of Health
12. Ghana Health Service
13. Ward
14. Preceptor
15. Preceptorship
16. Nurses
17. Heads
18. Responsibilities
19. System strengthening
20. Enabling
21. Challenges
22. Clinical Education
23. Equipment
24. Implementation
25. Dissemination
26. Accountability
27. Language barrier
28. District
29. Financial
30. Pre-clinical and post clinical discussion/conference
31. Preceptor—institution relationship
32. Periodic meetings
33. Preparation of students
34. Budget for preceptors
35. Student challenges in clinical training
36. Selection of preceptors
37. Retired preceptors
38. NMCG
39. Workshop
40. Logistics (lack)

41. Supervision—mixed
42. Assessment/form
43. Monitoring and evaluation
44. Care plan
45. Accommodation for intra semester, feeding
46. Repeated work and students and teachers

MAIN THEMES

1. Challenges of clinical training/Preceptorship
2. Preparation of students for clinical Training
3. Effective Preceptorship
4. Assessment of students' clinical training
5. Curriculum/standard guidelines for preceptorship

1. CHALLENGES

The main challenges as contained in the various narratives from heads, students, preceptors and tutors in the various zones included; lack of motivation for preceptors, limited logistics for clinical training, increased students numbers, limited health facilities, accommodation for students, limited preceptors, effective collaboration between institution and facilities, politics between macro and meso level, students attitudes during clinical training, uncooperative attitudes of some nurses and lack of standard guidelines for preceptorship. The outstanding issues among these challenges were motivation, increased student numbers and lack of standard guidelines for preceptorship training. Whiles some institutions make effort to motivate preceptors by engaging them in examination supervision and given them some allowances; the general understanding is that motivation has been lacking which had impacted on the enthusiasm of many well experience nurses to precept students. An interesting question arising from this is that, should preceptors be motivated, who should bear that responsibility? The overriding view is that effective system should be created by top level management (government, MoH, GHS) to ensure that those who accept to be preceptors are motivated and trained. Others also shared those institutions can also play a role in supporting preceptors as in the case of some of the institutions in the northern zone. From the various narratives, it was noted that institutions in the northern zone are doing quite well in terms of motivation than those in the southern part. One other commonly noted challenge from all the zones was the increasing number of students with limited available facilities most especially in the northern zones. This situation especially in the northern zone has made it difficult for most institutions as students have to undertake their clinicals in already exhausted facility.

Given this scenario, students are unable to be trained well as student-preceptor ratio is not well balanced. One preceptor will be supervising more than 15 students. The situation coupled with inadequate facilities and equipment for training has also exacerbated the challenges. Another outstanding challenge has to do with lack of standard guidelines and policy on preceptorship. In all the various interviews and across zones, it was clearly established that preceptorship is a known concept among institutions and healthcare facilities. However, there is no standard and well-established system with guidelines for the practice. In all the zones, participants agreed that the concept exist but has not been effectively practice citing lack of support at the macro level, politicking, inadequate resources, increase student's numbers among others. From the interviews, it was clear that more effort is been made to address the challenges of preceptorship at micro and meso level with lack of support or very limited effort made at the macro level. It is also noteworthy to say that institutions and facilities at the northern zone are making effort in the practice of preceptorship given their system of communication, support for both students and preceptors as well as supervision. The main contested views/position are who should motivate preceptors, who should prepare preceptorship manual or ensure a well-functioning preceptorship practice. Why delays in having a well-structured system of preceptorship especially at the macro level as they are the decision makers. Can institution and facilities take decision to do that without broader high-level consultation? Who should update existing manual which have become old? Are institutions well positioned and resourced to take the responsibility to redesign and restructure preceptorship? Where and how should they access resource? How do they address or deal with the politics within the system?

2. PREPARATION OF STUDENTS FOR CLINICAL TRAINING

Another major theme which emerged from the interviews has to do with preparation of students for clinical training. Information gathered form participants shows that all the zones have some common standard of preparing students for clinical training. Preparation mainly involves sending letters to health facilities and communicating to potential supervisors or preceptors. The major challenge in this process has been delays in approving letters sent to the district/regional directorate for the preceptorship exercise. There is also the challenge of getting preceptors who will precept students as well as high number of students for facilities and provision of adequate materials for students' clinical training. In this process, students become the silent voices since they are unable

to express themselves in the ongoing challenge and suffer the consequences. The facilities become the dominant voice in this process as they decide the number of students, they can precept and whether they are willing to accept students or not. This contested issue of student numbers has not been properly settled as information gathered shows no standard number for facilities. Facilities accept students as and when they see fit. The effect of this challenge is limited attention given to students on clinical training given large numbers.

3. EFFECTIVE PRECEPTORSHIP

Several factors for effective preceptorship were common among all the zones interviewed. Motivation, logistics, communication, well-structured guidelines, adequate resources, good relationship between institutions and facilities, addressing increasing students' numbers were the main factors commonly identified among all the various zones. The major contested and unsettled opinion is the view that every nurse should make it a point to precept. This has been argued that nurses cannot be forced to precept against their will and must only accept to do so more especially where there are no systems of motivation. The question now is, should that be the case? Another contest has to do with the fact that preceptors do extra work and must be motivated. Should that not count as part of their normal work? Can't there be a way to make it their normal work and help resolve motivation issues?

4. ASSESSMENT OF STUDENTS' CLINICAL TRAINING

Students' assessment forms a key theme in preceptorship practices. In terms of student assessment, students remain silent voices and only accept what is provided on their assessment form and are unable to challenge or comment. The dominant voice in terms of students' assessment is the preceptor. Information gathered from interviews with students from the various zones revealed multiple assessors. Thus, it was noted that aside the preceptor, in-charges, other nurses, matron of the facility also assess students. This was not so in case of other zones. The contested issue is who should assess students? Must preceptors alone assess students? Some students revealed that assessment does not give a true picture of what they do given some of the issues that happens during clinical training especially doing errands. They indicated that given them assessment form and making them know they will be assessed will not give a true picture of them since most people will pretend. The contested view here is, should student be made known they are being assessed or not during clinical training.

5. CURRICULUM/STANDARD GUIDELINES FOR PRECEPTORSHIP

Interviews conducted shows that some form of guidelines exists but there were conflicting opinions. Some indicated there are few guidelines, but the provision is not enough especially in addressing key preceptorship challenges such as motivation and training. There is no major and well-designed policy that seeks to invest in preceptorship**.** Others also held that they are unaware of existing and well-structured preceptorship policy or guidelines. In curriculum development and preceptorship guidelines, views from the various zones indicate that the Ministry of Health or Ghana Health has the dominant voice in terms of design and implementation. However, given the power politics between these two key institutions, it makes one to believe that has resulted in the delays and challenges in having a well-structured curriculum or guidelines for preceptorship. The contested opinion here is who must develop the curriculum? Can GHS as an institution under MoH do that without consulting MoH? What effort is being made to ensure the two institutions work together?

Appendix O: Second, Third, Fourth, and Fifth Messy Maps


FIG 3. THIRD MESSY MAP
Lack of supervision
Limited resources
Accommodation
Limited space
Limited school support
Ethnicity
Bureaucracy
Limited school support
Lack of policy guidelines
Lack of collaboration
Lack of standard
Transfers
Skills lab
Transportation
Limited time for clinicals
Lack of training
Politicking
Increased student numbers
Limited time for clinicals
Logistics
Ineffective communication
Lack of preceptor willingness
Work overload
Compensation
Preceptor
Lack of support from colleague nurse
Work overload
Lack of Ministry support
Use of outdated manual
Motivation
Lack of recognition
Personal responsibility of heads
Limited preceptor commitment
Effective supervision
Dealing with politicking
Expansion of space
Training of more preceptors
Support from colleague nurses
Integration of old preceptors
Expansion
Ministry support
Logistics
Sponsorship programmes
Heads
Standard procedures
Classroom experience
Effective communication
Effective collaboration
Tutors
Student discipline
Well defined policy guidelines
Academic calender
Intra-semester
Personal commitment of preceptors
Student evaluation
Ward Manager
Clinical meeting
Inter-semester
Student supervision
Training of more preceptors
Time availability for clinicals

FIG 4. FOURTH MESSY MAP


FIG 5. FIFTH MESSY MAP
Silence voices
Tutors
Students
Ward Managers
Patient
Preceptor
GRNMA
Implicated Actors
Limited space
Limited school support
Accommodation
Lack of collaboration
Lack of supervision
Limited school support
Lack of policy guidelines
Lack of standard
Transfers
Skills lab
Bureaucracy
Transportation
Limited time for clinicals
Lack of training
Limited time for clinicals
Funds for training
Politicking
Increased student numbers
Limited resources
Logistics
Dissemination
Compensation
CHALLENGES
Ineffective communication
Lack of preceptor willingness
Work overload
Enabling
Equipment
Work overload
Lack of support from colleague nurse
Lack of Ministry support
Korlebu
Use of outdated manual
Personal responsibility of heads
PRECEPTORSHIP
Motivation
Lack of recognition
MOH
Hospital health facilities
ENABLERS
Limited preceptor commitment
Expansion of space
Northern Belt
Training of more preceptors
Effective supervision
Dealing with politicking
Institutions
Implementation
physical
Temporal
Support from colleague nurses
Effective collaboration
Integration of old preceptors
Expansion
Library
Student discipline
Heads
Ministry support
Lecturer
Logistics
Sponsorship programmes
Ridge hospital
Indigeneous people
Standard procedures
NMC
Classroom experience
Quality
Effective communication
Middle Belt
Well defined policy guidelines
Academic calender
IMPLEMENTERS
GHS
Policy guideliness
GCNM
Training
Intra-semester
Personal commitment of preceptors
Employer
Health Institutions
Kpembe
Kokofu
Goaso
Secondi
Dunkwa
NMTC
Role
Clinical meeting
Politicians
Skills
Teachers don't teach some topics
Student evaluation
Close offices of non-indigenes
Interesting
Student supervision
Inter-semester
COVID-19
some theory
left to preceptors
Training of more preceptors
Ketekrachi
Ethnicity
curriculum
Middle zone
Time availability for clinicals
CONTESTED ISSUES
Resources
Southern Belt
Share information
Leadership
System strengthening
Not every nurse should precept
Every nurse must precept
Tamale
Educational Training Institution
Clinical Education
Manual
Regions
Monitoring
KNUST
outdated manual
Clinicals
Whatsapp platform
Institution
Leckma
Clinical coordinator
UCC
UDS

Appendix P: Third, Fourth, and Fifth Ordered Maps

Note. Ordered Maps in these tables show changes made to organize the messiness into ordered maps

THIRD ORDERED MAP ADAPTED TO EXPLORE PRECEPTORSHIP CHALLENGES

INDIVIDAL HUMAN ELEMENTS/ACTORS Preceptor Students School heads	**NONHUMAN ELEMENTS/ACTORS** Outdated manual Logistics Ethnicity Politicking Motivation Compensation Transportation Bureaucracy
COLLECTIVE HUMAN ELEMENTS/ACTORS Personal responsibility of heads Lack of Ministry Support Lack of support from colleague nurses/midwives	IMPLICATORS/SALIENT ACTORS/ACTANTS Preceptor students
DISCURSIVE CONSTRUCTION OF INDIVIDUALS/COLLECTIVE HUMAN ACTORS Increased student numbers Ineffective communication between schools and healthcare institutions Lack of collaboration between dominant actors Limited preceptor commitment Lack of coordination among dominant actors	DISCURSIVE CONSRUCTION OF NON-HUMAN ACTANTS Increased numbers of schools Transfers Limited school support Lack of standard Lack of logistics Use of outdated procedure manual Lack of training Limited time for clinicals Lack of policy guidelines Lack of supervision Limited space
POLITICAL/ECONOMIC ELEMENTS Politicking Work overload Compensation Motivation	SOCIOCULTURAL/SYMBOLIC ELEMENTS Ethnicity
RELATIONSHIP ELEMENT Motivation Compensation Logistics Ineffective communication between schools and healthcare institutions Lack of coordination Limited preceptor commitment Lack of preceptor willingness Lack of supervision Student indiscipline Politicking Lack of standard	SUPPORT ELEMENT Lack of support from colleague nurses Lack of training Lack of logistics Lack of ministry support Lack of transportation

FOURTH ORDERED MAP ADAPTED TO EXPLORE PRECEPTORSHIP EFFECTIVENESS

INDIVIDAL HUMAN ELEMENTS/ACTORS
Preceptor
Students
Nurses/Midwives

NONHUMAN ELEMENTS/ACTORS
Accommodation
Logistics
Motivation
Compensation
Transportation
Compensation
Transportation
Bureaucracy

COLLECTIVE HUMAN ELEMENTS/ACTORS
Support from colleague nurses
Ministry Support
School support

IMPLICATORS/SALIENT ACTORS/ACTANTS
Preceptor
students

DISCURSIVE CONSTRUCTION OF INDIVIDUALS/COLLECTIVE HUMAN ACTORS
limiting student numbers

Student discipline
Personal Commitment of preceptors
Training of more preceptors
Integration of old preceptors

DISCURSIVE CONSRUCTION OF NON-HUMAN ACTANTS
Effective communication
Expansion of space
Dealing with bureaucracy
Effective supervision
Effective collaboration
Time availability for clinicals
Dealing with politicking
Standard procedures
Effective Coordination
Use of outdated manual
Lack of training
Limited time for clinicals
Well defined policy and guidelines
Effective supervision
Expansion of space
Dealing with politicking

POLITICAL/ECONOMIC ELEMENTS
Dealing with politicking
Compensation
Motivation

SOCIOCULTURAL/SYMBOLIC ELEMENTS

RELATIONSHIP ELEMENT

Motivation
Compensation
Logistics
Ministry Support
School support
Effective coordination
Well defined policy and guidelines
Effective supervision
Student discipline
Standard procedures
Bureaucracy
Politicking
Lack of standard

SUPPORT ELEMENT

Support from colleague nurses
Ministry support
Logistics
Transportation
Accommodation
Compensation
Motivation

FIFTH ORDERED MAP ADAPTED TO EXPLORE STUDENTS CLINICAL TRAINING

INDIVIDAL HUMAN ELEMENTS/ACTORS Preceptor Students Nurses/Midwives Ward managers Medical superintendent Tutors/Faculty Heads Old preceptors	NONHUMAN ELEMENTS/ACTORS Accommodation Logistics Motivation Compensation Transportation Sponsorship programs Classroom Skills lab Equipment
COLLECTIVE HUMAN ELEMENTS/ACTORS Heads of institution Ministry Support School support	IMPLICATORS/SALIENT ACTORS/ACTANTS Preceptor Students Ward managers Nurses/Midwives Tutors/Lecturers/Faculty
DISCURSIVE CONSTRUCTION OF INDIVIDUALS/COLLECTIVE HUMAN ACTORS Training of more preceptors Student discipline Personal commitment of preceptors Student discipline Integration of old preceptors Support from colleague nurses	DISCURSIVE CONSRUCTION OF NON-HUMAN ACTANTS Placement challenges Expansion of space Student evaluation Effective supervision Effective collaboration Time availability for clinicals Intra semester Inter semester Standard procedures Effective Coordination
POLITICAL/ECONOMIC ELEMENTS Dealing with politicking Compensation Motivation Motivation	Clinical meetings Lack of training Post clinical Conference Limited time for clinicals Well defined policy and guidelines Effective supervision Sponsorship programs Dealing with politicking Provision of logistics Limited supervision
	SOCIOCULTURAL/SYMBOLIC ELEMENTS
RELATIONSHIP ELEMENT Motivation Academic calendar Logistics Ministry Support School support Effective coordination Well defined policy and guidelines Effective supervision Effective communication Clinical meetings Student discipline Standard procedures, Tutors, ward managers, Equipment, Intra semester, support from colleague nurse Inter semester	SUPPORT ELEMENT Support from colleague nurses Ministry support Logistics Transportation Accommodation Compensation Motivation