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# The role of the academic in clinical practice: a systematic review

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# The Role of the Academic in Clinical Practice: A Systematic Review



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July 2007

Salford Centre for Nursing, Midwifery and Collaborative Research

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## **Executive Summary**

The role of the nurse educationalist in clinical practice has a long history of ambiguity which has never been reliably solved. Although professional bodies such as the English National Board provide some guidance, this is limited and does not present clear advice to those seeking role clarifications. Indeed, standards published by the English National Board advocate that 20% of a nurse teacher's time must be spent in clinical practice. This notional time remains resolute today.

Despite a plethora of research evidence about the role of the nurse lecturer in practice, a systematic review of the role activities had not previously been undertaken. The school of nursing believed that it was timely to review the evidence base and provide clarity on the subject.

The aim of this review was to identify the role activities of the academic in clinical practice (AiP). A team based approach was adopted to identify and subsequently refine a list of database search terms for research literature published between 1990 and 2006. Calls for grey literature were also made to UK schools of nursing and projects listed on the National Research Register. Following initial assessment of 248 retrieved abstracts, documents were obtained for further analysis. Of these 32 studies (reported in 36 research documents) met the project inclusion criteria and were subject to supplementary searches on citation indexes and critically appraised using assessment tools (University of Salford 2005). Three themes emerged: staff related activities (with sub-themes of education, practice development, staff development, communication and liaison), student related activities (with sub-themes of teaching, liaison and support, assessment) and development of self (with sub-themes of hands-on care, keeping up-to-date, issues of credibility). Although the composition of the AiP role is not surprising, the range of activities was found to be broad and diverse.

Whilst there are no definitive models of practice to be gleaned from this review, the themes uncovered provide insight into the role activities

undertaken by the academics in practice at a national level. This has subsequently validated the activities that academics within the School of Nursing at the University of Salford are currently undertaking as part of the 20% workload allocation in clinical practice. The findings are also consistent with contemporary NMC standards (2006a), which have contextualised the role activities within clinical practice.

Our findings can therefore be used at two levels. Firstly they could provide reassurance for academics currently undertaking the AiP role. In addition, our themes could provide direction for schools of nursing who are seeking to refine the role of the academic in practice.

## The Project Context

### Introduction

The role of the nurse educationalist in clinical practice has a long history of ambiguity which has never been reliably solved. Various attempts have been introduced to engage nurse educationalists in supporting students in clinical practice and contribute to patient care. Prior to schools of nursing moving into higher education a range of roles existed such as the clinical nurse teacher, joint appointments between schools of nursing and service providers and nurse tutors/teachers. Reviewing the literature has illustrated different approaches to creating a meaningful presence and contribution in clinical practice. Many of the approaches appear to have grappled with tensions between being a teacher and the need to demonstrate clinical credibility. With the move of nurse education into Higher Education the uncertainty surrounding the role of the nurse educationalist in clinical practice has merely transferred to a new setting and remains the subject of different opinions and interpretations (Goorapah 1997, Murphy 2000, National Board for Nursing Midwifery and Health Visiting Scotland (NBS) 2000, Williamson 2004, Fisher 2005).

Although professional bodies such as the English National Board provide some guidance, this is limited and does not present clear advice to those seeking role clarification. Indeed, standards published by the English National Board in 1993, 1995 and 1997 advocate that 20% of a nurse teacher's time must be spent in clinical practice. This notional time remains resolute today (Nursing and Midwifery Council 2006a).

A review into nursing and midwifery education by the United Kingdom Central Council (UKCC 1999) recommended Higher Education Institutes (HEI's) should provide time in practice for lecturers. No time periods were suggested in the report and the original notional figure of 20% has lingered even though the English National Board and the UKCC have since been dissolved. This figure has resurfaced recently as an approximation in the latest Nursing and



Midwifery (NMC) standard 'To Support Learning and Assessment in Practice' (2006a). Contracts between Consortia/Strategic Health Authorities and Higher Education Institutions for nurse education however have included this 20% time for practice activity (Day et al 1998) but there remains a lack of consensus between these parties and the professional body to *how* this period of time should be spent.

Universities preparing programmes for the roles are guided by the "Standards for the Preparation of Teachers of Nursing, Midwifery and Specialist Community Public Health Nurses" (NMC 2004a). This requires that teachers achieve outcomes associated with teaching, learning and assessment across a range of educational and practice settings. The UKCC (1999) and the NMC (2006a) recognised that teachers may specialise in teaching, research and practice but accept they cannot be experts in all areas and might experience conflict between the specialities. These reports further fuel the conflict and add to the confusion surrounding the role of the lecturer in clinical practice. Arguably such conflict has created dissonance between the preparation and implementation of the AiP role resulting in a lack of professional body guidance on the role activities and unrealistic expectations of the AiP by others such as Strategic Health Authorities, Trusts, practitioners, students and even employers'. As Ramage (2004, p294) concluded that "*a role title does not make a role, nor does it erase decades of negative influences on the viability of educational roles in practice. It is the clarity of purpose of the role and the expectations of others in practice that defines role potential.*" Without a clear purpose and specified role activities, expectations become aspirations and the roles future and potential impact are limited.

Against this backdrop, the school of nursing at the University of Salford implemented an Academic in Practice (AiP) role in May 2003 as a component part of the nurse lecturer's clinical responsibilities. This system was introduced to provide some direction to nurse lecturer's clinical role but tended to favour a regulatory element to the activities. Strong associations to the professional body requirements for practice placements (NMC 2004b) and mentorship (NMC 2004c) and the contractual requirements of the pre-

registration contract with the local Strategic Health Authority were integral components. The role, whilst meeting the regulatory elements has over time induced some tensions with the competing demands of developing subject specialisms and a research profile within Higher Education. These problems were not unique to our School. Nationally, roles, work expectations and professional requirements for nurse education have changed and fuelled further confusion. In 1998 Day et al, and later the UKCC in 1999, argued for the need to provide a clear definition of the role. However, the nurse lecturer's role in practice education has never been adequately defined. Despite a plethora of research evidence about the role of the nurse lecturer in practice, no one to date has undertaken a robust systematic review. The school of nursing believed that it was timely to review the evidence base and provide clarity on the subject.

## **The Project Team**

A small project group was set up in February 2005 to undertake a systematic review of the literature with the purpose of informing the profession on the subject and the possible future direction which could be taken.

The project team consisted of four school of nursing members of staff. This included a research fellow with a library and information background, and three members with a nursing background (two lecturers and a senior lecturer). Team members equally participated in all four stage of review which involved: literature searching, critical appraisal, extraction of themes and writing of the report.

## **Aims and Objectives**

To explore the extent of the academic role in practice the research team sought to undertake a systematic review of research literature. It was anticipated that systematically searching for and then appraising the evidence base would provide a comprehensive picture for the school of nursing and signal some direction to the activities AiP's undertake.

To focus the review, the following research question, aim and objectives were agreed upon.

### ***Research Question***

- What is the role of the academic in clinical practice?

### ***Aim***

- To examine and synthesize the evidence base regarding the role of the lecturer in clinical practice

To achieve the aim, three objectives were developed.

### ***Objectives***

To consider:

- The policy factors that have influenced the role of lecturer in practice

To critically evaluate the research literature which best describes:

- The activities of the lecturer in clinical practice (what they actually do!)
- The robustness of research methodology used to evaluate the role

## **Terminology and Structure of This Report**

For consistency, the term Academic in Practice (AiP) will be used throughout this report to represent all identified academics, lecturers, nurse tutors or nurse teachers who engage in clinical practice as part of their job role. Lecturer practitioners are addressed in a separate chapter.

## Chapter One: Methodology

### 1.1 The Concept of a Systematic Review

It is recognised that the aptitude of single studies to provide answers to some questions is unusual (Cook et al 1997). Alternatively, systematic reviews have the ability to cope with and manage a vast array of research evidence because they can reduce large amounts of [single] studies into key findings (Droogan et al 1998). The magnitude and scope of evidence which has explored or evaluated the role of the AiP further supported the need to undertake a systematic review to identify and potentially clarify the role.

Although some support the need for systematic reviews, Bandolier (2001) have cautioned against over-reliance of this type of evidence and argue that whilst systematic reviews can offer a unique insight into the evidence base about a particular topic, they may also be of divergent quality. This was especially pertinent in their critique of 'disappointing' systematic reviews, in which they state that systematic reviews can be "awful and even completely wrong" (Bandolier 2001 p93).

The view that traditional 'narrative' reviews are open to bias is not new, and many have argued that systematic reviews avoid such pitfalls through using protocol driven systematic methods to search for, appraise and report on the evidence (Grant et al 2000). Such views are also supported by White et al (2005) who argue that prior to systematic reviews, writers inherently introduced bias into their reporting through the simple action of picking and choosing which papers to include in a review. The extraction and use of evidence therefore play a pivotal role in determining the success and quality of a review.

The type of evidence used in a review is also important. A recent review undertaken by UK Centre for the Advancement of Interprofessional Education (CAIPE) in conjunction with the Cochrane Collaboration revealed many limitations to following a medical hierarchy of research evidence. As Rolfe

(2002) and others suggest, the concept of evidence based practice is to include *appropriate* and *relevant* evidence to support the development of practice.

In light of the above, and given the potential nature of the AiP evidence base (i.e. non-experimental) the team felt that all types of research evidence - qualitative, quantitative and mixed method study designs – should be considered and, where appropriate, be included to enhance the credibility of the review and provided a complete picture of the activities of the AiP.

## **1.2 Framework for the Review**

As Hart (1998) suggests the goal of any systematic review is to produce an analytical evaluation of the topic area. Similarly the aim of our systematic review was to locate and retrieve relevant evidence related to the development of the academic, lecturer or nurse teacher in practice. To ensure that a review is robust, the review was based on the stages outlined in the University of York's Centre for Reviews and Dissemination guidance (Khan et al 2001). These include:

1. Planning the review (including the development of a review protocol)
2. Conducting the review (including identification of research, selection of studies, assessment of study quality, and data extraction and synthesis)

Initial framing of the review question took place in February 2004. The team met on regular occasions to explore key concepts and remove any ambiguity about the nature and purpose of the review. A protocol outlining initial review questions, search strategy, study selection criteria, appraisal tools and proposed method of data synthesis were developed to guide the review process.

### 1.3 Searching the Literature

A structured search strategy based on Grant et al's (2000) iterative approach to scoping, refining and confirming the literature was used to develop a systematic approach to literature identification.

An initial search strategy was developed through monthly team meetings, through which relevant terms used to describe the role of the AiP in practice were identified (see Appendix 1). Between March and July 2005 these terms were used to undertake free-text searches on a range of biomedical, allied health professional and educational bibliographic databases and full-text journal aggregators (see Table 1). Following the initial assessment of database records, pertinent documents were obtained for further analysis. Additional search terms were also identified, discussed within the group and supplementary searches were undertaken. A total of 248 database records, excluding duplicates, were identified as potentially relevant documents. To enhance rigor abstracts were independently assessed by two members of the research team and areas of disagreement discussed. Where ambiguity remained, a third team member undertook a further assessment and a final decision agreed amongst the research team.

**Table 1 – Bibliographic Databases and Citation Indexes Searched as Part of the Review**

<i><b>Bibliographic databases</b></i>	<i><b>Citation indexes</b></i>	<i><b>Full-text Journal Aggregators</b></i>
British Nursing Index (BNI)	Science Citation Index (SCI)	Ingenta
Cumulative Index to Nursing and Allied Health (CINAHL)	Social Science Citation Index (SSCI)	Science Direct
Educational Resources Information Center (ERIC)		Swetswise
Health Management Information Consortium (HMIC)		
MEDLINE		

Documents meeting the inclusion criteria were used to initiate searches on citation indexes (see Table 1) and were supplemented with letters to named contact of potentially relevant projects listed on the National Research Register (n=26; see Appendix 2), calls for grey literature including a letter to Schools of Nursing in the UK (see Appendix 3 and Appendix 4), and contacting authors of key documents for clarification of data.

In total, 32 studies reported in 36 documents were identified as meeting the project inclusion criteria (see Appendix 5); 30 of documents meeting the inclusion criteria were obtained in time for incorporation into the review. The British Library indicated that there were no UK libraries able to supply a copy of two remaining papers identified during the search process. Acknowledging the desirability of obtaining all potentially relevant documents the team was confident that acquired papers had achieved theoretical saturation (Glaser et al 1967), that is, existing themes were recurring with no additional items arising from the literature.

#### **1.4 Critical Appraisal of the Evidence**

Data extraction and quality assessment were achieved through the use of critical appraisal techniques developed at the University of Salford (see Appendix 6). This includes a range of tool designed to help reviewers assess the quality of qualitative, quantitative and mixed method research designs. This allowed the reviewers to examine the research papers in some depth and ascertain the rigour, relevance and trustworthiness of the studies. To enhance the credibility of the review, inter-rater reliability checks on 25% of the appraised papers were undertaken by the review team. Finally, a constant comparative analysis methodology allowed the development and refinement of emergent themes. The team held monthly meetings to discuss the key findings, summarise and interpret the evidence.

Within the review a critical appraisal of individual documents is presented at the point at which it first makes a major contribution to the report. A summary of all studies (research methodology and sample and data collection

techniques) is also presented in Appendix 7 which details summaries of studies included in the review.

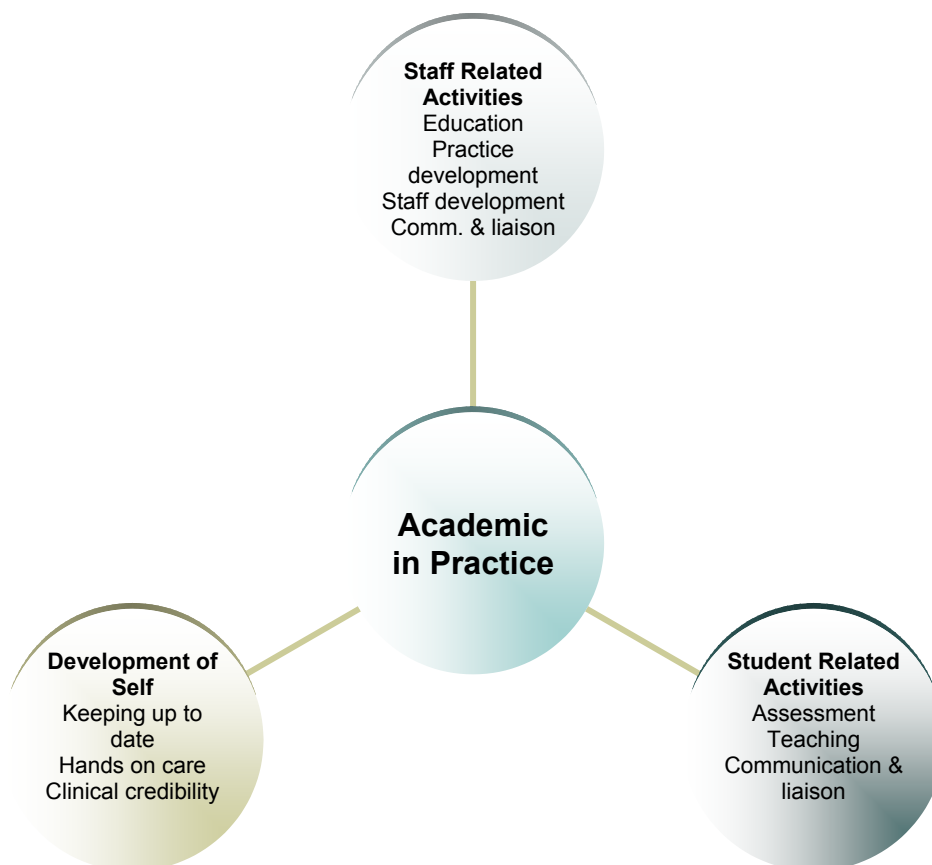


## Chapter Two: Emergent Themes

Three broad areas of activity with multiple sub-themes emerged from the appraised research literature. These were 1) staff related activities, 2) student related activities and 3) development of self. These themes (see Figure 1) are quite broad, but reflect the current issues addressed in the literature. In addition, the themes identified suggest commonalities between organisations in the way in which the AiP role has evolved. Not surprisingly, although the interpretation of the role varies, the activities identified in the evidence base illustrated that academics are utilising these broad areas to support staff, students and their own personal/professional development.

Each major theme has a number of similar sub themes, which suggests that the shared AiP role characteristics uncovered in this review are in fact evident in all researched AiP roles. This runs parallel with current expectations from the NMC and also goes some way in validating our theoretical saturation techniques (Glaser et al 1967) i.e. no additional themes were emerging from the literature, whilst existing themes recurred. In relation to staff development, the evidence suggests that the AiP role should focus on the education, development of practice staff through activities such as practice development and good communication and liaison. Similar activities are revealed in terms of how academics support students in practice. In this instance, the evidence illustrates how students are supported by academics through a range of teaching, assessment and liaison and support activities. Finally, a key theme which we identified in the evidence base indicated that many academics had some sense of professional and personal development; this includes for example the need to keep up to date, hands on care and issues around clinical credibility. To broaden this scope and compare some of the academic activities with similar roles, we have also reviewed the evidence base relating to the lecturer-practitioner. To some degree, these roles are similar in their attributes but divergent in their relationships with practice. Notwithstanding our assumptions, the systematic review team are confident that these identified themes embrace the central activities of the AiP.

**Figure 1 – Three Key Themes**



## **2.1 Staff Related Activities**

Staff related activities fall broadly into four sub-themes. Each of these relate to the AiP role in terms of how the AiP is utilised to promote education, facilitate practice development, ensure that staff development activities take place and how they use communication and liaison skills to accomplish these aspects. These four key sub-themes are interrelated and have helped to structure a deeper understanding of the nature of the AiP role in relation to staff activities.

### **2.1.1 Education**

The majority of the evidence in this sub-theme focuses on how the AiP has helped develop the clinical learning environment. The evidence reveals a range of strategies and methods which have been employed by the AiP to facilitate a good learning environment. This involved the education of mentors through updates and supporting the mentors and managers in the clinical context. In addition, a number of research papers purport that the successful preparation of clinical staff bolsters the development of a quality clinical learning environment.

Staff support and development was one of the findings from Crotty's (1993a) mixed method study which explored the emerging role of the nurse teacher in Project 2000 programmes. The study population included 25 out of 28 colleges, which had implemented Project 2000 between September 1989 and April 1991. The participants in this study saw their role as trouble shooting, supporting clinical supervisors in their new role, following the system in terms of assessing students rather than hands on care, updating regarding the programme and helping to develop the clinical learning environment. Crotty (1993b) identified that some activities in the clinical area supported qualified staff for example, through updates about the course and through help with learning outcomes. These findings imply that the liaison role includes supporting clinical staff and preparing them for Project 2000 programmes. This approach to staff development embraced clinical staff updates about the programme and helping them to develop the clinical learning environment.

Updating mentors on changes in the curriculum and students assessment was also viewed as a key element of the AiP role. This was illustrated in, Camiah's (1998) work which examined the impact of changes in nurse education on the role of nursing lecturers in practice. Camiah noted that for the majority of lecturers only short periods of time (not specified) are spent visiting their link areas. Nurse lecturers were engaged in a range of activities and believe the most useful of these were 1) forging links and close working relationships with service colleagues e.g. exchanging good practice and planning specific learning needs and outcomes; 2) facilitating teaching and

learning e.g. helping students integrate theory and practice; providing updates on education changes; psychological and pastoral care; 3) providing clinical teaching and supervision e.g. working alongside students; updating practice on continuous assessment and mentorship; and 4) educational audits e.g. assisting staff in creating, and subsequently monitoring, learning environment; and providing knowledge and skills to assist staff to maintain a high quality care service. However, there is a lack of detail about data analysis techniques and the discussion of documentary analysis is limited. In addition, the population under investigation was selected by Head of School as representing 'highly skilled' members of staff, and no rationale was given for this inclusion criterion. As a consequence, findings may not be representative of the wider nursing lecturer population. None-the-less, Camiah's paper suggests that there is a need for activities to be prioritised to provide teachers with clear guidance as to what is expected from this role and realistic goals set that both lecturers and practitioners accept.

Role ambiguity is not confined to any branch of nursing and different branches of nursing have been represented within the evidence base. For example, White et al (1994) explored the values and interpretations of the roles from within the context of adult and mental health branches in a Project 2000 course. Another example of research which contextualises education within mental health was undertaken by Ferguson et al (2003). Their study explored the continuing professional development needs of the mental health lecturer workforce teaching in Higher Education Institutions in England. Ferguson et al used an exploratory qualitative research design to investigate the experiences of mental health lecturers who taught on courses with a clinical or practice component in HEI's in England. The aims of the study were to elicit a range of views on the issues around the clinical/practice activity of academic staff, barriers to regular practice and approaches taken to engaging in practice and finally translate these findings into pertinent and realistic recommendations for the future development of the mental health lecturer workforce. This was achieved through a three stage study which used questionnaires and interviews as the main data collection tools. A postal questionnaire was distributed to the Heads of all 189 departments or schools of nursing in all HEI

institutes in England. Focus group interviews and semi-structured interviews which represented all five disciplines were then conducted. In addition, face to face or telephone interviews were undertaken.

Ferguson et al's three staged research project resulted in an in-depth exploration which revealed a range of activities undertaken by the AiP. In particular, the focus groups highlighted eight themes which included talking to practice colleagues about new developments, working with practitioners, service users and carers on curriculum development and delivery, running staff development activities for practitioners and attending clinically focused conferences. Similar to other research findings, for example, Fisher (2005), Ferguson's study illustrated the complexities of the AiP role even in relation to the education and support of clinically based staff.

Facilitating a quality learning environment however, seems to take precedence within the evidence base. Indeed, some authors have commented on and explored the nature of the learning environment and how this is sustained through the AiP involvement. One such paper is Hardiman (1993) who originally explored the effect that the Project 2000 curriculum had on the teacher's role and how the nurse teachers felt about the changes in their role arising from its implementation. Using a qualitative grounded theory approach, Hardiman's study identified four core categories which related to the role of the teacher. These included teaching a specialist subject, working in the clinical area, working with personal students with specific responsibilities and identification of change e.g. workload issues resulting from moving to a specialism. These findings were similar to Clifford's (1999) study which suggested that some teachers acted as a "source of knowledge" about education programmes and the clinical learning environment. Hardiman (1993) is another researcher who also identified that although participants expressed concern at not being able to achieve the required hours of clinical involvement, they also revealed that their clinical role had changed. The participants in Hardiman's study believed that their role now included a wider responsibility and a greater amount of clinical involvement

e.g. staff development and supporting trained staff to ensure a learning environment.

The importance of staff development is reiterated by Jowett et al's (1994) longitudinal qualitative study. In their paper, the role of the academic in clinical practice was explored but this was only a small part of a bigger study. Jowett et al's study provides an overview of findings amassed during the research of 13 demonstration sites which were originally selected to implement Project 2000. Although Jowett et al provide no details about the teachers, HEI staff or managers within the sites they did feature in the study. Questionnaires and interviews were exploited to elicit data about the process of change; the analysis of which highlights what has been achieved and how further progress may be made. Many of the respondents were involved in the educational audit of practice areas as well as student evaluations of placement.

Jowett et al covered a wide range of issues around organisational development, links with H.E., development and implementation of the course, impact of lecturers and practical staff, preparation of students as practitioners. Students from the first six intakes of the demonstration sites were chosen. The questionnaire was distributed to 420 students. Three hundred and seventy one (371) completed the questionnaire several months into their common foundation programme (72% response rate). Of these 77 were approached following a systematic sampling process which took part in the first round interviews. Every fourth questionnaire returned was selected and the sample drawn was checked against the total characteristics of age, gender, educational qualifications on entry and Branch programme undertaken. The authors indicate that this produced a representative group but no details were provided around the numbers from each of the four branches of nursing.

In relation to the interviews, in Jowett et al's study , all the 13 hospital and community sites were potentially available for the research, however, the heterogeneous intakes resulted in a systematic sample being used in an attempt to reflect the key characteristics of the population in those

approached for interview. Ninety practice based staff were interviewed in the first round. The sample included 29 sisters/charge nurses, four teacher practitioners, 35 student supervisors and 22 community nurse personnel. However when the students entered their branch programme some of the staff had moved on and their posts were no longer in existence. When this occurred, new staff was recruited for the second round of interviews. In other cases someone else from the original area was selected.

Jowett et al (1994) advocate the active involvement of clinical staff in the development of the learning environment. This they believed was achieved through regular education updates on changes in nurse education, advising and assisting staff in their own academic work, clarifying students' learning objectives and assessment documentation and advising on professional development. Overall, the study provides an insight to the role at this particular time for nurse teachers and the lack of clarity about who should take primary responsibility for the linking and teaching in practice areas. The data also revealed a number of problems in relation of the role of the nurse teacher in clinical practice. This related to tensions of other workload pressures in fulfilling a presence in clinical practice. Nurse teachers often found their practice liaison duties hard to fulfil with or without "hands on" teaching input a component of the role about which both education and service continued to have divided views.

### **2.1.2 Practice Development**

Evidence about practice development included key attributes such as ownership and the ability of the AiP to influence the learning environment. The range of research has resulted in some diversity in the nature of findings. For example, whilst Clifford (1999) identified strategies such as helping to develop the learning environment, Ferguson et al (2003) focused on the development of practice through research, secondments and joint appointments.

Practice development is considered to be a generic aspect of the lecturer role, which has been discussed in other research. For example, Clifford's (1999) qualitative study used a sample from a large college of nursing in England

prior to move into the higher education sector to develop a conceptual framework and illustrated how nurse teachers managed the clinical aspect of their work. Although the methodology used in this study was reported elsewhere, Clifford's findings highlighted potential key characteristics of lecturers in practice which refer to three conceptual categories; role clarity, fitting in and role justification. These included working with a designated number of students on a particular course and providing 1-2-1 supervision and 'hands on care'. Clifford discovered that most teachers made a conscious effort to assist with 'menial tasks' e.g. washing up cups and making beds, and patient care when working with a clinical area for the first time. Teachers viewed themselves as a source of knowledge and a resource about educational programmes. For the majority of tutors (n=8) their link areas were determined by organisational need rather than to reflect their clinical expertise. Clifford's semi-structured interviews also revealed that whilst most respondents were dubious about the nurse teachers' ability to influence care in the clinical areas some lecturer admitted to using strategies to help the staff in the clinical areas develop ideas in such a way as to feel "the ownership lay with them". In this study, the empowerment of staff through ownership thought to be key in the development of practice.

The way in which lecturers engage in practice was explored by Ferguson et al (2003) who identified a number of findings, which suggested that the need for lecturers to engage in clinical practice was not always recognised by the university. In this research a mixed method approach was used which highlighted an emphasis on the roles of research and teaching (despite the fact that 89.29% of respondents indicated that they were involved in practice development). This study also explored whether lecturers were actively involved with clinical practice activities and revealed a number of barriers. These included the pressure of work, limited resources, heavy teaching responsibilities, the pressures to do research and publish and finally, having to support large numbers of students and mentor in a large number of link areas across a wide geographical area. Ferguson's findings also illustrate that despite the constraints faced by the lecturers to undertake aspects of clinical activity, practice development remained a key aspect of their role. For



example, in one university practice development activities were promoted through secured funding to support a long term CPD activity for teaching staff to deliver education programmes that meet the new agenda. In addition, the trust and HEI jointly funded the development of Nurse Consultant Posts. Although this type of partnership is not unique, it does highlight the need for a continued and joint strategic effort to sustain practice development activities.

### **2.1.3 Staff Development**

The professional development of staff (Clifford 1993) is an aspect of the lecturer's activities which is considered to play a pivotal role in the development of the learning environment and in the maintenance of quality patient care standards. Elcock (1998) echoes this stance and suggests that there could be excellent opportunities for the AiP to take an active role in establishing their role, and influence the clinical environment. This is supported by other evidence which suggests that the AiP role is also reciprocal with practice based staff involved providing education updates on changes in nurse education, advising and assisting staff in their own academic work, clarifying students' learning objectives and assessment documentation and advising on professional development (Jowett, 1994, Aston 2000).

Whilst it is clear that the development of staff is closely aligned to staff education, there are some examples in the literature which highlight how specific staff development activities can support practitioners and promote a good learning environment. For example, Ferguson et al's (2003) study discusses activities such as organising staff development activities for practitioners and facilitating staff support groups. This suggests that whilst the AiP involves student support, the innovative way in which this is achieved through staff development can be exploited to enhance the relationship between clinical and academic staff.

Research across the UK reveals a similar picture. For example, the Scottish lecturers' perspectives of the role of the nurse teacher in clinical practice was explored by Duffy et al (2001) who used an interpretive research approach

incorporating focus groups. Many role characteristics identified in this study highlighted the importance of staff development and in particular, the methods used to support staff. Duffy et al's study involved 18 participants who reflected the different branch programmes, roles and responsibilities. The participants were then divided into focus groups. Interview questions were organised around current literature and were tape recorded. Following analysis, Duffy et al revealed three consecutive patterns that had emerged from the data. These were related to the role, the experience of the role and dilemmas faced in the role. Each pattern was then qualified through further description and analysis. The 'role pattern' was divided between being an advisor, a supporter, a regulator, an interpreter and a net worker. In relation to being an advisor, analysis of this theme suggests that the lecturers thought they were advisors to both staff and students. This also included providing academic and career advice in particular with staff.

When describing the role of being a supporter, Duffy et al (2001) highlight the need for emotional support for staff and students as the main foci. In addition, improving morale through developing relationships was also seen as important. Being a regulator was thought to influence practice and maintain professional standards and was the main reason why nurse teachers entered the role. This involved trouble-shooting. However, being a regulator also meant being involved in the assessment of students. Being an interpreter related to interpreting assessment documents and policies, this helped staff to identify learning opportunities for the students. Being a 'net worker' reflected the relationship development between staff and lecturers. Linking with specific areas was considered to be crucial to help these relationships form. Experiencing the role included the benefits and the difficulties. Finally, the third pattern – 'dilemmas' included data about future concerns and being 'hands on'. Although Duffy et al's paper was transparent, it did however lack depth. For example, the researchers role was not disclosed, sample information was limited but insight into groupings of sample and justification of methodology was provided. Whilst two of the constitutive patterns were discussed (being in the role) the other two themes – experience and concerns were not disclosed.

A similar research design was adopted by Hardiman (1993) who used a qualitative method modelled on a grounded theory approach. This study acknowledged that participants identified their clinical role as changing to include a wider responsibility and a greater amount of clinical involvement e.g. staff development, supporting the trained staff and ensuring a learning environment is provided. This philosophy of enhanced clinical involvement has influenced other studies, particularly in relation to the type and level of practitioner included in the development of the environment. For example, an action research study undertaken by Owen (1993) provided a favourable illustration of how the ward managers teaching role and subsequent learning environment is developed through careful planning by the lecturer. As part of a plan to develop an improved learning environment efforts were made to develop the ward manager's teaching role by facilitating alternate student teachings sessions with the ward manager thus providing an opportunity for role modelling, reflection on performance and feedback (Owen, 1993). Although this study was weakened through limited application of the action research cycle it does provide some insight into the need for partnerships between practitioners and educationalists about how to bring about changes in practice.

Other evidence alludes to a range of activities which have been employed to elicit and promote a quality learning environment. Using an action research approach, McElroy (1997) sought to address specific questions relating to the current and future development of the lecturer in practice role. Three research questions which related to the role of the nurse teacher were formulated. These included what nurse teachers viewed as their current role, how they thought that their role ought to develop and what vision they held about the role for their future. Ten focus groups were conducted involving 52 teachers. Each focus group lasted 1.5 hours duration, with one hour of taped discussion. Data from the focus groups were then used to generate a range of opinions about the role and purpose of teachers in clinical areas. In total, four themes were identified which referred to clinical links, time to think and reflect, personal tutor and teaching strategies. However, no details were provided

which described how the categories were developed. Indeed, McElroy admits that although the data analysis could be criticized for lack of rigour e.g. simply listening to the tapes, making notes and reporting general findings, he felt that they did provide complete transcription. Although McElroy attempts to place the sample within a broader context, information was limited regarding the total number of teachers and their professional backgrounds. It is difficult to ascertain whether this sample reflected the whole population of teachers in the college.

Although the conclusions of McElroy's study were weak, the issues raised in the findings for discussion were pertinent. For example, McElroy's findings illustrate divergent opinions as to how the role should be developed. All the participants in the study saw the importance of what teachers did in clinical areas as something which must be given a priority. However, it was thought to be the first activity to go with pressure of work. Examples of these activities included supporting students and qualified staff, undertaking research, keeping up to date in specific areas of practice and improving the learning environment. Other findings also reveal the need for staff to have time to think and reflect upon their work, keep a professional portfolio and develop support systems in the school such as peer supervision. In addition and commonly referred to in other research (Jowett et al 1994, Murphy 2000, Nelson et al 2002) the need to keep up to date in their specialist subject was of concern especially when considering the expectations of nurse teachers to provide a research output.

#### **2.1.4 Communication and Liaison**

Supporting qualified staff through liaison and communication is espoused by a number of authors (Crotty 1993b, Hardiman 1993, McElroy 1997, Fisher 2005) and is seen as central to the successful learning environment. In Camiah's study (1998) it was noted that for the majority of lecturers only short periods of time are spent visiting their link areas. In addition, staff believe that 20% was a 'reasonable amount of time' to spend in practice provided demands were realistic. In this instance, nurse lecturers were engaged in a range of activities and believed that the most useful of these were forging

links and close working relationships with service colleagues. It was felt that the ability of the AiP to influence the learning environment is enhanced through good communication and liaison with the clinical staff.

Other research by Murphy (2000) also illustrated the lecturer role as being someone who is accessible and who can be utilised as a resource person. Murphy used a three stage action research approach to develop a strategy for developing the clinical role of the nurse lecturer through collaboration with practitioners in teaching and research. The first cycle was based on the identification of two key problems which related to students having little knowledge of gynaecological nursing and practitioners being unfamiliar with the pre-registration curriculum. To address this, it was agreed that a teaching programme would be introduced and delivered in partnership between the lecturer and the practitioners. The programme consisted of one hour weekly tutorials using a reflective practice framework. The first cycle lasted over a five month period. The programme was monitored and modified in the light of this feedback. The second cycle identified the potential benefits in participating in the programme. A team was developed which included the lecturer and five practitioners. Data were collected from students, practitioner and the lecturer throughout the duration of the programme. The third cycle used data collected from the second cycle which was further modified to accommodate suggestions from practitioners and students. This data revealed the need for in-service sessions and reflective practice to be accommodated.

The findings from Murphy's study suggest that the lecturer was able to meet the liaison role allowing students and practitioners to meet with the lecturer on a regular basis. In addition, the lecturer was seen as accessible and could be utilised as a resource person. With regards to the teaching role, the lecturer was actively involved in teaching the programme and integrated the theoretical components of the curriculum with practice. In relation to the practice component data obtained from the lecturer indicated that they were able to maintain clinical credibility through the teaching activity. This included focussing on incidents from clinical practice and discussing these with practitioners and students. The research element also was met as the lecturer

was seen to move from liaison and teaching towards research, therefore acting as a facilitator and resource person in the management of the research process. Finally, Murphy (2000) argued that lecturers who were able to meet the liaison role also provided an opportunity for practitioners to meet on a regular basis. This promoted a 'change agent' role which enabled the strategy to be implemented, evaluated and sustained.

The notion of communication and liaison to support staff development has been studied widely; most notable by Clifford (1993, 1995, 1999). Using a mixture of research methods Clifford has illustrated the impact of good communication with practice on the role of the AiP. For example, in 1993, Clifford explored the role of the nurse teacher in teaching, research, clinical practice and management. This particular study highlighted that 35 out of 40 academics had specific responsibilities for liaising with between 1 and 18 named clinical areas (wards or units); though 24 felt they spent too little time on this activity. Indicators suggest that time spent in clinical areas tends to be minimal, satisfying a social need, with visits acting as a 'token gesture' rather than fulfilling a defined or planned role.

In an ongoing study into nurse teachers' perceptions of their role, Clifford's later study in (1995) used a questionnaire survey of four Colleges of Nursing in England to report trends, concerns and conflicts identified by nurse teachers in relation to their role. Whilst little or no detail given of questions included in survey, Clifford's study does highlight a range of concerns with the AiP role. These included the number of links (assigned to as many as 75 wards/units), the frequency of visits (ranging from rarely, more than once a week, weekly and 2-4 weeks), and the length of each visit (less than an hour up to between 5-7 hours) which varied considerably. In addition, nurse teachers roles were frequently motivated by the number of students they were allocated and the demands of students and staff for support. Interestingly, it was noted that one college had developed a contractual arrangement within clinical areas that specified the amount of time a nurse teacher should spend in the area. Teachers in this college generally had a smaller number of link areas and disagreed with the idea of liaison and suggested that this should be

focused on working with students. None of the nurse teachers in this study appear to have received guidance as to what activities to engage in when linking with clinical areas. Factors such as age, educational grade and length of time working in nurse education appeared to influence how nurse teachers approach this role.

Another key influence of the role was related to teacher experience. For example, Clifford's study found that length of employment and age resulted in a higher expectation to undertake a liaison and supervision role. Teachers who were aged 40 or less tended to spend longer in practice spent longer working with students and were more confident in their ability to give care to a proficient standard. Nurse teachers believed that they 'worked with students', provided 'liaison or support' 'links with trained staff' and sought to 'update their own knowledge and skills'. Good links were perceived as being related to 'good communication through the link teacher system' whilst poor links were views as resulting from 'insufficient time' and 'poor communication'. As illustrated here, the importance placed on communication was reciprocated between practice and academic staff. Finally in 1999, Clifford drew on her previous work and set out to present a conceptual framework to illustrate how nurse teachers manage the clinical aspect of their work. This study revealed anomalies in the construction of the lecturer role as they battled to locate themselves within practice and understand their role.

More contemporary research by Smith et al (2001) explored the current role of the link lecturer. In this study AiPs are described as academic staff that liaise with identified practice areas. Their prime aim is to support students and clinical staff and undertake innovations, assessments and audits. In addition, several key points were revealed in the interviews which confirmed the importance of the role in sustaining the emotional labour of student nurses. These were liaison with senior clinical staff/mentors on behalf of students, providing a symbolic link of support between clinical and educational contexts, which to some extent reinforces the more contemporary thoughts about the role of the AiP as that of staff supporter.

### **2.1.5 Summary**

Staff related activities described here present one element of the role. This theme has highlighted essential attributes which are needed to ensure that practice staff receive as much support as students in developing the learning environment. We argue that limited investment in supporting practice staff will almost certainly negatively manipulate the ability of practice staff to critique, amend and evaluate the learning environment. This could compromise student erudition and render potential learning opportunities redundant. Undoubtedly, this would be deleterious to the students who rely on a partnership between practice and academic staff to smooth their progress through the practice arena. The importance therefore of staff support through education, practice development, communication and liaison cannot be underestimated and should play a reciprocal role in relation to student support and the professional development of the academic.

## **2.2 Student Related Activities**

Student related activities fall within three sub-themes in terms of how the academic engages in clinical practice. These relate to teaching and learning activities undertaken in placement areas (which for some involved taking responsibility for a patient caseload), a liaison role which provided support for students and staff and finally involvement in the assessment of student nurses.

### **2.2.1 Teaching**

The evidence found in this sub-theme initially focused on whether nurse teachers viewed clinical teaching as part of their role and the nature of the activities which were performed. Crotty (1993b) undertook her study with 25 out of 28 colleges of nursing which had implemented Project 2000 courses between September 1989 and April 1991. The views of nurse teachers were collated and analysed via a Delphi survey (Crotty 1993b). In round 2 of the survey of 201 teachers from a possible sample of 1000 nurse teachers, the role was rated as important by 82% but this figure dropped to 40% in round 3 even with the attrition of 50 subjects between these rounds.



Twelve of the 201 respondents in Crotty's study (representing 6 colleges) were invited to participate in interviews. No rationale was provided as to the sample size or how they were chosen. In addition no information was provided on why six out of 25 colleges were used or where they were located. The study suggests that 69% of her sample thought that clinical teaching as part of their clinical role and 99% as important. Clinical teaching in this context was associated with "hands on care" and despite the view of its importance, none of the teachers in the study were actually involved in this activity and expressed a lack of commitment to this function. However, whilst qualitative researchers would support the context bound nature of the work, the small sample size used in this study could limit the generalisability to the wider nurse education network.

The notion of hands-on-care was also reported in another study into Project 2000 by White et al (1994). This study explored the relationship between teaching, supervision and role modelling in clinical areas within the context of Project 2000 courses. This report had many aims and objectives and the presentation of findings was ambiguous. The authors have not provided an overview or discussed the findings in any depth and merely presented the verbatim quotes and some discussion around the design of the report itself. There was little comparison of the findings with other literature. The authors used a case study approach of three centres, involving two branches of nurses and they collected data from tutors, mentors and practitioners. The sample was purposive but no inclusion or exclusion criteria were provided. From the adult nurse tutors perspective there appeared to be a degree of confusion about the role and the descriptions offered by tutors. Some felt that clinical roles (i.e. hands on) were no longer required and that helping students to reflect on their experiences was now a priority. Others however held polarised views and suggested the tutors should work with the student in practice and act as a role model. For mental health tutors there was a great deal of dissatisfaction with their involvement in clinical practice. Unless there was a problem they were not contacted. Similarly to the adult nurses the mental health tutors felt unprepared for their role.

Another study conducted during 1990–1994 by Luker et al (1995) explored the evolving role of the nurse teacher in the light of educational reforms such as Project 2000. A multi-method approach was adopted which used a case study, a modified Delphi Survey involving three stages and telephone interviews. Luker et al provide detailed information about the methodological processes but the majority of the report explored changes to the role rather than what exactly nurse teachers actually do. What did emerge was that 61% of the 60 nurse teachers from the case study of one educational centre stated that their role was largely one of making supportive visits. The participants in this study saw it as desirable for the nurse teacher to have an increased clinical role. This included working with students providing direct care and teaching students clinical skills; however only 19.4% of the sample actually helped students deliver patient care and only 2.8% were involved in teaching clinical skills.

Subsequent studies by Day et al (1998), Ferguson et al (2003) and Clifford (1999) all report findings of involvement by nurse teachers in teaching students through the delivery of patient care whereas Aston et al (2000) found the direct teaching role via a caseload was relatively rare and tended to be linked with the Lecturer Practitioner role. The evidence emerging in these later studies should be interpreted cautiously. For example, this Clifford's (1999) sample was limited to ten subjects with only one participant effectively engaging in this role activity. Generalisability is therefore limited. Ferguson et al (2003) reported a mixed situation between different professional groups with some nurse teachers engaging in the delivery of patient care.

Some studies (Aston et al 2000, Day et al 1999) revealed the importance of a direct teaching role within a specialist area in which nurse teachers engaged in teaching students through patient care activities. This was particularly evident in post registration courses such as intensive care setting described in Clifford's (1999) study and midwifery and children nursing outlined in Day et al's (1998) work. Both these studies highlight the clinical expertise of the

teachers involved in these programmes combined with a smaller number of students which enabled one to one supervision.

Clifford (1999) suggested that a lack of role clarity was a contributing factor which influenced whether teachers engaged in this activity. Conversely Crotty (1993a) and Luker et al (1995) found that teachers did not see teaching through patient care as part of their role, whilst in Jowett et al's (1994) study teachers did not consider it appropriate to patients' needs. Their findings suggested that it was viewed as the role of the qualified staff on placement who were seen as the clinical experts. Many felt that their clinical practice was extremely limited (Luker et al 1995) and skill teaching needed to be provided by placement staff who possess current clinical experience (Jowett et al 1994, Ferguson et al 2003).

In response to concerns about the link teacher in clinical practice Ramage (2004) carried out a study which focussed on how nurse teachers had managed their role since the move from schools of nursing to Higher Education. This qualitative study using grounded theory took place between 1991 and 1998 within educational and practice settings in an inner city and provincial areas in the South of England. Ramage (2004) identified that nurse teachers had to negotiate multiple roles. She reported on how the nurse lecturer's involvement had become less significant, and had been reduced to gaining access to placements through negotiating with placement staff as to what role they should have in clinical practice. Whilst the study provides an insight to the multiple roles undertaken by tutors little information was provided about the analytical process or what protocols were adopted for data collection and analysis. The sample of twenty eight subjects was purposive and included link lecturers and clinical teachers who were likely to have experienced the phenomenon of teaching in clinical practice. However what does emerge from the study and is consistent with other findings (Luker et al 1995) are the views of the subjects' sense of vulnerability in clinical practice in addition to feeling a lack of confidence, competence and credibility in their role.

Findings from Ramage's (2004) study demonstrate some consistency with the findings of Day et al (1999) who asserted that lecturers could potentially impede patients rights especially in mental health and learning disability settings. The outcome from this issue resulted in changing relationships with students who subsequently seek guidance from the nurses on placement rather than the nurse teachers. This led teachers to question their involvement as a role model in clinical practice (Ramage 2004).

Other dimensional elements associated with the sub-theme of teaching and learning were briefly mentioned in the literature. An early evaluatory study of Project 2000 by Jowett et al (1994) provided evidence of nurse teachers working with students on placements by introducing them to the area of work and through organising visits to other areas for observation. In addition the nurse teachers provided opportunities for students to discuss their learning objectives, experiences and written work. These elements do not appear in more recent studies where there seems to have been an increased move towards a more facilitatory rather than organisational role. This move has been associated with the facilitation of student groups to develop learning (Ferguson et al 2003) and the promotion of reflective activities in which discussions are used to "shape the educational experiences of the student nurses" and "to support the student nurses' emotional labour" (Smith et al (2001, p233).

### **2.2.2 *Liaison and Support***

This sub-theme is referred to in several studies (Crotty 1993c, Clifford 1993, White et al 1994, Luker et al 1995, McElroy 1997, Aston et al 2000). However the terms 'liaison' and 'support' are used interchangeably and are not defined. To illustrate this Crotty (1993c) refers to a "liaison role" which includes supporting students whereas Clifford (1995, p14) discusses a "liaison or support role in clinical practice." Whilst this inconsistent use of terms has fuelled the confusion about the role of the AiP what does emerge consistently from the literature is that the role has slowly evolved from a teaching role to one that supports students (White et al 1994) and practice based staff (Jowett 1994, Smith et al 2001). Crotty's (1993c) findings describe this role change as

a “clinical liaison” role indicating that teachers in her study were strongly committed to the “clinical liaison” role.

The purpose of the “liaison role” is to provide support for students and practice staff although Jowett et al (1994) found that some teachers visited placement areas primarily to see students whilst others viewed the role as providing support and advice to clinical staff. Several authors indicate the purpose was merely a “visiting role” (Clifford 1993, Luker et al 1995) due to time restrictions which prevented a more extensive input. Teachers tended to visit students who were weak or not coping (Luker et al 1995) whereas in other studies the teacher assert that visiting the clinical area “was to show my face to let them know who I am” (Clifford 1999, p181).

The nature of the activities were not clearly defined in many studies but some studies allude to a range of activities such as updates on current educational developments (Camiah 1998), the role of student advocate (Day et al 1998) or as a trouble shooter if problems arose with students progress (Luker et al 1995) and as a resource for students and staff (Murphy 2000).

One exception was Smith et al’s (2001) study which contained more detail about the nature of the role activities of nurse teachers. This work indicated that AiPs were the chief role models for learning to care and provided emotional labour and support to students. Emotional labour is a broad concept and is thought to be a support for student nurses, qualified nurses, patients, relatives and other healthcare staff. Smith’s study found link lecturers assumed a central role in student nurses’ clinical learning and helped sustain their emotional labour by providing a symbolic link of support between clinical and educational contexts and fostering reflective learning based largely upon shared experiences. Link lecturers often gave examples of their past experiences and difficulties in nursing in order to illustrate a present problem that student nurses had. Discussion was used to shape the educational experience of the student nurse and storytelling was utilised to help establish interpersonal relationships between the student nurse and link lecturer. This also helped with the application of these experiences to nursing practice.

The findings of Smith's six month pilot study drew from the traditions of empirical qualitative data collection, ethnomethodology and feminist methods in healthcare research. However no details were provided about why these approaches were chosen, what was being observed or what results emerged. In addition details about the opportunistic and purposive sample were unknown nor how representative they were of the total population. There was limited disclosure of the locations used in terms of their suitability to provide relevant exposure to the concepts of emotional labour. Little detail was provided about fieldwork activities and data analysis. The findings from this pilot study were restricted to one area so generalisability (even though qualitative research does not lend itself to this) may be limited.

### **2.2.3 Assessment**

The assessment of students did not emerge as a strong sub-theme but was commented upon briefly in several studies (Aston et al 2000, Clifford 1993, Crotty 1993c, Elcock 1998). In particular, Crotty's (1993c) study provides no detail or clarity about the nature of activities indicating they followed 'the system' in terms of assessing students.

In another study into the role of the nurse teacher/lecturer in clinical practice Day et al (1999) adopted a mixed method approach which sought the views of practitioners, lecturers, students, educational and service managers across four fields of nursing in five educational institutions. The study had a number of aims including identifying factors which promoted or inhibited the practice role and effective models to meet clinical competence and/credibility. Specifically in relation to assessments Day et al (1999, p120) state that "all the respondents agreed that practice assessments should be undertaken by practitioners. Lecturers had a role to play in supporting fair and equitable assessments." This was evident in the learning disability sample where programme leaders indicated that all lecturers assess students in practice and even carry out the moderation of assessments in clinical practice. The strength of this study lies in its mixed methodology which collected and analysed data from five case study sites and from a national survey

questionnaire. Similarly a subsequent study by Aston et al (2000) demonstrated that nurse teachers did participate in the assessment process however this was primarily to prepare the clinical staff not the students.

#### **2.2.4 Summary**

Evidence about the role of nurse teachers focussed upon three main areas in relation to students – namely teaching and learning, the liaison role and assessment. For some the role manifested in teachers engaging in hands on care whilst others viewed teaching and assessment in clinical practice as the domain of the expert practitioners in these environments. What does emerge is that the role of the nurse teacher has changed over time from a teaching to a supporting role, often acting as a liaison between Higher Education and the placement areas for students and qualified staff. The nature of the liaison activities are not clearly defined but range from providing updates on educational developments, acting as a student advocate or as a resource for students.

Evidence also revealed that some teachers identified a sense of vulnerability in clinical practice which arose from feelings associated with a lack of competence and credibility in clinical practice. The lack of role clarity compounded these feelings and contributed to a lack of engagement in clinical practice. The outcome from this has resulted in changing relationships with students who seek guidance from nurses on placement rather than nurse teachers (Ramage 2004).

### **2.3 Activities Related to the Development of Self**

Literature in this section falls within three sub-themes indicating how the academic seeks to optimise their links in clinical practice for their personal development. Whilst the sub-themes represent discrete areas of activity they are also interrelated and complementary. The three themes are keeping up-to-date, maintaining clinical credibility and providing hands-on care.

### **2.3.1 Keeping Up-to-Date**

AiPs viewed links with clinical practice as providing an opportunity to maintain their skills base and keep abreast of the realities of ward practice. For example, in 2003, results from Ferguson et al's questionnaire survey indicated that mental health lecturers were given opportunities to undertake clinical or practice focused courses to update their skills. However this was not common place, and the AiP role emerged as providing a more generalised opportunity to engage in self development activities.

A similar survey by Clifford (1995) of college of nursing lecturers indicated that they went to the clinical areas simply to update their own knowledge and skills. This view was echoed two years later through focus group interviews of nurse teachers held by McElroy (1997). In this study the teacher viewed their AiP role as providing an opportunity to keep up-to-date with specific areas of practice. On occasions, links with clinical practice were also utilised to update their own skills as an activity distinct from that obtained whilst supervising students (Clifford 1999).

In 2005 a qualitative study by Fisher noted the opportunity to practice clinical skills took on a specific purpose, with respondents reporting a desire for 'security' in the light of the future for nurse education and the changing NHS. An emergent theme in this study was the desire of AiPs to maintain up-to-date clinical skills in the event of a possible return to practice; although Fisher does not expand on how this could be achieved.

### **2.3.2 Hands-on Care**

The role of the AiP appears to have evolved into one primarily of liaison and supervision with clinical practice. The issue of AiPs engaging in hands-on care, that is, direct contact and provision of care for patients either with or without student involvement, is an intriguing one. This was highlighted in Forrest et al's (1994) qualitative study which explored the perceptions of the clinical teacher present role as viewed by wards managers, teachers, students and staff nurses. Forrest et al sought to compare perceptions with



the reality of the role and, using semi-structured focus group and individual interviews. This is a methodological sound study, which provides quotes to support its analysis. For example, in illustrating that trained staff felt overburdened the quotes also reveal that assessing and supporting students in practice was given a low priority. Nevertheless, the reported findings make interesting reading and reveal that AiPs define themselves primarily in one of two ways; either as a nurse or as a teacher.

In relation to hands-on care, Forrest et al's study demonstrated that teachers did not consider engaging in the clinical care of the patients as part of their remit. They believed that students might feel as though they were being examined if the teacher chose to work alongside them in clinical practice. Instead they adopted the role of enabler or the manager of the learning experience choosing to focus on educational issues and providing students with 'time out' for reflection and discussion about practice. In contrast, those who defined themselves as teachers favoured hands-on teaching and were generally concerned with being perceived as clinically credible. This group undertook teaching clinical skills such as caring for patients – even when the students weren't present. The activity of caring for patients was a point reiterated in the findings of Day et al's UK wide survey of 1998. In this study, the teachers saw involvement in caring as helping to maintain their skills and clinical credibility.

The perceived importance of hands-on care was exposed in Aston's (2000) mixed method study of Deans, Heads of School and Programme Leaders in the UK. Hands-on care was viewed as essential to being perceived as credible as a nurse. However, as Ferguson et al (2003) noted, the percentage of staff who regularly undertook face-to-face therapeutic activity as part of their role – approximately 52% of staff spending less than 25% of the academic role in practice in hands-on care - was perhaps hindered because this activity was not usually reimbursed by practice, something which also occurs in medicine. Ferguson suggested that this is because the need for practice is not formally recognised by many universities and that in some

cases there is no strategic guidance on expectations relating to the clinical activities of lecturers.

### **2.3.3 Clinical Credibility**

Clinical credibility is an ill-defined concept and term and, was widely used seemingly interchangeably with alternative descriptors (Camiah 1998, Clifford 1999, Murphy 2000, Ferguson 2003, Williamson 2004, Fisher 2005). These included clinical currency (Fisher 2005) and clinical awareness (Fisher 2005). What is meant by these terms is influenced largely on the timing of the study, on the context (academic or clinical setting) and on individual perceptions.

Within the academic setting, clinical credibility appears to be based on the teacher being viewed as trustworthy and reliable within the clinical setting. In 1993, AiPs reported that rather than performing as an expert practitioner, clinical credibility could be achieved via theoretical updating and maintaining basic skills (Crotty 1993a). Participation in clinical practice was also seen as important for respondents in a 1998 study by Camiah who indicated that to achieve credibility, AiPs needed to have a theoretical understanding of a clinical area, and be able to work alongside students; especially in relation to specialist areas. However, a shift appears to be present in the very late 1990's (Clifford 1999) in which it is noted that AiPs are reticent to create time for clinical work. This may be attributed to their reduced credibility in the clinical area; both from a personal perspective and in their perceptions of student and clinical staff opinions. The notion of educational credibility, including adopting the role of an educational programme resource, was also noted in Clifford's (1999) study as a possible way of addressing the teachers' perceived credibility gap. More recent studies indicate that AiPs generally believe themselves to be credible – and to be perceived as credible by students – primarily through their teaching activities (Murphy 2000, Ferguson 2003). In particular they believe that by being able to demonstrate a link between theory and practice, possibly drawing on recent examples from the clinical setting, they were clinically credible (Williamson 2004). This perhaps reflects the shift to a facilitative rather than clinically engaged persona.

Teachers perceptions of clinical credibility were explored further by Fisher (2005) who used semi-structured focus group and individual interviews to identify how nurse lecturers maintained their clinical credibility. The study is methodologically ambiguous and leaves the reader with questions about the nature of the sample and, more importantly, the way in which the study findings were interwoven with literature rather than being presented separately. In addition, the recommendations for practice appear to bear little resemblance to the findings discussed. Nonetheless, Fisher's (2005) study highlighted the issue of clinical currency versus clinical competence.

Clinical credibility seems to be linked to clinical competence and in 1993 Clifford undertook a questionnaire survey 66 nurse teachers in a single English College of Nursing during the introduction of Project 2000. However, a lack of detail pertaining to data collection and analysis, and limited depth of participant responses restricts the interpretation of her findings. Interestingly what emerged from the data collected (60.6% response rate – 40 respondents) was a general concern regarding their competence as skilled practitioners. Despite half of all respondents describing themselves as skilled, reservations will still expressed. This was particularly noticeable in relation to becoming deskilled due to lack of opportunity to maintain links with their specialism.

#### **2.3.4 Summary**

Findings from Crotty's (1993a) survey and Fisher's (2005) later study both indicated a belief that it was not necessary to perform as an expert practitioner in order to maintain clinical credibility. They purport that this could be achieved by maintaining basic skills and updating theory (Crotty 1993a), particularly in specialist areas of theory and practice (Camiah 1998), by reflecting on practice and relating theory to practice (Crotty 1993b), and through teaching by discussing critical incidents in practice and discussing with practitioners and students (Murphy, 2000). Whilst developing oneself may not be an obvious component of an academics role in clinical practice, this evidence suggests that it is an integral part in not only maintaining credibility but in being sufficiently integrated to have a positive impact on

practice development. It can be viewed as a welcomed by-product of the AiP role which is utilised both implicitly (whilst working with staff and students) and explicitly (when using the links with practice for independent activity).

## **Chapter Three: The Role of the Lecturer Practitioner**

A recurring theme based on research about the lecturer practitioner (LP) suggests that roles originated due to the specific needs of individual clinical areas (Lathlean 1997, Elcock 1998, Carnwell 2005). Lathlean's (1997) study identified how the impetus for the role came from the hospital's Chief Nurse who saw a new role of LP as enhancing the practical experience of students. Other studies revealed that LP posts were specifically developed to meet demands in clinical practice (Elcock 1998) and Redwood et al 2002). In particular, the LP's in Redwood's study were keen for such diversity to remain, and one of the key findings from Elcock's study was that the education element of the LP role arises from and remains integrated within the practice role. This may be the reason why a second theme identified in Elcock's paper reports the diverse nature of the clinical role activities and asserts that the LP role should be flexible enough to meet local needs.

The three themes of staff related activities; student related activities and the development of self identified from this systematic review are echoed in the LP literature. However, there was a lack of clarity in most of the papers as to whether the activities described formed part of the Higher Education or clinical practice component of the overarching LP role.

### **3.1 Staff Related Activities**

Staff related activities fall broadly into the same four sub-themes as identified from the AiP literature. Each of these relate to the LP role in terms of how the LP is utilised to promote education, facilitate practice development, ensure that staff development activities take place and how they use communication and liaison skills to accomplish these aspects. The fact that LP's had often worked in senior clinical positions and had the authority and power to change practice was seen as an advantage when functioning in the role.

### **3.1.1 Education**

Similar to the AiP role (Clifford 1993, Crotty 1993b, Camiah 1998) a key function of the LP's role is the preparation and development of mentors (Lathlean 1997, Elcock 1998, Carnwell 2005). For example, Carnwell (2005) explored the influence of the LP, mentor and link tutor roles on the integration of theory and practice in the curriculum within two Higher Education Institutions in North Wales. This mixed methodological three phased study commenced in 2003 and was reported on in April 2005. The study aimed to collect data from a range of stakeholders; students; mentors; link tutors; and Higher Education and NHS Managers and LP's. Carnwell's study illustrates useful data about the nature of the LP role in terms of preparation and support for mentors. A case in point was the view that LP's assist mentors by explaining and dealing with mentors perceptions of students' abilities. As most clinical areas had an allocated LP, it was the LP whom the mentor could contact first to discuss student progress. Often the LP would offer pre-placement briefing sessions and in some instances developed 'Lead Mentor Forums' to support mentors in their role.

Whilst Carnwell's study provides valuable insight into the role and expectations of the LP, the use of a non-random sample of LP's coupled with a poor questionnaire response rate raised some concerns about the reliability of the findings. Nonetheless, Carnwell utilises her comprehensive literature review on the role of LP, mentor and link tutor to make sense of the overall findings of the study. In an attempt to enhance the transferability of the findings, Carnwell also seeks evidence from more than one NHS institution.

Other research has explored the role of the LP through qualitative methods. One example is Elcock (1998) who used Rodgers' Evolutionary Model (1993) to explicate the concept of the LP. Rodgers' model requires the collection of data regarding the attributes of the concept, which Elcock interpreted through conducting a literature review of the LP role. This enabled Elcock (1998) to investigate the concept of an LP within a multi-disciplinary context and provided an opportunity to explore a concept in terms of how they related to policy and practice. In an attempt to clarify the role and examine the

implications for nursing Elcock attributed staff development as an important characteristic in the literature. This resulted in a review which was too focussed and therefore limited the application of Rodgers' model. This reduced the credibility of findings from the concept analysis. However, the findings were useful in illustrating key attributes of the LP role in terms of adequate mentor preparation.

The support and preparation of mentors was a role attribute also highlighted by Lathlean (1997). Lathlean conducted a study to understand the working lives of LP's in one practice and Higher Education Institution as they developed over a period of time and to consider the implications for nurse education and practice of the LP concept in action. This study used a mixed method approach to understand the nature and reality of the job of LP. In her study, Lathlean identified a significant role of the LP related to the selection, development and support of mentors. This longitudinal ethnographic study of six of the first LP's in post over a period of three years is supported by interviews with people working most closely with the LP's and a subsequent survey of all LP's in one institution (n=55). Very little information is offered in terms of study setting though the impetus for the development of an LP role in one NHS Trust is clearly identified from the outset. Although some of the findings illustrate that the role was seen as both as support and teacher of other nurses, it is unclear from the study (as with others - Redwood et al 2002, Richardson et al 2003, Fairbrother and Mathers 2004, Williamson 2004, Carnwell 2005), whether the context of this support was located within the practice or university environment.

A further dimension to the education element of the LP role is reported in a study by Redwood et al (2002). This particular research study focused on the personal experiences of 10 LP's and their managers with a view to drawing out common features of the role as well as highlighting differences. All 10 LP's were interviewed with a purpose of obtaining narratives of their experiences of being an LP. Survey interviews were also conducted with 17 stakeholders who offered either a managerial overview or who had a strategic role in planning education at the university or health care setting. They

reported that the LP was instrumental in creating and sustaining learning environments which both supported and motivated staff and students to develop professionally. Specific role activities included co-ordinating and leading on the development of an organisational structure that supported workplace learning and educational support of clinical staff. It was also identified that the LP undertook educational activities such as coordinating the teaching within the learning environment. Importantly, LP's viewed the activity of teaching as being integral to the LP role which enabled them to help mentors to develop the skills, abilities and capacity to support learning in practice. The study setting is one NHS Trust. Although a robust methodology is evident in this study, the local context of this study needs to be considered when making generalisations about the findings to other settings.

Redwood et al (2002) clearly identify a clinical teaching role of the LP, for example working with practitioners. These findings were reciprocated in Richardson et al (2003) mixed method study. Data was collected by Richardson et al via group interview and questionnaire from a range of professional viewpoints (senior nurse; management; Higher Education Institution and LP's themselves) on the value and impact of four LP's working within one NHS Trust and Higher Education Institution. Findings suggest that the education role focuses on the teaching of staff within the clinical area via a range of approaches. These included one-to-one informal group discussion with junior staff; small group teaching; one-to-one teaching at the patient bedside and hospital classroom teaching. They report that the LP is viewed most effective in the role when directly delivering a service, for example, supporting skills development. However, as with Redwood et al (2002), this study provides a local evaluation only. Therefore the local context of both studies needs to be considered when making generalisations to the wider population as the activities undertaken by LP's are often context bound.

### ***3.1.2 Practice Development***

Whilst most papers report on the impact of the LP role on students through mentor development, some identified how LPs have influenced practice



development. Elcock (1998) identified that although the LP role is unique and multi-faceted, a practice development element of the role was clearly evident in terms of how the LP's encouraged and supported research based practice rather than undertaking primary research. In other examples, this was undertaken by LP's through the development of nursing within the ward or unit (Lathlean 1997). This was achieved for example by changing the way nursing was organised, moving away from a traditional team nursing approach to primary nursing. Evidence from studies by Redwood et al (2002) and Richardson et al (2003) demonstrate how the LP would often collaborate with colleagues to develop new ways of working, thus challenging existing practice and lead on practice development projects. This could also involve driving through policy at departmental and organisational level, often as a result of their critical evaluation of the research (Williamson 2004). LP's are therefore in a unique position to respond to the educational needs of staff identified as a direct result of a practice development initiative (Redwood et al 2002).

To implement change in practice requires the empowerment of staff, with a clear need of the LP to influence the organisation of care and the management of the service, whilst at the same time understanding the educational implications of staff when implementing change. Redwood et al (2002) attributes personal skills of the LP, which contribute to its role success, to include leadership skills and the ability to act with 'emotional intelligence' Emotional Intelligence is a term they use to describe the LP's "ability to understand how other people work and to understand what motivates them in order to work collaboratively with them" (p31). Redwood also notes an LP's ability to manage uncertainty and ambiguity without becoming demotivated. The majority of LP's had previously been in a clinical leadership role or management position and many identified that this experience was essential in preparation for the role. The seniority of the post was thought to be vital as it gave the post holder the authority to function in a leadership role within both organisations. Those LP's who worked in specialist areas assumed an important role in the development and articulation of expert knowledge to be shared with the team of practitioners and students alike. They would facilitate practice and service development within their practice area and throughout

the organisation. The notion of being able to change practice through expert power was also identified by Lathlean (1997), Elcock (1998) and Nelson et al (2002).

### **3.1.3 Staff Development**

There are examples in the LP literature which relate to the staff development aspect of the role. Lathlean (1997) provided examples of LP role activities that can be grouped under the sub-theme of staff development related activities. Akin to other research (Redwood et al 2002, Richardson et al 2003, Fairbrother and Mathers 2004, Williamson 2004, Carnwell 2005), Lathlean emphasised that the clinical role of the LP differs with each LP. Role activities include developing teams of nurses and encouraging nursing practice that can be exposed. This was achieved through the visibility of the LP in clinical practice by working or being on the ward. Further activities include implementing individual staff development programmes; facilitating staff support groups; developing new roles and then developing the person into the role. Developing and maintaining the workforce, particularly in relation to critical care was also identified by Richardson et al (2003) in their study.

The way in which staff development takes shape is dependent on the LP. This was evident in Redwood et al's (2002) report which identified how the LP was seen as being a coaching role, thus enabling practitioners to reappraise their practice. This was as a result of their working relationships with a range of practice staff. A major function of the role in this example was to enable others to develop skills, abilities and capacity to support learning in practice. Similarly Richardson et al (2003) reported how LP's provided opportunities for staff to ask questions, helping them to feel more confident in their role. An interesting concept evident in the literature (Lathlean 1997, Redwood et al 2002) is that the staff development function of the LP role can be attributed to the fact that the LP's are clearly visible within the clinical learning environment.

### **3.1.4 Communication and Liaison**

Whilst the AiP literature identifies communication and liaison as a distinct role activity, this activity is an integral part of the activities already discussed; particularly involving education and staff development,

The role of LP acting as a link between university and practice is reported in the literature (Elcock 1998) and is identified as a reason why the role was initially introduced (Nelson et al 2002). Using a phenomenological approach Nelson et al (2002) attempted to understand the lived experience of being an LP from the perspective of four LP's. Data analysed from the unstructured interviews suggest that the LP role primarily focused on student learning, but that this was also extended to clinical staff in terms of acting as a link between practice and the university. The study sample was drawn from one university and the researchers acknowledge the findings reflect a local study only and that this may have limited application to other universities. Although data generated from the unstructured interviews was analysed utilising a process of thematic content analysis (Burnard 1991) a lack of rich data and inadequate description of fieldwork poses doubt around the credibility and generalisability of the study findings to other settings.

Interestingly, the term 'mediator' is often associated with an LP role to describe communication and liaison activities. However, this is used differently depending on the context. In Redwood et al's (2002) study, the term is used to describe a role that mediates between theoretical input at the university and the practice experience, thus addressing the theory practice gap. Alternatively, Carnwell (2005) uses the term to describe communication or mediation between clinical and education staff; link tutors and trust managers, and students and mentors. What is evident however, is the emergence of a clear role in relation to the support of mentors which includes mentor development (Lathlean 1997); preparing mentors to supervise and assess students (Elcock 1998); keeping practitioners involved with the learning needs of students (Nelson et al 2002) and working with mentors to enable them to make sense of the required programme outcomes (Carnwell 2005). Indeed there appears to be a strong correlation between the evidence

about the mediator role and its relationship and impact on the mentor role. Support and preparation for mentors is therefore thought to be integral to the overall educational infrastructure, and is the responsibility of the LP to develop and implement.

### **3.1.5 Summary**

Evidence about the role of LP focussed upon the four areas of promotion of education, facilitation of practice and staff development and in the use of communication and liaison skills to accomplish the above three areas. The development of mentors was seen as an important element of the role. Evidence also suggested key responsibilities in creating and sustaining the clinical learning environment and a role that would collaborate with other professions to drive through policy at both a local and organisational level. The need for the LP to have the authority and power to change practice was seen as a crucial element of the role as well as having the skills to function in the role.

## **3.2 Student Related Activities**

Student related activities fall within two sub-themes in terms of how the LP's engages in clinical practice. These relate to teaching in placement areas and a communication and liaison role which provided support for students and staff.

### **3.2.1 Teaching**

In some studies, it was difficult to discern the clinical aspect of the LP's teaching and learning role. For example, in Lathlean's study (1997) the researcher alludes to direct student contact as conducting tutorials; working with or alongside students; being in the clinical area, assessing students and actually being a mentor. In this study, all the LP's believed that it was important to help students to reflect, however, this was also viewed as being the main role of the mentor. Strategies used by the LP's to support reflection included being available in the clinical environment to reflect with the student. Lathlean's study also suggests that the LP's would work on an 'ad hoc' basis

with students, first judging how mentors worked with the students. They would provide individual tutorials and weekly support meetings for students to offer the student a guarantee to see an LP and to reflect. In addition, meetings with the students half way through the placement were often instigated by the LP to monitor student progress. This would involve a three-way reflection with LP, student and mentor. The LP would work with the student if the mentor was unavailable.

Other teaching methods used by the LP in practice were observed by Nelson et al (2002). Their findings suggest how the LP facilitates student learning through discussion of current practical experience in both university and clinical settings. The LP's encourage students to reflect on their own practice by application of the underpinning theory. Similarly Redwood et al (2002) reported that an LP role provided opportunities for students to reflect in both the practice and Higher Education setting, with the aim of linking learning 'back and forth' between theory and practice Redwood et al discuss the implicit assumption that this 'bridging activity' consists of helping students in the application of theoretical or propositional knowledge to the practice context.

Less traditional ways of teaching were highlighted by Lathlean (1997). In this study, the LP was described as being available to act as a useful resource rather than working with the students as this was seen to be the role of mentor; however it was recognised that the LP might work with students as a member of the clinical team. Interestingly, in this study, there was agreement from LP's that little or no time would be spent working with students in the clinical area. All LP's described their role as being different to that of the mentor. The mentor was seen as the students' main reference point; somebody who works alongside the student. The mentor would also assess the student whilst the LP would validate the mentors' assessment. LP's therefore have an overall responsibility for students in the clinical area, which Lathlean terms as facilitating learning by working through mentors, by direct contact with students and by the assessment process. Elcock (1998) also refers to the facilitation of teaching and learning in terms of planning and

organising student learning in the clinical learning environment. Similarly Redwood et al (2002) identify that LP's would teach students in the practice setting, but also has a wider facilitation role of teaching within the learning environment.

In Carnwell's (1995) exploration of the LP role, other teaching and learning activities were identified in relation to student nurses. For example it was identified that a number of LP's spent time in practice working with students. However it was recognised that these practice sessions were seldom reflective of normal clinical practice, other than in areas of specialist practice. LP's believed that only the mentors were real practitioners and were therefore likely to be the only group who could show students what practice was really like. A key purpose of the LP role was termed as getting students fit for practice and included a number of activities including pre-placement preparation for students. This activity was often performed in conjunction with the clinical areas allocated link tutor. The LP would also prepare the student for practice by increasing the realism for students using what they had learnt in theory and making it come alive in practice. This reinforces the findings from Redwood et al's study (2002) which asserted that the LP's role plays an important part in addressing the theory–practice gap.

### ***3.2.2 Liaison and Support***

The role of LP in a support/communication and liaison role has been discussed in detail under the theme of staff related activities and includes the indirect support to students by organising and facilitating the learning environment. However, Lathlean (1997) makes particular reference to a supportive role for students as running support groups.

Reviewing the research on the role of the LP research revealed little evidence that they embraced a link tutor or a liaison role outside of their own clinical learning environment. One exception was Carnwell's study (2005) which suggested that both a link tutor and LP have clinical responsibilities in a shared area, and that there is sometimes confusion between the link tutor role and that of the LP when this occurs. For example, the LP quoted 'treading on

other peoples toes' to illustrate this dilemma. This was overcome by forging relationships and negotiating clinical responsibilities for both roles. What is seen as crucial is that both the LP and link tutor provide equivalent information to the student.

Findings from Carnwell's study also suggested how the LP and link tutor role can complement each other. Whilst LP's saw both themselves and link tutors as part of the same team, Carnwell reports that the LP's were very clear about the ways in which their role differed. However on reading Carnwell's study, this was not made explicit. Academic support for students during placement was seen as the role of link tutor, together with auditing placements, dealing with student placement documentation and assignments, and giving pastoral support; although sometimes the LP carried out the roles too. What is unclear from the literature is under which circumstances this overlap occurred. Carnwell (2005) also identifies how the link tutor contract expects contact with each student at least once during each placement acknowledging that the emergence of the LP role had reduced this necessity.

### **3.2.3 Summary**

In the LP literature there appears to be a distinct connection between student and staff related activities, particularly in relation to the LP role that facilitated teaching and learning, and liaison and support.

Evidence located in our review suggested the diverse nature of the clinical teaching role and that not all LP's worked in a clinical role that involved student contact in a 'hands on' way. Reported teaching roles were dependent on the needs of the clinical learning environment. Consensus in the evidence has revealed an LP role that assisted students to reflect on practice. The literature differentiated the LP role from the mentor role. The LP would facilitate and develop a clinical learning environment to support mentorship systems whilst the mentor would guide the student on a day to day basis. Confusion was noted in clinical areas where both an LP and link tutor worked. The need for both parties to develop strategies to forge relationships was required.

### **3.3 Activities Related to the Development of Self**

Literature in this section relates to keeping up-to-date, maintaining clinical credibility and providing hands-on care.

#### **3.3.1 Keeping Up-to-Date**

The nature of the clinical role of the LP means that they are able to keep up to date in their own area of expertise. Nelson et al (2002) identified how LP's gained a wealth of experience and were able to continue to develop clinical skills in the practice area whilst learning new teaching and academic skills in the university. However, in Carnwell's study (2005), LP's working in the acute sector identified that it was difficult to maintain clinical credibility due to the nature of the acute care setting.

#### **3.3.2 Hands-on Care**

By virtue of the nature of the LP role, evidence from the literature outlines an obvious hands-on role for the LP. Interestingly, the reasons for this are polarised with the AiP who often used links with clinical practice to update their own knowledge and skills (Clifford 1995). Lathlean (1997) identified a range of LP's clinical roles which included that of a primary nurse or working as a member of the clinical nursing team. A similar diversity of the LP's clinical roles were identified by Elcock (1998).

Part of Lathlean's study (1997), followed up an in-depth case study with a survey questionnaire to LP's (n=55) working in the institution. LP's were given a list of activities engaged in by the six LP's and were asked to indicate which of the activities described the practice element of their jobs to them. Developing clinical practice (through staff development and support, research, quality assurance "and the like" (p78) (91%); working with or supporting others who actually gave the care (78%); giving clinical advice (76%). Providing direct patient care was identified by 96% of respondents. This was further broken down to demonstrate a range of roles adopted including primary nurse or own caseload (for average 2 days per week) (42%); working



as an associate nurse or team member (40%); occasionally working as a primary nurse or in similar role (15%); working clinically in exceptional circumstances (9%). A very small proportion said that they were rarely able to work clinically (5%).

Other evidence suggest that the LP's value their 'clinical' role. Fairbrother and Mathers (2004) purport that all of the LP's in their study were very positive about the importance they attached to their professional practice proposing that LP should spend at least part of the week doing the same role as their colleagues. In other studies, LP's identify a 'hands-on' teaching role, demonstrated by working with junior nurses (Redwood et al 2002) and teaching by example, an activity also termed as coaching. Richardson et al (2003) identified a similar teaching or coaching role which included working one-to-one at the patients' bedside with a junior nurse; this they saw could assist in the development of competence. As with the AiP role, it appears that the clinical role is both diverse and valued. This was particularly evident under the guise of clinical credibility. Certainly for the AiP clinical credibility was especially important; however, it is considered to be a different concept with the LP evidence.

### **3.3.3 Clinical Credibility**

Clinical credibility in relation to the LP role is key theme within the literature and, as with the AiP literature, adopts differing descriptors and is used interchangeably with the term clinical competence. One example is Lathlean (1997) who links clinical credibility of the LP to that of being able to work clinically, and to clinical competence. By being on the ward the LP could appreciate the value of staff nurse work. Lathlean also links clinical credibility to the LP's authority within practice. One LP in her study had no automatic clinical responsibility but clinical credibility meant that others saw them as people to turn to for advice and guidance on clinical matters (in the broadest sense and not just in relation to individual patient care). Here clinical credibility is linked to education competence.

Only one study (Carnwell 2005) identified an issue for the LP to maintain their clinical credibility. LP's who worked in the acute sector found it more difficult to keep up-to-date their clinical credibility as practitioners. Here Carnwell clearly links clinical credibility to possessing up-to-date clinical skills. The LP's from specialist areas were in a much better position to go back and work in practice. Many of the LP's were specialist nurses felt that keeping up to date meant going back into practice for a week and doing some visits in their own area. However for LP's working in the acute setting 'slotting into a ward setting' was identified as being problematic (Elcock 1998).

Maintaining clinical credibility to address the theory-practice gap was highlighted as a key point in Elcock (1998) study. Findings from the literature review indicated that the LP evidence was almost unanimous in stating that LP's were implemented to address the theory-practice gap and to maintain clinical credibility/competence for teachers. Elcock discovered attributes common to the LP concept. These included the need for the LP to be viewed as a competent practitioner and competent educator; the need to demonstrate excellent interpersonal skills; negotiation skills and excellent time management and organisational skills. Authority to change practice through expert power was also recognised, a concept previously identified from Lathlean's study (1997). However, Elcock's study suggests how the LP concept offers teachers a chance to enhance their teaching by rooting it in practice and to enhance their clinical credibility by utilising their clinical experience to identify appropriate research opportunities. This resonates with an interesting point raised by Fairbrother and Mathers (2004). Following their multi-professional exploration of the LP role, they related credibility to education (theory) as opposed to other people. Fairbrother and Mathers used a quote from an LP in field of law which stated that the LP needs to be "bang up to date in their particular area" (p543). They also suggested that LPs are more equipped to provide students with the finest selections in terms of linking theory to practice if university teaching matches the LP's area of practice expertise.

Similarly, Redwood et al (2002) identified that LP's highly valued their clinical credibility as it was their greatest source of confidence when teaching formally in the university setting. They saw clinical credibility as their unique contribution to the educational process in which they were involved, and the LP role allowed them to experience the reality of practice whilst equally being immersed in practice. Correspondingly, Nelson et al (2002) found that LP's believed that their joint role made teaching easier as they had equal time in both areas. All LP's studied believed this made them credible in the eyes of students, a finding also reported in a study by Fairbrother and Mathers (2004), who clearly report how students do not see them (academics, lecturers) as credible teachers unless immersed in practice. This was due to LP's 'still having a foot in practice' and 'being out there doing the job in the real world' and being able to link theory to practice (Williamson 2004). Across the professions the LP's saw themselves as providing occupational expertise in their professional disciplines, thus giving credibility to the theoretical modules delivered in the universities.

### **3.3.4 Summary**

Evidence about the role of LP within this theme related to keeping up-to-date, maintaining clinical credibility and providing hands-on care. Evidence suggested that a role that allowed the post holder to maintain clinical credibility and competence was a requirement for the development of the role from the outset. The LP literature adopted differing clinical credibility descriptors and was used interchangeably with the term clinical competence. LP's however attached great importance to professional practice and the need to be seen as clinically credible to both practice staff and students. As with the AiP literature the LP often used links with clinical practice to update their own knowledge and skills. Strategies included working as a primary nurse or working as a member of the clinical nursing team.

## **Chapter Four: Discussion**

This review started out with the premise that the ever changing developments in the role of the nurse educationalist in clinical practice has left it shrouded by ambiguity and tension. The changing role has received constant attention from research. As a result, a plethora of evidence exists about the nature of the role. Despite policy rhetoric and the evaluations of the role, the accumulation of this research has never been assimilated in a systematic way, nor used to produce any coherent agreement on what the role of the nurse educationalist should be in practice.

Our review sought to seek out and appraise relevant evidence and by doing so has combined some of the leading authors of research and provided a comprehensive insight into some of the many diverse activities. The range of activities have revealed themes which could help provide future direction to support activities which AiPs are involved in.

### **Patterns of Publishing**

Although the composition of AiP activities is not entirely surprising, the range of activities is broad and diverse. This may be as a result of the disparate authorship uncovered in this review or indeed the diverse nature of the role itself. For example, 30 documents were included in our review which had 46 authors. Twenty-seven of these were unique first authors. These documents were reproduced by 12 publications/publishers: five peer review journals, five higher education or research based organisations, and a book publisher. In some instances reports of the same research project were produced by different publishers, whilst the findings from large reports were divided and presented in different formats and published in different outlets. Similar issues surrounding publication duplication have been cited, notably in other systematic reviews, for example Linde et al 1996, whilst the European Journal of Public Health Policy clearly states that “duplication publication is a form of scientific misconduct” (p79). Other authors (Song et al 2000, Melander et al 2003) hold more moderate views and have debated the duplication of papers

and the potential impact on publication bias. For example, a Health Technology Assessment review explored this problem in some depth. Their work found evidence of publication bias and suggests that all studies need to be registered (Song 2000). Concerns have also been raised by Melander et al (2003) in their discussion about selective reporting – particularly in relation to the pharmaceutical industry. They concluded that the value of systematic reviews should not be disputed; however, anyone relying on published data alone should be cognisant of the problems caused by publication duplication which could be detrimental to the review itself.

Duplication in our review is not deleterious to the findings of this review, though readers should be mindful of this limitation and consider the potential impact on review findings and future research activity within this field. In addition some studies did not reflect all of the themes identified in our review. Whilst many discussed a singular key characteristic of the role activities, these were invariably insular and did not address all the attributes. This is not surprising given the complex and diverse nature of the role. For example, some authors may refer to staff and student related activities (Duffy et al 2001) but not the development of self. This was consistent with the majority of papers (see Table 2) and further compounds the rationale for our review which has drawn together disparate papers and provided a cohesive analysis of the activities of the role of the AiP.

## Table 2 - Patterns of Publication

(Key - *Italics* = First Author; ***Bold Italics*** = Second Author; ***Bold Italics Underlined*** = Third and Subsequent Authors)

Staff	Student related	Self	Publisher
<b><u>Andrewes 2002</u></b>	<b><u>Andrewes 2002</u></b>	<b><u>Andrewes 2002</u></b>	<b><u>UoB</u></b>
<i>Aston 2000</i>	<i>Aston 2000</i>	<i>Aston 2000</i>	<i>NET</i>
<b><u>Aylott 2002</u></b>	<b><u>Aylott 2002</u></b>	<b><u>Aylott 2002</u></b>	<b><u>UoB</u></b>
<b><u>Baguley 2003</u></b>	<b><u>Baguley 2003</u></b>	<b><u>Baguley 2003</u></b>	<b><u>Trent NHS WDC</u></b>
	<b><u>Brown 1994</u></b>	<b><u>Brown 1994</u></b>	<b><u>JPMHN</u></b>
<b><u>Burrows 2002</u></b>	<b><u>Burrows 2002</u></b>	<b><u>Burrows 2002</u></b>	<b><u>UoB</u></b>
<i>Camiah 1998</i>	<i>Camiah 1998</i>	<i>Camiah 1998</i>	<i>NET</i>
	<b><u>Carlisle 1995</u></b>		<b><u>ENB</u></b>

Carnwell 2005	Carnwell 2005	Carnwell 2005	NE Wales HEI
<b>Childs 2002</b>	<b>Childs 2002</b>	<b>Childs 2002</b>	<b>UoB</b>
Clifford 1993	Clifford 1993	Clifford 1993	JAN
Clifford 1995	Clifford 1995	Clifford 1995	NET
Clifford 1999	Clifford 1999	Clifford 1999	JAN
Crotty 1993a	Crotty 1993a	Crotty 1993a	JAN
Crotty 1993	Crotty 1993b	Crotty 1993b	NET
Crotty 1993c	Crotty 1993c		JAN
<b><u>Davis 1994</u></b>	<b><u>Davis 1994</u></b>		<b><u>ENB</u></b>
	Day 1998	Day 1998	ENB
		<b><u>Day 1998</u></b>	<b><u>NET</u></b>
<b><u>Day 2000</u></b>	<b><u>Day 2000</u></b>	<b><u>Day 2000</u></b>	<b><u>ENB</u></b>
Duffy 2001	Duffy 2001		NET
Elcock 1998	Elcock 1998		JAN
		Fairbrother 2004	JCN
Ferguson 2003	Ferguson 2003	Ferguson 2003	Trent NHS WDC
Fisher 2005		Fisher 2005	NEP
	Forrest 1994	Forrest 1994	Lothian College of Health Studies
	<b>Fraser 1998</b>	<b>Fraser 1998</b>	<b>JPMHN</b>
<b><u>Fraser 2000</u></b>	<b><u>Fraser 2000</u></b>	<b><u>Fraser 2000</u></b>	<b><u>NET</u></b>
<b><u>Gray 2001</u></b>	<b><u>Gray 2001</u></b>		<b><u>NET</u></b>
Hardiman 1993			JAN
Jowett 1994	Jowett 1994		NFER
	<b><u>Kirk 1995</u></b>		<b><u>ENB</u></b>
Lathlean 1997	Lathlean 1997	Lathlean 1997	Butterworth-Heinemann
	Luker 1995		ENB
	<b><u>Mallik 1998</u></b>		<b><u>ENB</u></b>
<b>Mallik 2000</b>	<b>Mallik 2000</b>	<b>Mallik 2000</b>	<b>NET</b>
		Mathers 2004	JCN
McElroy 1997	McElroy 1997	McElroy 1997	NET
<b>McSherry 2002</b>	<b>McSherry 2002</b>	<b>McSherry 2002</b>	<b>NEP</b>
Murphy 2000	Murphy 2000	Murphy 2000	JAN
Nelson 2002	Nelson 2002	Nelson 2002	NEP
Owen 1993			JAN
<b>Owen 2003</b>	<b>Owen 2003</b>	<b>Owen 2003</b>	<b>Trent NHS WDC</b>
<b><u>Payne 1994</u></b>	<b><u>Payne 1994</u></b>		<b><u>NFER</u></b>
	Ramage 2004		JAN
Redwood 2002	Redwood 2002	Redwood 2002	UoB
Richardson 2003		Richardson 2003	NCC
<b><u>Riley 1994</u></b>	<b><u>Riley 1994</u></b>		<b><u>ENB</u></b>
Smith 2001	Smith 2001		NET
<b>Turnock 2003</b>		<b>Turnock 2003</b>	<b>NCC</b>

<i>Twinn 1994</i>	<i>Twinn 1994</i>		<i>ENB</i>
<i>Walton 1994</i>	<i>Walton 1994</i>		<i>NFER</i>
<i>Watson 2001</i>	<i>Watson 2001</i>	<i>Watson 2001</i>	<i>NET</i>
<i>White 1994</i>	<i>White 1994</i>		<i>ENB</i>
<i>Williamson 2004</i>		<i>Williamson 2004</i>	<i>JCN</i>

Key:

*JAN = Journal of Advanced Nursing*

*JCN = Journal of Clinical Nursing*

*JPMNH = Journal of Psychiatric and Mental Health Nursing*

*ENB = English National Board for Nursing, Midwifery and Health Visiting*

*NEP = Nurse Education in Practice*

*NET = Nurse Education Today*

*NE Wales HEI = Centre for Health and Community Research, North East Wales Institute of Higher Education*

*NFER = National Foundation for Educational Research*

*Trent NHS WDC = Trent NHS Workforce Development Confederation*

*UoB = Institute of Health and Community Studies, Bournemouth University*

## **The Strength of the Evidence Base**

Using Khan et al's (2001) guidance on carrying out a systematic review, the review team aimed to seek out and include research which was methodologically robust and applicable to the aims of the review. In reality, the publishing disparity impeded this as many of the papers reported on a range of role activities which resulted in limited transparency about the actual research process. This made appraisal of some studies problematic as authors tended to focus on describing the findings as opposed to discussing how they conducted about their research. This subsequently reduced transparency, initially hindering the review and necessitating the location of associated papers and acquisition of full project reports to identify more details of the published studies.

Such is the diversity of AiP roles, that honing down the applicability and relevance of the research was difficult. Although the vast majority relate directly to the aims of our review, it would be fair to say that some studies did not specifically explore the key concepts we searched for. In these instances, findings were used that aided the review and helped develop the inclusion and exclusion criteria.

## **What does the literature tell us?**

What does emerge through the literature are the changes in the quality and robustness of papers since 1990. This could be attributed in part to the requirements of journal editors and publishing criteria, but can also be directed at the lack of empirical rigour applied by researchers, making generalisability of findings very difficult.

To iron out some of the complexities involved, a range of issues debated in the evidence base have been included. Whilst some of these relate directly to the themes uncovered, there are a number of perceptions about the role which will continue to fuel dissatisfaction. Concerns about clinical credibility, empowerment and the teacher 'v' nurse concept, although not relevant to the actual activities described in the evidence, are thought to be major influences of the role and have helped to shape individual roles. So what drives the role? Historical and contemporary policy has provided limited guidance. Furthermore, the NHS is undergoing great changes and with the future of professional regulation uncertain (Nursing and Midwifery Council 2006b) it is unforeseeable that the AiP role will be addressed at any length in the short to medium term. Evidence located in our review reveal recurrent themes, but application is dependent on both the individual and the organisation.

## **Teachers 'v' nurse**

Surprisingly, and given the fact that all lecturers continue to maintain their registration, some no longer perceived themselves as 'nurses' (Forrest et al 1994). What emerges from the literature is that unless a specific academic/clinical role was developed, for example an LP role, the educationalist role took precedence. The role becomes more influential if the teacher becomes involved in clinical activities. This may have been an easy option and welcome relief for those who did not wish to engage in this sub-role anyway, but for others there was a marked shift towards adopting this educational position with the mere movement into a Higher Education setting. A pragmatic position of being an educational resource on teaching, learning and assessment issues was adopted by teachers in such areas as the



promotion of a quality learning environment and supporting the development of students and practitioners.

The shift towards acting as an educational resource has been influenced by other factors. For example, factors such as heavy teaching and administrative workloads may have constrained the opportunities for involvement by teachers in teaching students through patient care activities. Day et al (1998) and Luker et al (1995) identified that following the move of nurse education into higher education, nurse lecturers were trying to gain academic credibility. For lecturers concentrating on this area this meant a definite change of culture within schools of nursing, seeing the clinical role as playing second fiddle to the academic role. Other reasons for reduced 'clinical' input were the wide geographical spread of clinical practice areas and the sheer volume of students that needed supporting in clinical practice (Ferguson 2003). There is also evidence to suggest that many Higher Education Institutions lacked clear guidelines on the role of the lecturer in practice and that lecturers would welcome guidance (Ferguson 2003).

A further reason includes a change in professional policy placing emphasis on the role of mentor in support of student nurses in clinical practice. Courses were developed to educate practitioners, for example the English National Board 998. Currently the NMC indicate a student teaching requirement within their 'Code of Professional Conduct: Standards for Conduct, Performance and Ethics' (NMC 2004d) and their document 'Standards to Support Learning and Assessment in Practice' (NMC 2006a) identify competencies of the mentor in clinical practice. More often than not job outlines of a qualified nurse have a definite teaching role.

Over time clinical credibility and confidence has become reduced in teachers but equally damaging was that teachers were not viewed as either clinically competent or credible by students and practitioners. Ramage (2004) identified how teachers negotiated new roles in what can really be regarded as survival tactics in an attempt to placate professional bodies and employers.

If teachers of nursing do not engage in patient care activities the application of theory to practice could potentially prove difficult; a position which has been highlighted in a recent debate facilitated by the Royal College of Nursing (2006). This debate explored the notion that teachers should be removed from the professional register. However, if this position were to become a reality, clinical credibility would be at risk, therefore the conclusion from the debate thus far advocates that lecturers should remain on the professional register.

Against this backdrop, our review has clearly identified the range of activities that academics engage in with the sole purpose of developing themselves clinically. What has emerged is a lack of consensus in the literature as to what form this role should take. For example should the lecturer work in a 'hands on' role, either with or without a student teaching element or can the academic remain clinically up to date by reading the evidence base and undertaking non-hands on activities? As yet there is no definitive answer emerging from the evidence base.

### **Clinical Credibility**

The concept of clinical credibility was discussed in most of the literature. In particular, our review discerned that clinical credibility still appears to be an ill defined term. Within both the AiP and LP literature the term is used interchangeably notably in relation to the concept of clinical competence. The LP literature suggests that LP's themselves are able to maintain clinical credibility and competence and this is due to the nature of the practice role. This is despite a number of LP's having limited direct patient contact for example as a primary nurse or specialist nurse. In an LP context, credibility is gained through the educational input they offer. This is an aspect of the role which the AiP evidence does not describe. At no point does the evidence emphasise the credibility of the AiP. However, the LP evidence frequently refers to their ability to demonstrate competence and credibility to practice staff and students in the clinical environment and in the university setting.

There is a distinct difference as to how the AiP and LP are referred to when working in clinical practice. This is particularly acute within the sub-theme of communication and liaison. Whilst the AIP is often referred to as a visitor (Camiah 1998) to the clinical area, the LP is often referred to as being visible in the clinical area (Lathlean 1997, Redwood et al 2002). The implications of the difference in terminology could be great and have implications for credibility and empowerment.

### **Context specific role**

Undertaking a systematic review has illustrated the complex nature of the AiP role. Perhaps and unsurprisingly is the revelation that many lecturers in the studies felt a need to be linked to clinical practice areas within which they were 'comfortable'. This return to 'familiar territory' was thought to provide a sense of confidence and therefore credibility within the practice context. As with teaching, some lecturers were opposed to being involved in clinical aspects which they have limited nursing experience whilst others expressed a desire to maintain up-to-date clinical skills in the event of a possible return to practice (Fisher 2005).

The 'safety blanket' which familiar territory offers provides security and is seen to help develop relationships with practice staff. The ability to act as a resource is further enhanced by the AiPs experiential knowledge of the practice environment. It could therefore be surmised that the professional background of the AiP bears some considerable influence on the direction of the role and the responsibilities which the AiP adopts in practice. This was particularly evident in the work of White et al (1994) who discussed the potential differences and viewpoints of adult and mental health lecturer roles in practice. Whilst some may agree with this analysis, there will be others who argue that the AiP doesn't necessarily need to link with 'familiar ground'. Evidence uncovered in this review highlighted a range of research which suggests that the AiP links to and develops the clinical learning environment through generic concepts such as research and mentor updates. Essentially, this does not require a pre-requisite knowledge of the clinical area and if done

in partnership with the practice staff can sustain meaningful relationships which could help to promote and maintain quality clinical learning environments.

To some extent, this contextual versus experiential position was reflected more within the LP evidence which illustrated the differences between the designs of the roles and also highlighted the LP's limited role in assessment. Many argue that key aims of the LP imply reciprocated generic properties. This review has uncovered evidence which revealed similarities and differences between the role of the LP and the role of the AiP. Whilst AiPs reported that a key component of their role related to student assessment, LP's saw this to be the role of the mentor.

The role of LP seems much clearer as each role is usually context specific to the clinical area and invariably had a clear vision for the role from the outset (Lathlean 1997, Elcock 1998, Carnwell 2005). Conversely the AiP literature consistently reported divergent opinions on how the role should be organised. What is evident from the LP literature is that the LP working in clinical practice functions in a senior position which allows them to make overall decisions regarding the clinical learning environment (Redwood et al 2002). However, what is not clear when reviewing LP role activities is whether the activities form part of the Higher Education or clinical practice component of the overall job of the LP.

Interestingly, the NMC document 'Standards to support Learning and Assessment in Practice' (2006a) suggests that academics are able to support learning and assessment in both academic and practice settings. They maintain that academics should spend a proportion of time supporting student learning in practice; the nominal figure of 20% remains prominent but advisory only. This new document does not offer a definitive framework as to how the role should be organised. Instead it is implied that local policy should operationalise the role. However, operationalisation of the role, based on clear outcomes is missing in many institutions according to the literature (Ferguson et al 2003). The NMC do offer a number of strategies which may

be adopted by academics to support practice based learning. These strategies are clearly visible in a range of formats within academics current practice role. The strategies include acting as a clinical or link teacher; preparing, supporting and updating mentors and practice teachers; contributing to practice development and undertaking practice- based education. Higher education institutions who aim to develop or change local organisational policy relating to the role of AIP in light of current professional guidance may need to consider that academics might specialise in teaching, research or practice and that at times these specialities may be in conflict (NMC 2006a).

Concurrently a report commissioned by the Department of Health “Modernising Nursing Careers: Setting the Direction” (2006) recognises that nursing careers must respond to profound changes taking place in the structure and delivery of health care. The vision of a modern career structure must enable practitioners to take on new roles and responsibilities in the context of an evolving health service. This has resulted in practitioners developing a variety of generalist and specialist skills and being able to undertake education and training as required.

Whilst the Department of Health document focuses mainly on clinical careers it does briefly indicate the need for careers in education and research to take place in or between service and the university. This may provide opportunities for joint appointments in the form of Lecturer Practitioners. However, a fundamental issue which nurse teachers need to identify relates to the role they will play in the future development of nurses within a modern health service. There is an increasing emphasis on skill and work based learning, and development, and the delivery of nurse education will have to change in the future to adapt to this. The outcome could result in nurse teachers clarifying what role contribution they will make in delivering these programmes in clinical practice.

## Implications of the Review Findings

Since commencing this review, the NMC has published 'Standards to Support Learning and Assessment in Practice' (2006a) though this omits to provide clear professional direction as to the activities required of the academic in clinical practice. Despite this guidance, academics are still trying to reconcile divergent roles which have increased the frustration felt by many. Whilst some would agree that some guidance is required, it is arguable, that such guidance needs to be relevant, transparent and achievable. Historically, however, academics have been left to define these activities for themselves.

A notable absence in the NMC standards (2006a) is the concept of continued professional development which, within the context of the review, co-exists and informs the wider activities undertaken in connection to clinical staff and students. Our review however has located the concept of 'self' within the evidence base and provided a platform for its acceptance within future role development. Ostensibly, the ability and flexibility to develop one's own role will invariably impact on the learning environment and ultimately the students. To some extent, professional development is seen as a key strategy within the NHS, and whilst scholarly activity is endorsed by HEI's, this doesn't necessarily reflect the need to develop one-self in terms of practice. Readers should be mindful of the need to ensure a central place for developing the AiP and its potential relationship with practice development.

This review has validated the current activities that academics are currently undertaking in their 20% of time recommended to be spent in practice. In addition they are consistent with NMC standards (2006a) and contextualise the role activities within clinical practice. What is evident from our review is the consistency of reported activities of AiP's. Despite disparate interpretations of the role and ambiguous guidance from professional bodies, it would appear that AiP's are functioning in similar ways and adhering to NMC recommendations. This would suggest that boundaries exist within the

role, and that these boundaries, whilst generic, are flexible enough to be applied to a range of contexts.

## Chapter Five: Conclusion

The illusion that the role of the nurse teacher in clinical practice can be operationalised and reduced into a workable description has left many bereft of an adequate solution. The complex nature of the nurse teacher and indeed other positions in health are invariably dictated by the clinical and personal context inherent within the individual. Like nursing, the process and attributes of a lecturer and AiP define conventional definition. This review has illustrated one facet of the AiP role, namely the role activities whilst in clinical practice. This, in itself, has been divided into a plethora of key attributes and responsibilities.

It is interesting to note that each of the three activities (relating to staff, students and development of self) could – theoretically – be undertaken in isolation as much as cohered into a more expansive role. This supports the notion that the role is multi-faceted, sometimes bound within the practice context and professional expertise of the lecturer.

Acknowledging that nurse teachers' primary client base is the student, some might argue that the main foci of the nurse teacher in clinical practice should be devoted to student related activities. It is perhaps surprising the limited amount of time spent developing staff in the clinical setting. The changing nature of the role has witnessed nurse teachers increasingly disengage from providing hands-on care whilst clinical staff act as student mentors. This could rationally account for and justify the time spent developing these staff to provide indirect support to students.

Conversely a host of authors support a polarised view beyond engaging in student related activities. This dichotomy has further blurred the debate and has been responsible for the amount of research attempting to clarify the role. What is evident is the need to ensure that the learning environment and the social, political and professional drivers should be central to the future development of the nurse teacher in clinical practice.



The role of LP seems much clearer on the surface; each role usually being set up according to the needs of the clinical area. However, what is not clear when reviewing LP role activities is whether the activities form part of the Higher Education or clinical practice component of the overall job of the LP. What is evident from the LP literature is that the LP working in clinical practice functions in a senior position which allows them to make overall decisions regarding the clinical learning environment.

In our quest to explore the reality of the AiP role, the research literature represents some mixed, but repeated themes in the literature. The evidence did not yield any research which reported on any single aspect of the AiP role. Instead, we identified disparate publishing often with similar authorship. At present nurse teachers appear to be engaging in activities which they feel comfortable with, but are they doing what they should be doing?

Although nurse teachers and LPs are engaging in similar activities, the lack of purpose has enhanced role ambiguity and direction. There is a need for the purpose of the nurse teacher in practice to be clearly defined to draw a line under the theoretical and political drift surrounding role activity. Ideally this should involve the NMC, the Department of Health, HEI's, practitioners and teachers. This partnership working could help clarify practice activities within the role of the nurse teacher. From this position a working model could be developed, based on this systematic review and evaluation through collaborative research.

Whilst there are no definitive answers or models of practice to be gleaned from the evidence base, the range of activities described that could be used to develop an eclectic model for the future role of the academic in clinical practice. This could be context specific either locally or general for a national audience.

Acknowledging the different political drivers and contractual agreements for HEI e.g. NHS contracts and the NHS, the nurse teacher's AiP role needs to

move with the NHS and non-NHS organisations in order for the role to make a meaningful contribution to the educational structure. What is now needed is for professional groups and employers alike to work together to define the purpose of the role so that it is responsive to nurse education and practice in the future. The findings from our review, specifically the generic themes uncovered, could pave the way for such future development and offer some reassurance for the direction of the AiP role.

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## Appendices

### Appendix 1: List of Terms Used to Describe the Role of Nurse Lecturer in Practice

- Academic in practice
- Clinical facilitator
- Clinical instructor
- Clinical practice facilitator
- Clinical teacher
- Clinical tutor
- Fieldwork educator
- Generic teacher
- Home sister
- Lecturer practitioner
- Link lecturer
- Long arm practice tutor
- Nurse educator
- Nurse lecturer
- Nurse teacher
- Nurse tutor
- Off-site practice tutor
- Practice educator
- Practice link educator
- Practitioner lecturer
- Practitioner teacher
- Theoretical consultant

## Appendix 2: Letter to Named Contact of Potentially Relevant Projects Listed on the National Research Register

12<sup>th</sup> September 2005

«First\_Name» «Surname»

«Job\_Title»

«Address\_1»

«Address\_2»

«Address\_3»

«Address\_4»

«Address\_5»

«Address\_6»

Dear «First\_Name»

My name is Maria Grant and I am a Research Fellow at the Salford Centre for Nursing, Midwifery and Collaborative Research at the University of Salford.

One of the projects I am currently involved in is producing a systematic review of the role of the academic (lecturer in nursing) in clinical practice. As part of the review, I have undertaken a search on the National Research Register and have become aware of your project «**Project\_Title**». This project sounds really interesting, and I would potentially like to include details of it in the review. I wonder if you could tell me more about your findings? Have you produced any internal reports or publications that I might be able to obtain/you could send me?

I would also be grateful if you could advise me of any other research projects in this area, whether on a local, regional or national basis, that you are aware of and consider should be included in the review.

I very much look forward to hearing from you and, if it is of interest to you, would welcome the opportunity to tell you more about our project.

Yours sincerely

Maria J Grant

Research Fellow (Information)

*Salford Centre for Nursing, Midwifery and Collaborative Research (SCNMCR)*

*University of Salford*

*Allerton Building*

*Salford*

*M6 6PU*

*Email: [m.j.grant@salford.ac.uk](mailto:m.j.grant@salford.ac.uk)*

*Tel : 0161 295 6423*

### **Appendix 3: Cover Letter and Call for Grey Literature**



#### **School of Nursing**

The University of Salford

Peel House

Eccles, Greater Manchester  
M30 0NN United Kingdom

T +44(0)161 295 2727

F +44(0)161 295 2963

c.murray@salford.ac.uk

[www.nursing.salford.ac.uk/](http://www.nursing.salford.ac.uk/)

27<sup>th</sup> September 2005

Dear Colleague

Please find enclosed a leaflet requesting any information about research activities which may have been carried out in your place of work around the role of the 'Nurse Lecturer in Clinical Practice'.

The request is to uncover any grey literature on the subject to inform a systematic review being undertaken on the subject.

I would be grateful if you could pass this request on to any personnel who could help inform the systematic review.

Yours faithfully

Cyril Murray  
Senior Lecturer

## CALL FOR INFORMATION

The School of Nursing at the University of Salford is examining the role of the Nurse Lecturer in Clinical Practice. To inform the issue a systematic review of the literature is being undertaken by three nurse lecturers and a research fellow. We are keen to include all “grey literature” on the subject, specifically about any research activities on practices which have been introduced within your Higher Education Institution which may or may not have been published locally.

We would be grateful for any information. Please send this to either:

Cyril Murray Senior Lecturer School of Nursing Peel House Eccles Campus Albert Street Manchester M30 0NN  E-Mail <a href="mailto:c.murray@salford.ac.uk">c.murray@salford.ac.uk</a> Tel: 0161 295 2727	Jackie Leigh Lecturer School of Nursing Peel House Eccles Campus Albert Street Manchester M30 0NN  <a href="mailto:J.A.Leigh4@salford.ac.uk">J.A.Leigh4@salford.ac.uk</a> Tel: 0161 295 2732
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## Appendix 4: Schools of Nursing Contacted as Part of Call for Grey

### Literature

School of Health Studies  
Faculty of Medical Sciences  
University of Newcastle Upon Tyne  
Newcastle  
NE1 7RU

School of Health Studies  
University of Wolverhampton  
Wolverhampton  
WV1 1SB

School of Health Studies  
University of Birmingham  
52 Prichatts Road  
Birmingham  
B15 2TT

School of Health Studies  
Anglia Polytechnic University  
Bishops Hall Lane  
Chelmsford  
CM1 1SQ

School of Health Studies  
University of Lincoln  
Brayford Pool  
Lincoln  
LN6 7TS

School of Health Studies  
Keele University  
City General Hospital  
Newcastle Road  
Stoke  
ST4 6QG

School of Health Studies  
University of Bath  
Claverton Down  
Bath  
BA2 7AY

School of Health Studies  
University of Northumbria  
Coach Lane Campus  
Newcastle Upon Tyne  
NE7 7XA

School of Health Studies  
Sheffield Hallam University  
Collegiat Crescent Campus  
Sheffield  
S10 2BP

School of Health Studies  
University of Manchester  
Coupland III  
Oxford Road  
Manchester  
M13 5DD

School of Health Studies  
University of East London  
Docklands Campus  
4-6 University Way  
E16 2RD

School of Health Studies  
University of Plymouth  
Drake Circus  
Plymouth  
PL4 8AA

School of Health Studies  
University of Hull  
East Riding Campus  
Beverley Road  
Hull  
HU10 6NS

School of Health Studies  
Bournemouth University  
Fern Barrow  
Poole  
BH12 5BB

School of Health Studies  
University College London  
Gower Street  
London  
WC1E 6BT

School of Health Studies  
University of Hertfordshire  
Hatfield Campus  
College Lane  
Hatfield  
AL10 9AB

School of Health Studies  
Manchester Metropolitan University  
Hathersage Road  
Manchester  
M13 0JA

School of Health Studies  
University of Southampton  
Highfield  
Southampton  
SO17 1BJ

School of Health Studies  
University of Sunderland  
Langham Tower  
Sunderland  
SR2 7EE

School of Health Studies  
Leeds Metropolitan University  
Queens Square House  
Leeds  
LS2 8AJ

School of Health Studies  
City University  
Northampton Square  
London  
EC1V 0HB

School of Health Studies  
Chester College of HE  
Parkgate Road  
Chester  
CH1 4BJ

School of Health Studies  
University of Central England  
Birmingham  
B42 2SU

School of Health Studies  
Coventry University  
Priory Street  
Coventry  
CV1 5FB

School of Health Studies  
University of Huddersfield  
Queensgate  
Huddersfield  
HD1 3DH

School of Health Studies  
University of Greenwich  
Southwood Site  
Avery Hill  
SE9 2HB

School of Health Studies  
De Montfort University  
The Gateway  
Leicester  
LE1 9BH

School of Health Studies  
University of Liverpool  
Thompson Yates Building  
Quadrangle Brownlow Hill  
L69 3GB

School of Health Studies  
University of Bradford  
Trinity Road  
Bradford  
BD5 0RB

School of Health Studies  
Edge Hill  
Aintree Campus  
University Hospital  
Longmoor Lane  
Liverpool  
L9 7AL

School of Health Studies  
University of Central Lancashire  
Preston  
PR1 2HE

School of Health Studies  
University of Teeside  
Borough Road  
Middlesborough  
TS1 3BA

School of Health Studies  
University of Nottingham  
University Park  
Nottingham  
NG7 2RD

School of Health Studies  
Brunel University  
Uxbridge  
Middlesex  
UB8 3RH

School of Health Studies  
University of Reading  
Whiteknights  
PO Box 217  
Reading  
RG6 6AH

School of Health Studies  
University of Sheffield  
Winter Street  
Sheffield  
S3 7ND



## Appendix 5: Inclusion and Exclusion Criteria

<b><i>Inclusion Criteria</i></b>	<b><i>Exclusion Criteria</i></b>
<ul style="list-style-type: none"> <li>• Documents describing the activities of academics whilst in practice</li> <li>• Grey literature</li> <li>• Literature reviews which are robust in design and systematically carried out</li> <li>• Models which are in practice or are being tested</li> <li>• Research based articles within a nursing setting</li> <li>• Research based papers derived from Doctoral thesis</li> <li>• Student, practitioners views if nurse lecturer/nurse teachers were included in the sample</li> <li>• Studies published between 1990 and 2006</li> </ul>	<ul style="list-style-type: none"> <li>• Clinically based roles undertaken by a clinician</li> <li>• Medicine and other professional groups</li> <li>• Models which are proposed for the future role of the academic in clinical practice</li> <li>• Nature of the document: Commentary, book review, conference report, conference paper, conference abstracts, editorial or opinion based articles</li> <li>• Research in brief contributions, executive summaries and short reports where the full report has already been included as part of the critical appraisal</li> <li>• Setting: If the study was undertaken in a health service system dissimilar from that within the UK</li> <li>• Stakeholder expectations and perceptions e.g. students and practitioners, where the AiP was not part of the sample</li> <li>• Teaching methods</li> <li>• Non English language</li> </ul>

## Appendix 6: Critical Appraisal Tools

These checklists were developed as part of the following Department of Health funded study:

Long, A.F., Godfrey, M., Randall, T., Brett, A. and M. Grant. (2002). "Developing evidence-based social care policy and practice. Part three: Feasibility of undertaking systematic reviews in social care." Leeds: University of Leeds, Nuffield Institute for Health.

They can be found at <http://www.fhsc.salford.ac.uk/hcprdu/critical-appraisal.htm> [Accessed: 22nd January 2007]

### Qualitative Study

Review Area	Key Questions
<b>(1) STUDY OVERVIEW</b>	
Bibliographic Details	<ul style="list-style-type: none"> <li>• Author, title, source (publisher and place of publication), year</li> </ul>
Purpose	<ul style="list-style-type: none"> <li>• What are the aims of the study?</li> <li>• If the paper is part of a wider study, what are its aims?</li> </ul>
Key Findings	<ul style="list-style-type: none"> <li>• What are the key findings of the study?</li> </ul>
Evaluative Summary	<ul style="list-style-type: none"> <li>• What are the strengths and weaknesses of the study and theory, policy and practice implications?</li> </ul>

Review Area	Key Questions
<b>(2) STUDY, SETTING, SAMPLE AND ETHICS</b>	
Phenomena under Study	<ul style="list-style-type: none"> <li>• What is being studied?</li> <li>• Is sufficient detail given of the nature of the phenomena under study?</li> </ul>
Context I: Theoretical Framework	<ul style="list-style-type: none"> <li>• What theoretical framework guides or informs the study?</li> <li>• In what ways is the framework reflected in the way the study was done?</li> </ul>

	<ul style="list-style-type: none"> <li>• How do the authors locate the study within the existing knowledge base?</li> </ul>
Context II: Setting	<ul style="list-style-type: none"> <li>• Within what geographical and care setting is the study carried out?</li> <li>• What is the rationale for choosing this setting?</li> <li>• Is the setting appropriate and/or sufficiently specific for examination of the research question?</li> <li>• Is sufficient detail given about the setting?</li> <li>• Over what time period is the study conducted?</li> </ul>
Context III: Sample (events, persons, times and settings)	<ul style="list-style-type: none"> <li>• How is the sample (events, persons, times and settings) selected? (For example, theoretically informed, purposive, convenience, chosen to explore contrasts)</li> <li>• Is the sample (informants, settings and events) appropriate to the aims of the study?</li> <li>• Is the sample appropriate in terms of depth (intensity of data collection - individuals, settings and events) and width across time, settings and events (For example, to capture key persons and events, and to explore the detail of inter-relationships)? 18. What are the key characteristics of the sample (events, persons, times and settings)?</li> </ul>
Context IV: Outcomes	<ul style="list-style-type: none"> <li>• What outcome criteria are used in the study?</li> <li>• Whose perspectives are addressed (professional, service, user, carer)?</li> <li>• Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)?</li> </ul>

Review Area	Key Questions
<b>(3) ETHICS</b>	
Ethics	<ul style="list-style-type: none"> <li>• Was Ethical Committee approval obtained?</li> <li>• Was informed consent obtained from participants of the study?</li> <li>• Have ethical issues been adequately addressed?</li> </ul>

Review Area	Key Questions
<b>(4) DATA COLLECTION, ANALYSIS AND POTENTIAL RESEARCHER BIAS</b>	
Data Collection	<ul style="list-style-type: none"> <li>• What data collection methods are used to obtain and record the data? (For example, provide insight into: data collected, appropriateness and availability for independent analysis)</li> </ul>

	<ul style="list-style-type: none"> <li>• Is the information collected with sufficient detail and depth to provide insight into the meaning and perceptions of informants?</li> <li>• Is the process of fieldwork adequately described? (For example, account of how the data were elicited; type and range of questions; interview guide; length and timing of observation work; note taking)</li> <li>• What role does the researcher adopt within the setting?</li> <li>• Is there evidence of reflexivity, that is, providing insight into the relationship between the researcher, setting, data production and analysis?</li> </ul>
Data Analysis	<ul style="list-style-type: none"> <li>• How were the data analysed?</li> <li>• How adequate is the description of the data analysis? (For example, to allow reproduction; steps taken to guard against selectivity)</li> <li>• Is adequate evidence provided to support the analysis? (For example, includes original / raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity - searching for negative evidence, use of multiple sources, data triangulation); reliability / consistency (over researchers, time and settings; checking back with informants over interpretation)</li> <li>• Are the findings interpreted within the context of other studies and theory?</li> </ul>
Researcher's Potential Bias	<ul style="list-style-type: none"> <li>• Are the researcher's own position, assumptions and possible biases outlined? (Indicate how those could affect the study, in particular, the analysis and interpretation of the data)</li> </ul>

Review Area	Key Questions
<b>(5) POLICY AND PRACTICE IMPLICATIONS</b>	
Implications	<ul style="list-style-type: none"> <li>• To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?)</li> <li>• To what population are the study's findings generalisable?</li> <li>• Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?)</li> <li>• What are the implications for policy?</li> <li>• What are the implications for service practice?</li> </ul>

Review Area	Key Questions
<b>(6) OTHER COMMENTS</b>	

Other Comments	<ul style="list-style-type: none"><li>• What were the total number of references used in the study?</li><li>• Are there any other noteworthy features of the study?</li><li>• List other study references</li></ul>
Reviewer	<ul style="list-style-type: none"><li>• Name of reviewer</li><li>• Review date</li></ul>

## Quantitative Study

Review Area	Key Questions
<b>(1) STUDY OVERVIEW</b>	
Bibliographic Details	<ul style="list-style-type: none"> <li>• Author, title, source (publisher and place of publication), year</li> </ul>
Purpose	<ul style="list-style-type: none"> <li>• What are the aims of the study? If the paper is part of a wider study, what are its aims?</li> </ul>
Key Findings	<ul style="list-style-type: none"> <li>• What are the key findings of the study?</li> </ul>
Evaluative Summary	<ul style="list-style-type: none"> <li>• What are the strengths and weaknesses of the study and theory, policy and practice implications?</li> </ul>

Review Area	Key Questions
<b>(2) STUDY, SETTING, SAMPLE AND ETHICS</b>	
The Study	<ul style="list-style-type: none"> <li>• What type of study is this?</li> <li>• What was the intervention?</li> <li>• What was the comparison intervention?</li> <li>• Is there sufficient detail given of the nature of the intervention and the comparison intervention?</li> <li>• What is the relationship of the study to the area of the topic review?</li> </ul>
Setting	<ul style="list-style-type: none"> <li>• Within what geographical and care setting was the study carried out?</li> </ul>
Sample	<ul style="list-style-type: none"> <li>• What was the source population?</li> <li>• What were the inclusion criteria?</li> <li>• What were the exclusion criteria?</li> <li>• How was the sample selected?</li> <li>• If more than one group of subjects, how many groups were there, and how many people were in each group?</li> <li>• How were subjects allocated to the groups?</li> <li>• What was the size of the study sample, and of any separate groups?</li> <li>• Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn?</li> </ul>

	<ul style="list-style-type: none"> <li>• Is information provided on loss to follow up?</li> <li>• Is the sample appropriate to the aims of the study?</li> <li>• What are the key sample characteristics, in relation to the topic area being reviewed?</li> </ul>
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Review Area	Key Questions
<b>(3) ETHICS</b>	
Ethics	<ul style="list-style-type: none"> <li>• Was Ethical Committee approval obtained?</li> <li>• Was informed consent obtained from participants of the study?</li> <li>• Have ethical issues been adequately addressed?</li> </ul>

Review Area	Key Questions
<b>(4) GROUP COMPARABILITY AND OUTCOME MEASUREMENT</b>	
Comparable Groups	<ul style="list-style-type: none"> <li>• If there was more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not?</li> <li>• How were important confounding variables controlled (e.g. matching, randomisation, in the analysis stage)?</li> <li>• Was this control adequate to justify the author's conclusions?</li> <li>• Were there other important confounding variables controlled for in the study design or analyses and what were they?</li> <li>• Did the authors take these into account in their interpretation of the findings?</li> </ul>
Outcome Measurement	<ul style="list-style-type: none"> <li>• What were the outcome criteria?</li> <li>• What outcome measures were used?</li> <li>• Are the measures appropriate, given the outcome criteria?</li> <li>• What other (e.g. process, cost) measures are used?</li> <li>• Are the measures well validated?</li> <li>• Are the measures of known responsive to change?</li> <li>• Whose perspective do the outcome measures address (professional, service, user, carer)?</li> </ul>

	<ul style="list-style-type: none"> <li>• Is there a sufficient breath of perspective?</li> <li>• Are the outcome criteria useful/appropriate within routine practice?</li> <li>• Are the outcome measures useful/appropriate within routine practice?</li> </ul>
Time Scale of Measurement	<ul style="list-style-type: none"> <li>• What was the length of follow-up, and at what time points was outcome measurement made?</li> <li>• Is this period of follow-up sufficient to see the desired effects?</li> </ul>

Review Area	Key Questions
<b>(5) POLICY AND PRACTICE IMPLICATIONS</b>	
Implications	<ul style="list-style-type: none"> <li>• To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects?)</li> <li>• To what population are the study's findings generalisable?</li> <li>• Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?)</li> <li>• What are the implications for policy?</li> <li>• What are the implications for service practice?</li> </ul>

Review Area	Key Questions
<b>(6) OTHER COMMENTS</b>	
Other Comments	<ul style="list-style-type: none"> <li>• What were the total number of references used in the study?</li> <li>• Are there any other noteworthy features of the study?</li> <li>• List other study references</li> </ul>
Reviewer	<ul style="list-style-type: none"> <li>• Name of reviewer</li> <li>• Review date</li> </ul>



## Mixed Methods Study

Review Area	Key Questions
<b>(1) STUDY OVERVIEW</b>	
Bibliographic Details	<ul style="list-style-type: none"> <li>• Author, title, source (publisher and place of publication), year</li> </ul>
Purpose	<ul style="list-style-type: none"> <li>• What are the aims of this paper?</li> <li>• If the paper is part of a wider study, what are its aims?</li> </ul>
Key Findings	<ul style="list-style-type: none"> <li>• What are the key findings of the study?</li> </ul>
Evaluative Summary	<ul style="list-style-type: none"> <li>• What are the strengths and weaknesses of the study and theory, policy and practice implications?</li> </ul>

Review Area	Key Questions
<b>(2) STUDY, SETTING, SAMPLE AND ETHICS</b>	
The Study	<ul style="list-style-type: none"> <li>• What type of study is this?</li> <li>• What is the intervention?</li> <li>• What was the comparison intervention?</li> <li>• Is there sufficient detail given of the nature of the intervention and the comparison intervention?</li> <li>• What is the relationship of the study to the area of the topic review?</li> </ul>
Context I: Setting	<ul style="list-style-type: none"> <li>• Within what geographical and care setting is the study carried out?</li> <li>• What is the rationale for choosing the setting?</li> <li>• Is the setting appropriate and/or sufficiently specific for examination of the research question?</li> <li>• Is sufficient detail given about the setting?</li> <li>• Over what time period was the study conducted?</li> </ul>
Context II: Sample	<ul style="list-style-type: none"> <li>• What was the source population?</li> <li>• What were the inclusion criteria?</li> <li>• What were the exclusion criteria?</li> <li>• How was the sample (events, persons, times and settings) selected?</li> </ul>

	<p>(For example, theoretically informed, purposive, convenience, chosen to explore contrasts)</p> <ul style="list-style-type: none"> <li>• Is the sample (informants, settings and events) appropriate to the aims of the study?</li> <li>• If there was more than one group of subjects, how many groups were there, and how many people were in each group?</li> <li>• Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn?</li> <li>• What are the key characteristics of the sample (events, persons, times and settings)?</li> </ul>
Context III: Outcome Measurement	<ul style="list-style-type: none"> <li>• What outcome criteria were used in the study?</li> <li>• Whose perspectives are addressed (professional, service, user, carer)?</li> <li>• Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)?</li> </ul>

Review Area	Key Questions
<b>(3) ETHICS</b>	
Ethics	<ul style="list-style-type: none"> <li>• Was Ethical Committee approval obtained?</li> <li>• Was informed consent obtained from participants of the study?</li> <li>• How have ethical issues been adequately addressed?</li> </ul>

Review Area	Key Questions
<b>(4) GROUP COMPARABILITY</b>	
Comparable Groups	<ul style="list-style-type: none"> <li>• If there was more than one group was analysed, were the groups comparable before the intervention? In what respects were they comparable and in what were they not?</li> <li>• How were important confounding variables controlled (e.g. matching, randomisation, or in the analysis stage)?</li> <li>• Was this control adequate to justify the author's conclusions?</li> <li>• Were there other important confounding variables controlled for in the study design or analyses and what were they?</li> <li>• Did the authors take these into account in their interpretation of the findings?</li> </ul>

Review Area	Key Questions
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<b>(5) QUALITATIVE DATA COLLECTION AND ANALYSIS</b>	
Data Collection Methods	<ul style="list-style-type: none"> <li>• What data collection methods are used in the study? (Provide insight into: data collected; appropriateness and availability for independent analysis)</li> <li>• Is the process of fieldwork adequately described? (For example, account of how the data were elicited; type and range of questions; interview guide; length and timing of observation work; note taking)</li> </ul>
Data Analysis	<ul style="list-style-type: none"> <li>• How are the data analysed?</li> <li>• How adequate is the description of the data analysis? (For example, to allow reproduction; steps taken to guard against selectivity)</li> <li>• Is adequate evidence provided to support the analysis? (For example, includes original/raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity - searching for negative evidence, use of multiple sources, data triangulation); reliability/consistency (over researchers, time and settings; checking back with informants over interpretation)</li> <li>• Are the findings interpreted within the context of other studies and theory?</li> </ul>
Researcher's Potential Bias	<ul style="list-style-type: none"> <li>• What was the researcher's role? (For example, interviewer, participant observer)</li> <li>• Are the researcher's own position, assumptions and possible biases outlined? (Indicate how these could affect the study, in particular, the analysis and interpretation of the data)</li> </ul>

<b>Review Area</b>	<b>Key Questions</b>
<b>(6) POLICY AND PRACTICE IMPLICATIONS</b>	
Implications	<ul style="list-style-type: none"> <li>• To what setting are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?)</li> <li>• To what population are the study's findings generalisable?</li> <li>• Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?)</li> <li>• What are the implications for policy?</li> <li>• What are the implications for service practice?</li> </ul>

<b>Review Area</b>	<b>Key Questions</b>
<b>(7) OTHER COMMENTS</b>	

Other Comments	<ul style="list-style-type: none"><li>• What were the total number of references used in the study?</li><li>• Are there any other noteworthy features of the study?</li><li>• List other study references</li></ul>
Reviewer	<ul style="list-style-type: none"><li>• Name of reviewer</li><li>• Review date</li></ul>

## Appendix 7: Summary of Studies Included in the Review

Author and Date	Research Methodology	Sample and Data Collection
<p>Aston, L., M. Mallik, et al. (2000). "An exploration into the role of the teacher/lecturer in practice: Findings from a case study in adult nursing." <i>Nurse Education Today</i> 20(3): 178-188.</p>	<p>Mixed Methods</p> <p>3 Phase Study:</p> <ul style="list-style-type: none"> <li>• Questionnaire</li> <li>• Case study</li> <li>• Interviews</li> </ul>	<p>Stage 1 – National questionnaire (Deans of Faculty, Heads of School and Programme Leaders; all branches of nursing and midwifery).</p> <p>Stage 2 - Matrix case study design with 5 university schools (interviews, focus groups).</p> <p>Stage 3 - Interviews members Education Consortia for 5 schools.</p>
<p>Camiah, S. (1998). "Current educational reforms in nursing in the UK and their impact on the role of nursing lecturers in practice: a case study approach." <i>Nurse Education Today</i> 18(5): 368 - 379.</p>	<p>Mixed Methods</p> <p>Longitudinal case study including:</p> <ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Interviews</li> </ul>	<p>Tutorial staff, senior health professionals and students in either their second or third year of studies nominated by Dean or school heads as being highly skilled.</p>
<p>Carnwell, R. (2005). An exploration of the influence of lecturer practitioner, mentor and link tutor roles on the integration of theory and practice in the curriculum: final report. Wrexham, North East Wales Institute of Higher Education, Centre for Health and Community Research.</p>	<p>Mixed Methods.</p> <ul style="list-style-type: none"> <li>• Interviews</li> <li>• Questionnaires</li> <li>• Focus group interviews</li> <li>• Discussion groups</li> </ul>	<p>Phase 1 - LP's across North Wales, plus Newi and Bangor were interviewed</p> <p>Phase 2 - Stratified sample of mentors within four case study areas.</p> <p>In addition 61 link tutors (the entire population) were selected. A questionnaire was sent to both groups.</p> <p>The student group was selected through stratified random sampling.</p> <p>Phase 3 - Focus group interviews of Senior NHS and HEI managers.</p> <p>Four discussions groups were</p>

		held – 3 with Senior Nurse Managers from Trusts and one from the two HEI's involved
Clifford, C. (1993). "The clinical role of the nurse teacher in the United Kingdom." <i>Journal of Advanced Nursing</i> 18(2): 281-289.	Mixed Methods <ul style="list-style-type: none"> <li>• Questionnaire survey</li> </ul>	66 teachers in one English college of nursing
Clifford, C. (1995). "The role of the nurse teacher: concerns, conflicts and challenges ." <i>Nurse Education Today</i> 15: 11-16.	Mixed Methods <ul style="list-style-type: none"> <li>• Questionnaire survey</li> </ul>	Four colleges of nursing in England
Clifford, C. (1999). "The clinical role of the nurse teacher: a conceptual framework." <i>Journal of Advanced Nursing</i> 30(1): 179-185.	Qualitative <ul style="list-style-type: none"> <li>• Semi-structured interviews</li> </ul>	Large college of nursing in England
Crotty, M. (1993a). "The changing role of the nurse teacher." <i>Nurse Education Today</i> 13(6): 415-20.	Mixed Method <ul style="list-style-type: none"> <li>• Delphi survey</li> <li>• Interviews</li> </ul>	Stage 1 – Delphi survey had 3 rounds.  25 out of 28 colleges implementing Project 2000 participated  Stage 2 – Focus interviews from 6 colleges.  12 teachers chosen out of 201. No rationale provided
Crotty, M. (1993b). "Clinical role activities of nurse teachers in Project 2000 programmes." <i>Journal of Advanced Nursing</i> 18(3): 460-4.	Mixed method <ul style="list-style-type: none"> <li>• Delphi survey</li> <li>• Interviews</li> </ul>	As in Crotty 1993a study, but focused predominantly on the interviews
Crotty, M. (1993c). "The emerging role of the British nurse teacher in Project 2000 programmes: a Delphi survey." <i>Journal of Advanced Nursing</i> 18(1): 150-7.	Mixed Method <ul style="list-style-type: none"> <li>• Delphi survey</li> </ul>	Delphi survey had 3 rounds.  25 out of 28 colleges implementing Project 2000 participated.  Out of 1000 teachers, 201 started the survey and 151 completed all 3 rounds
Day, C., D. Fraser, et al. (1998). <i>The role of teacher/lecturer in practice: researching professional education</i> . London, English National Board for	Mixed method <ul style="list-style-type: none"> <li>• Survey</li> <li>• Case study</li> <li>• Focus group</li> </ul>	Phase 1 - National survey Deans of Faculty, Heads of School, Programme Leaders, Heads of Service Units, Lecturers, students,

<p>Nursing, Midwifery and Health Visiting.</p>	<ul style="list-style-type: none"> <li>• Interviews</li> </ul>	<p>practitioners</p> <p>Phase 2 - Case study 5 Higher Education Institutions</p> <p>Phase 3 - Case Study 6<sup>th</sup> Higher Education Institution and interviews consortia members</p>
<p>Duffy, K. and H. E. Watson. (2001). "An interpretive study of the nurse teacher's role in practice placement areas." Nurse Education Today 21(7): 551-558.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>• Interpretive design</li> <li>• Focus Groups</li> </ul>	<p>18 lecturers from different branches in Scotland</p>
<p>Elcock, K. (1998). "Lecturer practitioner: a concept analysis." Journal of Advanced Nursing 28(5): 1092-8.</p>	<p>Concept analysis</p>	<p>Literature review formed basis of data collection and analysis</p>
<p>Fairbrother, P. and N. J. Mathers (2004). "Lecturer practitioners in six professions: combining cultures." Journal of Clinical Nursing 13(5): 539-546.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>• Modified grounded theory</li> </ul>	<p>3 Northern universities</p> <p>LP's in post (11 interviewed)</p> <p>Two heads of Department who had previously been LP's were also interviewed</p>
<p>Ferguson, K., S. Owen, et al. (2003). The clinical activity of mental health lecturers in higher education institutions: report prepared for the Mental Health Care Group Workforce Team. Mansfield, Trent NHS Workforce Development Confederation.</p>	<p>Mixed Methods</p> <ul style="list-style-type: none"> <li>• Survey</li> <li>• Focus group</li> <li>• Interview (face to face and telephone)</li> </ul>	<p>Phase 1 - Survey questionnaire Heads of departments and Schools in all Higher Education Institutions in England</p> <p>Phase 2 - Focus group and interview (face to face and telephone)academic staff involved in mental health teaching</p>
<p>Fisher, M. T. (2005). "Exploring how nurse lecturers maintain clinical credibility." Nurse Education in Practice 5(1): 21-9.</p>	<p>Qualitative</p> <p>Focussed group interviews</p> <p>Individual interviews</p>	<p>Purposive sample of six senior lecturers involved in pre-registration nursing who were known to the researcher</p>
<p>Forrest, S. and N. Brown (1994). "The clinical role of the nurse teacher: an exploratory study of the nurse teachers' present and ideal role in the clinical area." Edinburgh, Lothian College of Health Studies.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>• Semi-structured questionnaire</li> <li>• Focus groups</li> <li>• Interviews</li> </ul>	<p>11 nurse teachers</p> <p>13 staff nurses</p> <p>30 learner nurses</p> <p>12 ward managers.</p>

<p>Hardiman, R. H. (1993). "Teachers' experiences of their role following the implementation of Project 2000: a qualitative approach." <i>Journal of Advanced Nursing</i> 18(7): 1023-32.</p>	<p>Qualitative</p> <p>Modified grounded theory</p> <ul style="list-style-type: none"> <li>• Informal interviews</li> </ul>	<p>Interviewed six nurse teachers</p> <p>No information about sample selection</p>
<p>Jowett, S., I. Walton, et al. (1994). <i>Challenges and changes in nurse education: a study of the implementation of Project 2000</i>. Slough, National Foundation for Educational Research (NFER).</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>• Questionnaires</li> <li>• Interviews</li> </ul>	<p>Undertaken in 6 of the 13 first round demonstration sites for Project 2000.</p> <p>Stage 1 - A questionnaire to practice placement staff on wards which were selected at random by senior managers.</p> <p>A questionnaire to all students from the first intake of the six demonstration sites</p> <p>Stage 2 – Every 4<sup>th</sup> questionnaire was selected and a sample drawn for selection for interviewing against the characteristics of age, gender and educational qualifications on entry and to the Branch programme undertaken.</p> <p>Interviews were held with practice based staff, managers, HE staff and nurse educators. For some group this occurred over four rounds</p>
<p>Lathlean, J. (1997). <i>Lecturer practitioners in action</i>. Oxford, Butterworth-Heinemann.</p>	<p>Mixed Method</p> <ul style="list-style-type: none"> <li>• Ethnography</li> <li>• Survey</li> </ul>	<p>Longitudinal study of six LP's.</p> <p>Interview study of the people working most closely with the LP's.</p> <p>Survey of all LP's in the study institution.</p>
<p>Luker, K. A., C. Carlisle, et al. (1995). <i>The evolving role of the nurse teacher in the light of educational reforms</i>. London, English National Board for Nursing, Midwifery and Health Visiting: 249.</p>	<p>Mixed Method</p> <ul style="list-style-type: none"> <li>• Case Study</li> <li>• Modified delphi study (exploratory questionnaire,</li> </ul>	<p>Random sample of UKCC register</p> <p>Modified Delphi Study using random and purposive sampling (geographical and clinical speciality)</p>



	<p>focus group interviews, final questionnaire, telephone interview)</p>	<p>Questionnaire to nurse teachers (n=60)</p> <p>In-depth interview with nurse teachers (n=10)</p>
<p>McElroy, A. (1997). "Developing the nurse teacher's role: The use of multiple focus groups to ensure grassroots involvement." <i>Nurse Education Today</i> 17(2): 145-149.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>Action research with focus groups</li> </ul>	<p>Ten focus group involving 52 teachers.</p> <p>No information on sampling approach used</p>
<p>Murphy, F. A. (2000). "Collaborating with practitioners in teaching and research: a model for developing the role of the nurse lecturer in practice areas." <i>Journal of Advanced Nursing</i> 31(3): 704-714.</p>	<p>Qualitative</p> <p>Action research</p> <ul style="list-style-type: none"> <li>Questionnaire</li> <li>Focussed interviews</li> </ul>	<p>Opportunistic sample.</p> <p>No criteria identified.</p> <p>Questionnaire used with students, practitioner and the lecturer/researcher.</p> <p>The practitioners were interviewed</p>
<p>Nelson, L. and R. McSherry (2002). "Exploring the lecturer/practitioner role: individuals perceptions of the lived experience." <i>Nurse Education in Practice</i> 2(2): 109-18.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>Unstructured interviews</li> </ul>	<p>Purposive sample from one university.</p> <p>The 'lived experience' of six LPs were explored</p>
<p>Owen, S. (1993). "Identifying a role for the nurse teacher in the clinical area." <i>Journal of Advanced Nursing</i> 18(5): 816-25.</p>	<p>Qualitative</p> <p>Action research</p> <ul style="list-style-type: none"> <li>Situation analysis</li> <li>A ward learning environment questionnaire</li> <li>Observations</li> <li>Fieldwork journal</li> </ul>	<p>One psychiatric ward used but no details provided.</p> <p>The research involved working in collaboration with the permanent staff.</p>
<p>Ramage, C. (2004). "Negotiating multiple roles: link teachers in clinical nursing practice." <i>Journal of Advanced Nursing</i> 45(3): 287-296.</p>	<p>Qualitative</p> <p>Grounded theory</p> <ul style="list-style-type: none"> <li>Interviews</li> </ul>	<p>Sample was purposive and theoretical. Initially link lecturers and clinical teachers.</p> <p>As interview data was analysed, selective sampling of participants later occurred based on theoretical</p>

		<p>relevance.</p> <p>Interviews held with link lecturers, clinical teachers, LPs, joint appointees, professional development staff in trusts, ward managers, clinical nurse specialists</p>
<p>Redwood, S., J. Childs, et al. (2002). Beyond closing the gap: an evaluation of the lecturer-practitioner role. Bournemouth, Institute of Health and Community Studies, Bournemouth University.</p>	<p>Qualitative</p> <ul style="list-style-type: none"> <li>• Case study</li> </ul>	<p>Poole Hospitals NHS Trust</p> <p>10 LP's working in the Trust and 17 managers</p>
<p>Richardson, A. and C. Turnock (2003). "An evaluation of critical care lecturer practitioners." Nursing in Critical Care 8(6): 240-7.</p>	<p>Mixed Methods</p>	<p>Newcastle upon Tyne NHS Trust in conjunction with Northumbria University</p> <ul style="list-style-type: none"> <li>• Doctor (17)</li> <li>• Nurse (112)</li> <li>• Physiotherapist (6)</li> <li>• University Staff (8)</li> <li>• Manager (9)</li> </ul>
<p>Smith, P. and B. Gray (2001). "Reassessing the concept of emotional labour in student nurse education: role of link lecturers and mentors in a time of change." Nurse Education Today 21(3): 230 - 237.</p>	<p>Qualitative</p> <p>Drawing upon ethnomethodology and feminist methods</p> <ul style="list-style-type: none"> <li>• Interviews</li> <li>• Focus Groups</li> <li>• Questionnaires</li> <li>• Participant and non participant observation during student nurse classes in CFP</li> </ul>	<p>Opportunistic and purposive sampling occurred of students from 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> year of training, qualified staff and GP's.</p> <p>Lecturers were also involved but no details were provided</p> <p>Open interviews used initially and were then complemented by the other methods identified</p>
<p>White, E., E. Riley, et al. (1994). A detailed study of the relationship between teaching, support and supervision and role modelling in clinical areas within the context of project 2000 courses. London, English National Board for Nursing,</p>	<p>Mixed Methods</p> <ul style="list-style-type: none"> <li>• Case study</li> </ul>	<p>P2000K course students, staff and tutors in three centres and two nurse branches</p>

Midwifery and Health Visiting.		
Williamson, G. R. (2004). "Lecturer practitioners in UK nursing and midwifery: what is the evidence? A systematic review of the research literature." Journal of Clinical Nursing 13(7): 787-95.	Systematic review	Research into or evaluation of LP role in nursing or midwifery in the UK