NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

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DECLARATION

I, Alida Hettie Viljoen, declare that this research report is my own work. It is being submitted for the degree of Master of Science (Nursing) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signature .....

Date.....

Protocol Number M 131197

DEDICATION

I dedicate this to my late mother, Lilibet van Zijl. I ended with this degree where you started your nursing career: This is full circle for me. Thank you for always being my pillar of strength, my inspiration, role model and mentor.

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I thank God for His grace upon me every day. Your blessings have enabled me to do this.

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ABSTRACT

Background. The preceptorship model is widely used in both undergraduate and postgraduate nursing education. Primarily, preceptors engage in preceptorship to share knowledge, obtain recognition and achieve job satisfaction. However, the same preceptors are facilitating integration of newly hired staff in Intensive Care settings and these experiences are relatively unknown. Preceptors are highly qualified and valued staff, who undertake this role in addition to their nursing responsibilities and the risk of burnout exists if asked to assume additional obligations without appropriate rewards and support. Consequently, needs and expectations necessitate understanding so that preceptors, preceptees and clinical facilities may benefit from such programmes.

Purpose. The purpose of the study was to examine the relationships amongst preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role.

Method. A non-experimental, descriptive, correlational and quantitative survey design and a non-probability purposive sampling method were applied and used in this study. The setting for the research is the Intensive Care Units (n=13) of four major academic hospitals, including public and private sector, in Gauteng Province. The sample comprised of 80 (n=80) Intensive Care registered nurses, employed throughout the Intensive Care Units (n=13). Data was collected by means of a self-administered questionnaire (Dibert & Goldenberg, 1995) and participants were asked to rate all the items independently on a 4-point Likert scale.

Findings. Data analysis determined the incidence of preceptor's perceptions of the benefits, rewards, support and commitment to the preceptor role. Preceptors perceive there are benefits for the preceptor in preceptorship. The commitment of preceptors, if

rewarded and part of a beneficial goal, was seen with a positive response. The study indicated that if preceptors perceive there to be support for their role, their commitment to the role of preceptorship increases. Years of experience, age and gender had no significant role in the preceptor commitment.

Conclusion. Preceptors are committed to their role. It is the responsibility of the nursing education, health care institutions and nursing practice to provide benefit, rewards and support to sustain this role. Research in qualitative and quantitative studies on preceptorship is needed on this topic.

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

The Intensive Care environment is an emotional and intellectually challenging environment, which requires advanced knowledge, habitually applied skill and understanding of the value of caring holistically (Farnell & Dawson, 2006). The Intensive Care environment is one of patients with high acuity, fast actions related to critical thinking and an overload of technology. Technical mastery is essential to the caring of the Intensive Care patient (Farnell & Dawson, 2006; Karanikola et al, 2012) and the Intensive Care Unit (ICU) can be overwhelming for the new nurse. The ICU is an environment that needs excellent basic nursing care and ever improving specialised nursing care.

One of the biggest challenges nursing has been faced with, is the shortage of nurses (Dracup et al, 2012). There have been numerous strategies to ensure the profession will be able to provide the much needed nurses, including financial incentives, better working conditions, shorter working hours (Ihlenfeld, 2005). Still the profession is struggling to maintain adequate numbers of nurses to ensure continuity of patient care. The nursing profession has many areas of speciality and each area is doing everything possible to maintain itself. The shortages leave the inexperienced nurses exposed to the ICU environment and having to make decisions they are not experienced or trained to do. This leaves the nurse with feelings of helplessness and isolation. In the Intensive Care Units, the shortages of nurses has led to innovative strategies to maintain adequate staffing and hospitals have developed recruitment and retainment policies to ensure adequacy of staff. The staff see the strategies, which include a well–supported and valued workforce, as attractive to work with (Young, 2001). To ensure a well-supported workforce in a

profession that faces the loss of numerous experienced staff, the retainment of experience was also a strategy to be explored. Preceptorship is one such a strategy.

Preceptor programmes are widely used internationally in undergraduate and postgraduate nursing programmes, as well as in graduate programmes in hospitals (Morton-Cooper & Palmer, 1993). According to Bain, (1996) the preceptor model is used to bridge the gap between education and practice by helping practitioners to achieve confidence in their practice and to facilitate transition into their new role. The preceptor, an experienced clinical nurse, holds a dual role which includes carrying out nursing responsibilities, whilst providing orientation, supervision and guidance of a new graduate or student on a one-to-one basis.

1.1 BACKGROUND OF THE STUDY

Preceptorship has been in existence since the beginning of time. In its purest form it is the relationships that assist with the transfer of knowledge and skill from parents to their children; a father sharing his expertise as a carpenter to his son, a mother sharing the secrets of her cooking. Over the years the term has been refined and redefined. Preceptorship has been involved in most occupations and has changed from being the sharing of the family trade to allowing others to share theirs. Historically the term mentor was derived from a relationship that Odysseus allowed when he entrusted the upbringing of his son to his friend (May et. al., 1982).

Preceptorship is not a unique concept to nursing but represents an important strategy to clinical nursing education (Myriak & Yonge, 2005). Preceptorship is arguably an important dimension of nursing, whereby an experienced nurse helps new nurses to gain considerable knowledge and consolidate their ability to care for patients in the practice environment (Myriak & Yonge, 2005).

The preceptor model is used in an attempt to bridge the gap between education and practice by helping practitioners gain confidence in their practice and facilitating their transition into the new role (Bain, 1996). Preceptorship is a short-term relationship between a novice (preceptee) and an experienced person (preceptor) who provides individual attention to the preceptee's learning needs and provides feedback regarding performance. This enables the preceptee to move towards making independent decisions, setting priorities, managing time and providing skilled patient care (Muir et. al., 2013)

Literature often presents confusing terminology about preceptorship. In some countries the word "mentorship" is used to describe the process, while in others, especially the United Kingdom, mentorship describes the relationship that occurs between student nurse and the qualified nurse who supervises them in placements (Muir et al.,2013). However, in some countries the word "preceptorship" is used to describe the relationship between a newly qualified nurse and an experienced nurse. In this study the term preceptor will be used to describe the latter relationship.

A preceptor is defined by Smith, (2006) as a "competent, confident and experienced nurse who assists another nurse or nursing student in giving quality nursing care by guiding, directing, or training." This time-limited nature of the relationship was viewed by Wilson, (2000) as a transitional period until the novice practitioner has achieved some form of role transition, while Benner (1984) supported the progressive role development in achievement of expertise. Usher et al., (1996) described the preceptor is an experienced nurse who holds a dual position, which includes carrying out of nursing responsibilities, whilst providing orientation, supervision and guidance of new graduates or students on a one-to-one basis. Preceptors engage in the activity primarily to share knowledge, facilitate integration of newly hired nurses and obtain recognition and job satisfaction (Shamian and Inhaber, 1985; Yonge et al. 1989). Maddison, Watson and Knight, (1994) stated that preceptors are usually selected for the role as they are perceived by their supervisors or

authority figures to be knowledgeable and skilled and able to assume the responsibility of the newcomer.

Dibert and Goldberg, (1995) were among the first authors to study intrinsic and extrinsic rewards and benefits of preceptorship in nursing. Overall the study found that preceptors are likely to be committed to the role of preceptor when there are worthwhile benefits, rewards and supports (Dibert & Goldenberg, 1995). In literature, the most commonly cited benefits include opportunities to teach and influence practice and broaden one's own knowledge and stimulate thinking, reflect and evaluate one's own practice and see and participate in the growth and development of the novice nurse to be a more confident practitioner (Alspach, 1989; Hales, Karshmer, Williams, Mann & Robbins, 2004; Hyrkas and Shoemaker, 2007). Examples of benefits included pay differential and educational advantages, luncheons, journal subscriptions, tuition waivers, letters of recommendation and opportunities to attend conferences (Alspach, 1989; Usher et al., 1999).

Contradictory findings have been reported concerning the relationship between the rewards of preceptorship and job satisfaction. Earlier studies (Yonge et. al., 1989) reported job satisfaction even though increased workload was recognised as a disadvantage. Some reports have described the preceptor role as stressful (Bizek&Oermann, 1990; Yonge et. al., 2002), whilst others have indicated that preceptorship may actually help to prevent or reverse burnout (McGregor, 1999; Yonge et al., 2002).

Preceptors need support from educators, managers and administrators and the forms and means of support needed from each are different (Speers et al., 2004). Support from educators is, however, most essential to nurses staff who engage in the preceptor role, as they support preceptors with student issues and ultimately reinforce the values of the profession (Hales et al., 2004). Alspach, 1989, found that administrative support was

provided mostly by head nurses and less so by nursing and hospital administrators. Usher et al., (1999) have confirmed that support from the institution and fellow workers is vital for participation as a preceptor.

Hyrkas & Shoemaker (2007) replicated the study of Dibert & Goldberg, (1995) with the aim of increasing the current understanding of preceptorship. The study found the preceptors had higher perceptions of the benefits and rewards than earlier studies (Dibert & Goldberg, 1995; Usher et al., 1999), but perceptions about support were lower in comparison with findings from the study of Dibert and Goldberg, (1995). Overall the study found that the preceptor role is undergoing changes associated with many factors, including workplace environment, type of nursing and preceptees' varying learning needs (Hyrkas & Shoemaker, 2007).

1.2 PROBLEM STATEMENT

International trends have demonstrated that the preceptorship model is widely used for undergraduate and postgraduate nursing education programmes. However, the preceptors are also supporting newly hired staff in the Intensive Care settings and these experiences are relatively unknown. A literature survey shows no studies to-date have been conducted in South Africa to identify the preceptor's perceptions of the role. Further, preceptors are highly qualified and valued staff members who take on the role of preceptor in addition to their nursing responsibilities and the risk of 'burnout' exists if they are asked to assume additional obligations without appropriate reward and support. As the role of the preceptor is multi-factorial, evolving and complex, there is a need to increase the understanding and current knowledge about preceptorship today and preceptors perceptions of the benefits, rewards and commitment to the role.

1.3 RESEARCH QUESTIONS

The researcher attempted to answer the following questions:

- What is the relationship between preceptors perception of benefits and rewards associated with this role and the preceptors' commitment to the role?
- What is the relationship between the preceptors' support for the preceptor role and the preceptors' commitment to the role?
- What is the relationship between the preceptors' years of nursing experience and the preceptor's perceptions: (a) perception of benefits and rewards associated with the preceptor role; (b) perception of support for the preceptor role; (c) commitment to the role?
- What is the relationship between the number of times the preceptor has acted as a preceptor and the preceptor's: (a) perception of benefits and rewards associated with the preceptor role; (b) perceptions of support for the preceptor role; (c) commitment to the role?

1.4 PURPOSE OF THE STUDY

The purpose of the study was to examine the relationships among preceptor's perceptions of benefits, rewards, supports and commitment to the preceptor role. The findings will be used to answer the research questions and make recommendations for improvements of the future role of the preceptor in the clinical practice settings in Gauteng.

1.5 OBJECTIVES

The objectives of the study were:

- to explore, describe and compare the relationships among preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role.
- to elicit the extent to which years of nursing experience has on the preceptors' benefits, rewards, support and commitment to the preceptor role.
- to describe and make recommendations for improvements in the future role of the preceptor in the clinical practice settings in Gauteng.

1.6 SIGNIFICANCE OF THE STUDY

This study is significant to the preceptee as it will describe the needs of the preceptor. By being able to identify the preceptor's needs, organisations can support and reward the preceptor more effectively. Once the preceptor feels well supported and rewarded there is improved commitment to their role in preceptorship. The greater the commitment by the preceptor, the greater the preceptorship of the preceptee. This study is significant because the South African Nursing Council (SANC) and FUNDISA have chosen a preceptorship model as an educational strategy in an attempt to narrow the theory to practice gap that exists in clinical practice and to improve the standards and quality of nursing care, thereby also meeting higher education requirements. (FUNDISA, 2012)

1.7 PARADIGMATIC PERSPECTIVES

A paradigm is described as a global view on the general perspectives of the complexities of the world. A paradigm is also the magnifying glass that assists us to view the world in more detail, stimulating intellectual curiosity (Polit & Beck, 2012: 94). The paradigm is the

view the researcher has on the world and the material in the setting of the study. In a study, it reduces ambiguity and creates a clear view of the setting (Botma et al., 2010: 50;De Vos et al., 2006).

1.7.1 Meta- theoretical Assumptions

Meta-theoretical assumptions are the views of the researcher, though not testable, which are considered to be true (Polit & Beck, 2012: 96). Nursing is composed of four main concepts, namely the person, health, environment and nursing (Brink, 2013: 26). This study is based on the researcher's meta-theoretical assumptions regarding these four concepts.

- **The person**

The person herein refers to the Intensive Care nurses, managers of Intensive Care Units, clinical facilitators, preceptors, critically ill patients and the multidisciplinary team. The person is a unique individual and is recognised as a holistic being composed of body, mind and spirit. Each person is part of a family, community and society and integrated and interactive with their health, environment and nursing. The critically ill patient is the central focus of the Intensive Care Unit, Intensive Care nurse and the multidisciplinary team. The constant in the twenty four hour care provided is the Intensive Care nurse. The Intensive Care nurse interacts with the other persons involved, but remains the constant factor to the patient in the Intensive Care Unit. The Intensive Care nurse needs to be competent, multi- skilled, with up to date knowledge and skill to improve the patient outcomes and needs to have well developed knowledge and integrated skill usage on the multiple technological advancements in ICU. The teaching/transfer of knowledge, skill, attitudes and values requires the Intensive Care nurse to be involved in relationships that have the

ability to ensure this, as well as a sense of commitment to his/her role as preceptor in the form of benefits, rewards and support.

- **Health**

Health is body, mind and spirit being in a state of homeostasis. Disease and illness cause this state of homeostasis to be disturbed, whether by the patient's internal or external environment. The critically ill patient in an Intensive Care Unit is almost fully reliant on the Intensive Care nurse to restore the patients homeostasis related to health. The competencies needed by the Intensive Care nurse to help facilitate this return of homeostasis are determined by the health needs of the patient. The competencies needed to ensure patient's improvement of health are met through a variety of programmes and relationships. It is however aggravated through the critical shortage of nurses not only in ICU, but in all categories of nursing. In the setting of this study the loss of competent, expert nurses from the profession is a concern to ensure the competencies needed are maintained. The shortage also contributes to increased workload on the Intensive Care nurse and the lack of transfer of expertise in the environment.

- **The Environment**

The environment is composed of the internal and external environment. In the ICU, the multidisciplinary team primarily focuses on healing the haemodynamically unstable body and at a later stage of recovery may address the patient's mind and spirit. However, the Intensive Care nurse is responsible for ensuring a therapeutic environment in the ICU within which to provide comprehensive holistic nursing care to the seriously ill patient. The complexities and risks in an ICU related to patients' diseases, technology, practices and colleagues, requires the Intensive Care nurse to keep up to date with the latest developments. The ICU is a learning environment and provides for learning opportunities

for the Intensive Care nurse in all phases of his/her development. The ICU is also a highly dynamic, complex and demanding environment. The ICU nurse needs to be well adjusted and supported in this environment.

- **Nursing**

Critically ill patients need to be able to entrust ICU nurses with their lives. Patients' significant others need to know their loved ones are cared for by competent and honest Intensive Care nurses. The ICU nurse needs to sensitively implement the scientific nursing process into holistic caring for the critically ill in ICU. Evidence based practice provides the Intensive Care nurse with the tools with which to effectively and efficiently carry out his/her work. The expanded role of the Intensive Care nurse requires critical thinking skills to correctly interpret and analyse information, make accurate decisions and judgements about the patient, plan for and implement various complex interventions, evaluate the response thereof and reduce risks. Once working in the ICU after registration, the Intensive Care nurse is faced with an overwhelming continual amount of new information to process and master. Inexperienced nurses in ICU need to be precepted and coached to develop their knowledge and skill to develop competency (Brenner, 1984). The Intensive Care nurse needs support and development during the shortage of nurses, in order to retain and recruit nurses. Knowledge and skill development provides for the career and professional development of the Intensive Care nurse and the speciality nursing of Intensive Care. The benefits of preceptorship on continued learning has reciprocal benefits on ICU patients' outcomes

1.7.2 Theoretical Assumptions

The following theoretical assumptions derived from the literature review in relation to the preceptor, preceptorship, preceptee, outcomes are applicable in this study:

- Preceptorship assists in the transfer and safe keeping of valuable integrated theory-clinical expertise and assisting to develop nursing professionals.
- Preceptor is a clinical expert that assists nursing staff to socialise into ICU, integrate theory/clinical knowledge and improve the clinical practice of such a person.
- Preceptee is an individual that is guided, socialised and under the supervision of the preceptor in order to adapt to the ICU environment

The central theoretical statement is that improved patient outcomes are dependent on the Intensive Care nurse's current competency and authentic practice. Assisting the authentic practice development is Preceptorship as a strategy.

1.7.2.1 Operational definitions

Definitions for the purpose of this research are as follows:

- Critical / Intensive Care nursing

Critical Care nursing involves caring for patients and families who are experiencing life threatening illness or injury. Although Critical Care nursing can be applied in any setting, such as pre-hospital, or in the trauma unit, this term has been used interchangeably with Intensive Care nursing. Within the highly technological environment, nurses are required to have a broad knowledge base, display higher levels of decision-making skills and demonstrate a high regard for patients and families who are in vulnerable circumstances (Bucher & Melander, 1999). The same meaning is adopted in this study.

- Critical/ Intensive Care nurse

A Critical Care nurse is a clinical nurse who functions at an advanced level of patient care in a multidisciplinary nursing environment. She or he may be formally trained – a registered nurse with no formal ICU qualification, or formally trained.

According to the South African Nursing Council (SANC), a Critical Care nurse is a registered nurse who obtains an additional qualification in medical-surgical nursing: Advanced Medical and Surgical Nursing: Critical Care (Regulation 212 and amended: 119:2). In this study, a Critical Care nurse is one who has had training at a SANC, (1985) approved learning facility (university or college) under the Regulation 212 or informal training through orientation and in-service training.

- Preceptor

In this study, a preceptor is an experienced nurse, a resource person and role model for preceptee(s) in one-to-one, one-to-two or one-to-three/multiple relationship(s, who facilitates and evaluates learning, fosters independence, development of skills and competencies, confidence and socialisation of students or newly hired nurses to the nursing role through direct involvement in the teaching-learning process in clinical settings over a predetermined period of time defined by educational institution or employer (Bain, 1996; Hyrkas & Shoemaker, 2007:516; Letizia & Jennreich, 1998; Ryan-Nicholls, 2004; Stevenson, 1995).

- Perception

Perception is defined an idea, a belief or image that someone has as a result of how he/she understands something (Wehmeier, McIntosh and Turnbull, 2005). In this study, it

refers to the nurse preceptor role. In this study the questionnaire, developed by Dibert and Goldenberg (1995), will be used to determine the perceptions specifically in relation to the key constructs; benefits, rewards, supports and commitment of the preceptors role.

1.7.3 Methodological Assumptions

Methodological assumptions “are the basic underlying truths from which theoretical reasoning proceeds” based on the researcher’s views and approach to the research method, design and validity (Brink, 2013: 28). This relates to the way the research was conducted.

The researcher made use of a quantitative approach as it is concise and narrow, allowing the researcher to focus on a small number of concepts. The researcher was able to use a well-structured procedure in the form of a formal validated instrument to gather the data (Dibert and Goldenberg, 1995). The data was collected in a controlled setting, which gives the researcher the advantage of objectivity upon collecting and analysing of the data. The researcher took a passive role in collecting the data, with a definite distance between the participant and the researcher during collection. Data analysis is a logical, analytical and statistical approach in nature. The researcher adopted a functional approach to the study, in that the research was undertaken for the purpose of improving clinical practice and accepts the practical benefits of the research process and a criterion of truth, thus the study was contextual rather than universal (Burns and Grove, 2005).

The advantages of this approach are threefold. The approach is a highly efficient to communicate information due to the technology that supports the data analysis. It has the ability to model/represent the perceptions of the preceptors and allows the researcher to infer the data collected. The last advantage is the “powerful language” that is well established in quantitative approaches. It assists the researcher to have competence in

her interactions with the world, in other words, to present and make recommendations on the research done (Tredoux and Durrheim, 2013:5).

1.8 OVERVIEW OF RESEARCH METHOD

The study made use of a non-experimental, descriptive, correlational and quantitative design. A survey approach, using a questionnaire by Dilbert and Goldenberg (1995), was used to collect the data.

The setting for this study is the adult Intensive Care Units at four major academic hospitals in the Gauteng Province. These Intensive Care Units are responsible for the education and training of Intensive Care nurses through a dynamic partnership with a single public and private nursing college.

The thirteen adult Intensive Care Units of the selected institutions were considered by the researcher to be homogenous. The intensive care units represented specialised private sector Intensive Care Units, which accept critically ill patients from both medical and surgical disciplines. Some of the units accept patients in the cardiothoracic and neurosurgical specialities and others receive only trauma-related injuries. The number of official beds ranged from 8 to 30 Intensive Care beds per unit. Assigned nursing staff to patients generally follows a 1:1 ratio in the acute period of illness. Nurses practicing in these units have access to specialist health care professionals and technical support services on a 24-hour basis.

The population included all registered nurses working in the adult Intensive Care Units of the one public and three private hospitals, who were invited to participate in the study to ensure as representative sample as possible. The sample size was achieved according to

the response rate. Purposive sampling method was used to select the widest variety of participants typical of the population under study.

A survey instrument developed by Dibert and Goldenberg (1995), identified in literature and previously published studies (Hykas & Shoemaker, 2007; Usher et. al., 1999) was used to achieve the study objectives. The self-administered questionnaire contains four parts: Preceptors Perception of Benefits and Rewards (PPBR), Preceptor's Perception of Support (PPS) scale, Commitment to the Preceptor Role (CPR) Scale and a demographic sheet.

Face and content validity was tested by the developers in the sample of the original study (Dibert & Goldenberg, 1995) and further tested on a sample of 59 preceptors. Reliability analysis of the three scales (PPBR, PPS and CPR) was reported by Dibert and Goldenberg, (1995) as having alpha coefficients of 0.91, 0.86 and 0.87, respectively. Two subsequent independent cross-cultural studies (Hyrkas & Shoemaker, 2007; Usher et al., 1999) were found that utilised this questionnaire on independent samples of preceptors. These authors reported that alpha coefficients of the three scales were similar to the original study. Permission to use the instrument was sought from the developer (Dibert & Goldenberg, 1995) prior to commencement of the study.

Permission was sought and obtained from the CEO of the hospitals being requested to participate in the study (refer **appendix D**), then permission of the nursing services manager was obtained and thereafter the unit managers were approached. The researcher visited the respective Intensive Care Units and observed the respective allocation list for selection of participants. Those Intensive Care nurses who agreed to participate in the study were given an information letter outlining the study and its procedures (refer **appendix A**). A consent form was given to the respondents (refer

appendix B). Completed self-administered questionnaires were returned in sealed unmarked envelopes provided by the researcher.

Descriptive and inferential statistics was used for analysing the data. Nominal scaled variables were displayed as numbers and percentages (section two and four), interval scaled variables (section one to three) was reported as mean values and standard deviations. The following statistical tests were used in this study:

- Percentage, mean and standard deviation. The mean scores are not for the purpose of testing, rather to demonstrate the magnitude of the difference of opinion and the direction of the opinion.
- Statistical tests included the Cronbach's reliability alpha and Pearson's correlation coefficient (r), Spearman test (rho) and student t-tests. Testing was done on the 0.05 level of significance ($p<0.05$) and ensured a power of at least 95% accuracy of findings (to determine the direction and strength of interval scaled variables relationships of preceptor's perceptions).

Statistical assistance was obtained from a statistician at the Medical Research Council (MRC). Thematic analysis was applied to the qualitative written responses (fifth section of the questionnaire) and verified by the supervisor.

1.9 ETHICAL CONSIDERATIONS

The following ethical requirements were taken into consideration during and prior to the study.

- Submitted protocol for peer review to the Department of Nursing Education to assess the feasibility of the proposed study.

- Submitted protocol to the University Postgraduate Committee for permission to conduct the study.
- Application for ethical clearance to conduct research to the Human Research Ethics Committee (Medical) of the University of the Witwatersrand.
- Application for permission to conduct the study to the Hospital Management and Ethics Committee at the hospital (refer **Appendix D & Appendix E**).
- Informed and written consent was be obtained from all the participants (refer **Appendix A** and **Appendix B**)
- To ensure confidentiality and anonymity of the participants, no names were used during data collection and reporting.
- Participants were informed that participation in the study was voluntary and participants could decline at any time without incurring penalty.
- The data collection instruments were collected and only viewed by the researcher and her supervisor.
- The instrument data was captured electronically and saved on the personal computer of the researcher. This computer was password protected. Participants did not write any identifying information; once the data was captured the researcher used a code to identify the raw data.
- The original data collection instruments were kept secure by the researcher in a locked safe.

1.10 SUMMARY

This chapter of the research report focused on an introduction to the study. The problem is stated, the research questions are posed and the purpose, objectives and importance of the research and the researcher's paradigm are discussed. Terms are defined and essential elements of the report are detailed. The following chapters will include a review

of the literature, methodology, data analysis, description and interpretation of the research findings. Finally, the limitations of the study, summary of the research findings, conclusions and recommendations for further research will be presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Preceptorship is a demanding, complex and challenging method used to teach students. It is not a unique concept to nursing (Billay and Yonge, 2004) and has been gaining in popularity as a clinical teaching strategy over the past 15 years. It has been used in both undergraduate and post graduate programmes (Usher et. al., 1999) and has shown a vast benefit in the integration of theory and clinical practice (Happell, 2009).

In this chapter the researcher addresses preceptorship and various views of preceptorship. The preceptor and their relationship to the preceptee is discussed. The preceptors need for support and their commitment to preceptorship is addressed. The preceptee as a student and newly qualified is explained. The working environment in Intensive Care Units (ICU) and how it affects preceptorship is addressed. The benefit for the preceptor, preceptee and organisations is viewed. The chapter concludes with the preceptorship as a future strategy and preceptorship in practice.

2.2 PRECEPTORSHIP

Preceptorship is a method used to assist a student/newly qualified nurse in the transition and adaption to the new role and environment in which they are placed. It offers a period of support and socialisation into the new role being taken by the student upon achieving their qualification (Bain, 1996; Jiang et. al., 2012).

Hallin and Danielson (2010) describe preceptorship as “stimulating but time consuming.” Preceptorship is a time-limited teaching and learning strategy in the clinical environment where clinical staff act as role models (Harrison-White and Simons, 2012). Preceptorship is an educational relationship between a skilled and experienced individual and a preceptee in need of support in the environment of placement. When preceptorship is present in an environment it assists the preceptor to gain understanding of the nursing profession (Happell, 2009).

Preceptorship assists the preceptee to obtain a professional level of comfort during placement (Happell, 2009). Preceptorship was established to ensure the preceptee has immediate access to an expert to assist on a one-to-one basis to gain positive clinical experience (Myrick et. al., 2010). Preceptorship provides the preceptee with role models and resources to assist them to socialise into the profession. The availability of expertise and role models help the students to close the gap between theory and clinical practice (Giallonardo et. al., 2010; Myrick, 2010) and has been used in both undergraduate and post graduate programmes (Usher et. al., 1999).

For many nurses, the most stressful time of their career is the period immediately after graduation, or the start into a new speciality. Preceptorship is well described in literature as a strategy to assist these nurses and to make best use of the benefits of clinical nursing education in terms of knowledge and skill attainment, confidence and professional socialisation (Happell, 2009).

However, preceptorship is more than just the transfer of knowledge and skill; McKinley (2004) called it a method of fostering human growth. Preceptorship is more than managing, coaching, training and mentoring; even though the mentioned concepts have the potential of being part of the preceptorship, it does not, as a single unit, capture preceptorship (McKinley, 2004). Preceptorship assists the manager to reach the unit goals

and allows for performance management. Preceptoring also coaches the individual to be focused on the goal set. Like training and mentoring, preceptoring also has the purpose of allowing for the acquisition of skill. Preceptorship is a complex process that supports mutual enhancement of independent and critically reflective thinking (Nickle, 2007).

The preceptee in the nursing profession needs to be well adjusted and prepared to enter the profession. The change from student to being a professional nurse can be experienced as a “traumatic transition” (Harrison-White and Simons, 2012). In a practice based project on preceptorship for new nurses it was recommended that preceptorship be mandatory for this group. The positive effect of preceptorship on the transition into the profession led to the development and implementation of a preceptor programme (Harrison-White and Simons, 2012). Having exposure to learning opportunities alone is not sufficient to ensure a confident, competent and compassionate practitioner (Jiang et al, 2012). Myrick et al. (2010) emphasised the importance of preceptorship in the socialisation of new graduates into the profession. Learning through observing role models and drawing conclusions by making use of the expertise in the unit, allows for integration. Socialisation of new graduates into the profession is further supported by Giallonardo et al. (2010), who stated the preceptorship model assists the new graduate to identify the needed behaviours and attitudes through positive socialisation into the profession.

There is a period needed to obtain the necessary knowledge, skill and socialisation to the environment. The socialisation is the process of gaining understanding to the values, behaviours and attitudes necessary to be a professional in the Intensive Care Unit (Farnell & Dawson, 2006).

2.3 DIFFERENT VIEWS ON PRECEPTORSHIP

As the nursing profession developed, the teaching and supervision of the nursing students also developed. Just as a simple concept can get lost in translation, preceptorship changed meaning and is interpreted differently by other countries. Literature often presents confusing terminology about preceptorship.

In the United Kingdom (UK), mentorship describes the relationship that occurs between student nurse and the qualified nurse who supervises them in placements (Muir et. al. 2013; Billay & Yonge, 2004), whilst the term preceptor is used for clinical supervision. The UK has developed the training and supervision of the student nurse into various areas of expertise. The student's theory component is done by a person called a link tutor, who is associated with a higher education institution. Their focus is on knowledge acquisition and curriculum and monitors the preceptors/mentors in the units. Some European countries refer to it as Mentorship (Warne et. al., 2010), whilst Asian countries use the term Preceptorship (Jiang et. al., 2012).

The term mentor is used in the United States of America (USA) and Canada. Mentorship strategies have been implemented to assist the preceptee practitioner to render quality of work practice.

According to Giallonardo et al. (2010), Canada indicates they are moving towards the term preceptor, but according to Billay and Young (2004) and Nickle (2007), Canadians, in some instances, use both terms. Mentorship is used as a term to describe the relationship between the preceptee and the experienced nurse

In Australia, the term clinical facilitator is used to describe the relationship between the student and the person providing the support to adjust to the environment and the person responsible for the supervision of nursing students during their clinical training and placement (Lambert & Glacken, 2006). The Australians use various clinical models in different areas of the country to ensure theoretical clinical integration (Carnwell et al., 2007). The clinical facilitator is regarded as a person with experience and advanced knowledge. The relationship between the clinical facilitator and student is related to a fixed time period (Billay & Yonge, 2004; Fulton et. al., 2007; Lambert & Glacken, 2006). According to Happell (2009), a preceptorship model was explored and found to be the answer to overcome the limitations of the clinical facilitator model used.

In South Africa the terms clinical facilitators, mentors and preceptors are used interchangeably in both the public and the private sector. The term preceptor is used by the South African Department of Health and by South African Nursing Council (SANC) in the new clinical model (Nursing strategy, 2012). The use of the term preceptor is acknowledged by the Forum of University Nursing Deans in South Africa (FUNDISA) (FUNDISA, 2012: 59).

In this study the term preceptorship refers to the relationship between preceptor and preceptee. It is seen, as defined by O'Toole (2003), as the short term relationship between a novice nurse (preceptee) and an experienced nurse (preceptor). The preceptor provides individual attention to the preceptees' learning needs and provides feedback regarding their performance in independent decision making, setting priorities, managing time and providing skilled patient care.

2.4 PRECEPTORSHIP IN THE BUSINESS WORLD AND THE NURSING PROFESSION

Preceptorship in the business world differs from that in the nursing profession. In the business world it typically involves a high ranked member of the organisation and the entrance employee. It also involves promotions, salary increases and partnerships. In nursing, the preceptor and preceptee are commonly of equal qualification, but the preceptor has the experience and expertise to assist the preceptee. They work in the same environment, such as the Intensive Care Unit. In nursing the benefit of promotion or salary increases is not like the business world in reality; in nursing it is more a relationship where both parties have equal qualifications, but are unequal in experience (Rohatinsky, 2008).

2.5 PRECEPTORSHIP AS A RELATIONSHIP

The relationship between the preceptor and preceptee is crucial to the success of the preceptorship(Rohatinsky, 2008). The relationship entails different stages. The first stage is the introductory stage, followed by the stable stage where performance is ensured and then the ending phase. The introductory phase is when the preceptor and preceptee get to know each other and the specific needs of the preceptee is identified. This is where personality clashes, differences in opinion and the rules are established. The stability phase is where the actual development and guiding occurs. Then, as in any formal relationship in education, the preceptee reaches a saturated state where they feel confident and well supported. This leads to the end of the formal relationship (Seekoe, 2014). Preceptorship is an assisting relationship between the clinical expert and the preceptee for a limited time. The preceptee in the relationship can be a student, a newly qualified registered nurse or a specialised nurse. Bruce et al. (2011) described the

preceptor relationship as more formal and active. Preceptorship is structured so that one member coaches, teaches and supervises and the other learns. Preceptorship is also a time limited relationship.

The precepting relationship is seen as an important element of the nurse's satisfaction, allowing for the identification of the individual's development needs and also assisting in the professional development of that nurse (Warne et. al., 2010). A result of the preceptoring relationship with a preceptee, is an increase in the preceptee's work satisfaction. This type of preceptoring relationship ensures professional development (Warne et. al., 2010). The ICU staff/ preceptee need to feel emotionally connected to their unit manager who acts as their preceptor. Unit managers have to be role models and have to allocate time to precept the preceptee regarding patient care (Rouse, 2009).

The relationship starts with a high dependency of the preceptee on the preceptor. There is a great need for input from the preceptor by the preceptee (Dracup et al., 2012). As the relationship develops and the preceptee becomes more self-assured and confident in his or her own practice, the dependency on the preceptor reduces. The preceptor allows the preceptee (not so novice anymore) to function independently, slowly withdrawing until the relationship ends on a formal basis (Dracup et al., 2012).

2.6 THE PRECEPTOR

Preceptorship is provided by a variety of people. The clinical expert, who will take on the role of preceptor, has a solid technical foundation and well adapted critical thinking skills to ensure optimal care for the individual patient. Preceptors assist the student to overcome the uncertainties of the clinical environment. The preceptor is the registered nurse who has not only obtained her post basic Intensive Care qualification, but has also become an expert in the field through experience (Darcup et al., 2012). There might be a

need for some training on how to be a preceptor, as the preceptor needs to be able to guide the student in the environment. Ensuring that patient's outcomes are reached, the student could learn not only the knowledge and skill, but also the value of a task.

The preceptor displays critical characteristics essential to their role. These key characteristics are: the ability and motivation to share knowledge and skill with the preceptee; being able to identify the needs of the preceptee and assisting to meet that need; being thoughtful of the preceptees process of adjustment and integration into the new environment (Kaviani & Stillwell, 2000).

Dube and Jooste (2006) also elaborate on the characteristics that will be of benefit to the preceptee, which are being hardworking, credible, dedicated to their tasks, promote team building, be and promote flexibility and innovation, know weaknesses, have a good ethical code and be responsible for self-development. The preceptor is any person that assists the preceptee to socialise or in the transition into their new role in the profession. The effect of the preceptor on the preceptee can be positive or negative, therefore it is crucial for the preceptor to display the mentioned characteristics. (Dube &Jooste,2006)

The preceptors must have the ability to set goals, assess competencies and give constructive feedback. The preceptor is an active listener and facilitates preceptee development in problem solving skills. There is also a need for understanding the responsibilities and teaching and learning strategies to be utilised. Listening is a skill that preceptors need to acquire to be effective in their role. McKinley (2001) mentioned that listening is a skill that is not well developed in most individuals. Individuals always want to impose their view on someone else. To listen actively is to get absorbed in the persons words. This could be beneficial to both preceptor and preceptee. The preceptor will be able to fully understand the view of the preceptee and be able to build on that. The preceptee will be able to sort out his/her thoughts and views and organise them

(McKinley, 2001). Listening needs to be done in an environment where there is minimal disturbances. The ICU has many distractions in its environment, if the preceptee has to change alarm settings while supposedly listening, another solution needs to be found (McKinley, 2001).

The supervising relationship, or precepting relationship, was an important element in the preceptors work satisfaction. The preceptoring relationship assisted in identifying the students individual learning needs and support them (Warne et al., 2010). The importance of relationship building is emphasised.

The preceptor is able to prioritise care, demonstrate effective time management and participate in reflective clinical practice. It is important to note that the preceptors are not all-knowing resources, but individuals who know and understand their own limitations. Knowing their limitations, the preceptors are aware of available resources to assist them in obtaining the necessary knowledge required. The ability to do self-reflection on their own practice and the will to develop as a professional enables preceptors to deliver high standards of clinical practice at all times (Myriak, 2010)

2.6.1 The Preceptors Need for Support

The support of preceptors during preceptorship is an important component to be considered. The support in the preceptor programme is needed is from various stakeholders, including educational-, administrative- and managerial support. The educational support needed is orientation to the programme, continuous educational development, role definition and orientation (Usher et al., 2009).

Support in the form of workshops on preceptorship and educational development is needed to ensure commitment and success of preceptorship programmes" (Hyrkas &

Shoemaker, 2007). Martensson et al. (2013) support this by indicating that preceptors need sustained acknowledgement and feedback. Also the need for access to sufficient resources was found. Having the educational support assisted the preceptor to feel positive towards preceptorship and the goal of the programme.

Administrative support is needed to ensure continuity and consistency in the schedules, documentation and recording around training. Preceptors need to have the relevant administrative technology and support systems to ensure continued commitment by the preceptor (Dibert and Goldenberg, 1995; Hyrkas and Shoemaker, 2007)

Support from management is crucial and one of the most important factors impacting on preceptors (Aitken et al., 2011). Management need to be clear and supportive regarding time management, as the major barrier in preceptorship is time. The lack of time to be precepted due to the workload and the high demands of the patients in ICU is a concern (Aitken et al., 2011). Various studies indicate the conflict preceptors have with meeting the needs of the preceptee and that of the patient. This conflict means the preceptor has to choose between these two factors and also indicates the added workload of the preceptor (Hyrkas and Shoemaker, 2007; Lui et al., 2010; O' Brien et al., 2013). In Intensive Care Units especially, the demands of the patients make it increasingly difficult to fulfil the role as preceptor (Hyrkas and Shoemaker, 2007; Lui et al., 2010; O' Brien et al., 2013). In Intensive Care Units support related to time management is needed from management, to allow the preceptor sufficient time to meet the needs of both the preceptee and the patient.

Financial support related to education and programme expenditure is required to alleviate some of the perceptors' workload (Dibert and Goldenberg, 1995;Hyrkas and Shoemaker, 2007). Dibert and Goldenberg (1995) claim that such an investment may be lost if administrators fail to support preceptors once in the role. Furthermore, there is a risk of

burnout if these highly qualified and valued staff members are repeatedly asked to assume additional obligations without appropriate rewards or support (Morton-Cooper and Palmer, 1993; Turnbull, 1993). Thus the needs and expectations of preceptors need to be understood so that preceptors, preceptees and clinical facilities may benefit from such programmes.

Preceptors also indicated that time to do their own educational update and preparation for the preceptee is needed. Due to the overall shortage of staff within the nursing profession, the lack of preceptors is a huge concern. The preceptor needs to be an experienced, well developed professional to take up the role of a preceptor (Dracup et al, 2012). Management is required to make the financial and human resource commitment in view of the effect of preceptorship on nursing quality in the long term.

Preceptorship is a time consuming, highly responsible, challenging strategy. Passion and commitment to this strategy is needed to ensure it is sustainable as a teaching strategy. The original study by Dibert and Goldenberg (1995) describes what the benefits and rewards of preceptorship is.

2.6.2 The Preceptor and Commitment

Dibert and Goldenberg's (1995) study indicated a relationship between the benefits, rewards, support and commitment by the preceptors. The more the preceptor perceived the benefit and reward of the preceptor programme, the more committed they were. There was also a positive indication that the more support the preceptor experiences the more committed they are. Usher et al. (1999) contradicted this notion on support and commitment in a replication study. They found little statistical significance between support and commitment. In a third study by Hyrkas and Shoemaker (2007), that revisited the role of the preceptor in the rewards, benefit, support and commitment to the role, a

direct link was found between the preceptor's perception of support and their commitment to the preceptor programme.

2.7 THE PRECEPTEE

The preceptee represents a nurse who is in need of adjustment in the clinical area and can be a student, a newly qualified or an experienced nurse entering a new speciality such as ICU. The preceptee is in need of knowledge, skill, attitude and values of the unit he/she enters and needs socialisation into the new area of work. Students who are busy obtaining a qualification are busy learning skills and professional attributes from a role model (Billay and Yonge, 2004).

2.7.1 The Preceptee as Student

The goal, where the preceptee is a student, is that of meeting the students learning needs based on the curriculum of the educational institution that both the preceptor and student are associated with (Duteau, 2012; Harris, 2007). Harrison- White and Simons (2012) further stated that the preceptor is in the best position to assess the students "fitness to practice." Myrick et al. (2010), describe the dynamics of the preceptor-student interaction and the clear affirmation of the student's role. The preceptor is constant and present in facilitating learning, supporting, building trust, respect and encouraging professional development. The preceptor assists the student to optimise their potential. The role modelling that takes place serves as motivation for the student. Role modelling by the preceptor, indicating how the patient is the centre of the processes, inspires students to be the best caretaker of their patient (White & Simons,2012; Myrick et al. ,2010)

A South African study by Harris (2007) on the perceptions of the students on preceptorship as a work based strategy has been conducted and indicated that preceptorship was a useful strategy to assist the student to develop in their management role. Preceptorship was seen as the “scaffolding” in the learning experience of the student. The preceptoring relationship was seen as beneficial to both the preceptor and the preceptee. The perception of the students on preceptorship was, overall, a positive one. The assistance of a person with experience in an area helped the students with their transition into their new role (Harris, 2007). A study by Jeggels, Traut and Africa (2013) looked at the development of a training programme for preceptors. The training of preceptors in the future would be a key support for the preceptors, as it would assist them to be confident not only in the clinical expertise, but also in the educational strategies to ensure success of the clinical model.

Education and training of nurses in South Africa is regulated by the South African Nursing Council (SANC, 2008). The SANC regulates and ensures training of nurses has both a strong theory and clinical component for all programmes. The SANC also regulates post basic training. The current Diploma in Medical and Surgical Nursing: Critical Care (General) is the programme nurses complete to become Intensive Care trained. This programme has extensive theoretical and clinical components, which are integrated into the clinical setting to ensure good practice. In this research setting, the Nursing Education Institution (NEI) in collaboration with the health service, makes use of clinical facilitators to assist the student in becoming competent. The clinical facilitator guides the students to reach all the expected outcomes of the programme and the students are assessed throughout to ensure the outcomes are reached. As the clinical facilitator cannot be available all the time, the shift leaders are there to further assist the student. The student needs to obtain prescribed skills and knowledge during the period of training and will be found competent in the theoretical and clinical component. The NEI will then register the

student with SANC, who in turn will register the student as a critical care nurse (SANC, 2008).

The researcher identified that once registered, the student would fulfil the role of shift leader. Due to the shortage of ICU trained staff there is no time for socialising the now trained member into her new role. The stress of having to be a leader and taking the responsibility of caring for the ICU patient takes its toll on staff. There is no transition period, or time to gain experience in this new role. It is the expectation of management that the staff member is now an expert. This causes the trained member to experience an immense amount of stress and leads to them leaving the profession to pursue other less stressful avenues.

2.7.2 The Preceptee as a newly Qualified or Specialised Nurse

The preceptor also assists the newly qualified or specialised nurse to adapt to this new environment in which they find themselves (Wolak, 2007). The newly qualified needs not only change her role from student to professional practitioner, but also become comfortable with her practice and learn the know-how and the responsibilities this profession brings. The importance of adequate supervision and support during clinical placement was emphasised. The supervision in the ICU provides the nurse with the support needed to adapt to the environment and its challenges (Duteau, 2012; Harris, 2007; Johansson et al, 2010).

Wolak (2007) found new graduate nurses expressed a need for support to make the transition from student nurse to registered nurse. They have reported feeling overwhelmed and extremely vulnerable and acknowledge the importance of encouragement and guidance during this traumatic and stressful period (Wolak, 2007).

Preceptorship in the international setting is mostly focused on preregistration programmes and new graduates entering a speciality unit such as ICU. Throughout the world preceptorship of new staff to the ICU has been explored and well adapted programmes developed (Juers et al, 2011).

2.8 PRECEPTORSHIP AND THE WORKING ENVIRONMENT

To ensure the preceptee obtains the necessary skill and attributes required, the correct conducive learning environment is needed. Intensive Care environments are emotional and intellectually challenging and require advanced knowledge, habitually applied skill and understanding of the value of caring holistically (Farnell & Dawson, 2006). The Intensive Care environment is one of patients with high acuity, fast actions related to critical thinking and an overload of technology and mastery of this is essential to the caring of the Intensive Care patient (Farnell & Dawson, 2006; Karanikola et al, 2012). The ICU is an environment that needs excellent basic nursing care and ever improving specialised nursing care and can be overwhelming for the preceptee (Karanikola et al, 2012)

The ICU is an environment that offers a wide variety of new learning opportunities which should be utilised to develop nurses and students (O'Kane, 2011). ICU is found to be an area with multiple learning opportunities and students enjoy the challenge of the placement, as long as there was sufficient supervision. Students during placement in the ICU placed higher value on the duration of the placement and the level of supervision provided. The longer the placement the more satisfied and motivated the students were, as it allowed them to not only learn a new skill, but also to integrate it into their theoretical knowledge (O'Kane, 2011).

In an Australian study by Juers et al. (2011), the use of a workplace centred programme was implemented to ensure a minimum level of support and education for all working in

ICU. This programme assists the registered nurse new to the Intensive Care environment to evolve into their role as an Intensive Care nurse. Nurses in the highly complex environment of ICU, need to have sufficient support so as not to feel overwhelmed and out of their depth. Nurses in ICU need to feel a sense of being in control of the workload and meet the needs of patients with a specific quality associated to their care (Farnell & Dawson, 2006).

In the hospital setting, the shortage of nurses in the Intensive Care Units has led to innovative strategies, such as recruitment and retainment policies, to maintain adequate staffing. A hospital with these types of strategies has been successful in retaining staff as they view the strategies as attractive to work with. Recruitment and retaining strategies included a well–supported and valued workforce (Young, 2001). To ensure a well-supported workforce in a profession that faces the loss of numerous experienced staff, the retainment of the experience was also a strategy to be explored. Preceptorship is one such a strategy (Young, 2001)

The patient nurse ratio in South Africa is lower than that of first world countries and makes it increasingly difficult to ensure quality of clinical training. As the nurse patient ratio is so low, it increases the responsibility and workload of the registered nurse. The Nursing Strategy of 2012, published by the Minister of Health, emphasised that nurses have high workloads and that there are a multitude of activities that are non-nursing. This increased workload leads to further shortages of nurses as they leave the profession and country due to the shortages and workloads (South Africa, 2012). Nursing in the South African context, as in the international community, has been faced with the shortages of nurses (Dracup et. al., 2012). There have been numerous strategies to ensure the profession will be able to provide the nurses needed, including financial incentives, better working conditions, shorter working hours (Ihlenfeld, 2005).

2.9 THE BENEFITS AND REWARDS OF PRECEPTORSHIP

The benefactors of preceptorship are the preceptee, preceptor, institution, profession and the patient.

2.9.1 The Benefits and Rewards of Preceptorship for the Preceptee

The benefits for the preceptee include the following: (Rosser et al, 2004; McKinley, 2004; Rohatinsky, 2008).

- Gaining workplace knowledge and expertise
- The ability to use critical thinking as a bridge to close the gap between theory and knowledge
- Enhancing competence and productivity (Rosser et al, 2004)
- Gaining self confidence in clinical practice
- Getting individual recognition and support from the organisation
- Being assisted in career pathway development
- Developing increased professional relationships with experts in the field.
- Being able to balance work and other responsibilities(McKinley, 2004)
- Preceptorship assists in the development of advanced leaders in the profession
- Assists the preceptee to socialise into the profession (Rohatinsky, 2008).

Myrick et al. (2010) further added that the preceptee gets to internalise the values of the nursing profession. Some of the benefits include increased job satisfaction, personal growth and development, advanced leadership skills, self-fulfilment and retention of the mentor and mentee (Rohatinsky, 2008). According to Warne (2010), students who had a preceptor to follow as a role model in practice reported high job satisfaction.

2.9.2 The Benefits and Rewards of Preceptorship for the Preceptor

A benefit for the preceptor is creating a legacy. Satisfaction levels of preceptors are improved due to sharing of information. Having expert influence and seeing development of preceptees, the preceptor improves their own level of knowledge and standard of practice (Dibert & Goldenberg, 1995; Rosser et. al. 2004). This leads to preceptors having an increase in self-confidence and competence and increases networking with professional colleagues (McKinley, 2004). Preceptorship keeps the practice of the preceptor up to date with best practice principles and also increases their self-esteem. It also ensures the development of new solutions (Rosser et. al. 2004). Myrick (2010) added that to engage in authentic leadership is essential to the nurturing of practical wisdom. The preceptor has the opportunity to nurture practical wisdom built up over years of experience and ensure the wisdom is continued within the profession for years to come.

2.9.3 The Benefits and Rewards of Preceptorship for the Nursing Profession and Organisation

The profession and organisation benefit by the continuity of ensured quality care. The organisation develops a culture of satisfied workforce and retains staff, which further leads to the organisational goals subscription, development and promotion (Rosser et al, 2004). Employees in environments where preceptorship structures are in place are more committed to the organisation, are more likely to engage in positive organisational activities and experience less job strain and burnout (Wolak, 2007).

The positive effects of preceptorship include increased job satisfaction, personal growth and development, advanced leadership skills, self-fulfilment and retention of the mentor

and mentee (Rohatinsky, 2008). Creating a positive practice environment by making use of mentoring is used to assist in the recruitment and retention of registered nurses to reduce the shortages the profession faces (Rohatinsky, 2008).

Researchers want to explore and describe the reason for the success of preceptorship, as it is evident that preceptorship is an effective means of improving quality of nurses (Warne et al, 2010). According to Dibert and Goldenberg (1995) there are intrinsic and extrinsic benefits and rewards to preceptorship. Benefits that were of great intrinsic significance were the "opportunity to teach and influence practice, increasing own knowledge base, stimulate own thinking and individualised orientation to meet preceptee learning needs." Improvement of clinical skill, personal and professional growth and job satisfaction was also noted (Dibert and Goldenberg, 1995). The extrinsic benefits include "pay differential, educational advantages, luncheons, journal subscriptions, waver of tuition fee, letters of recommendations and attending conferences" (Hyrkas and Shoemaker, 2007). Hyrkas and Shoemaker, (2007) found there was a direct correlation between the benefits and rewards of preceptors and their commitment to preceptorship.

Usher et al, (2009) found that preceptors were more committed to their role as preceptor due to the benefits and rewards, of which non-material benefits, such as to be recognised as a role model, was considered more important than material rewards. The sustained availability of the benefits and rewards to preceptors is of great importance to the success and continued commitment of preceptors to their role (Usher et al, 2009).

2.10 PRECEPTORSHIP AND FUTURE STRATEGY

The nursing strategy set by the Department of Health, has accepted the new clinical model for nursing. This model includes preceptorship as a means of ensuring effective clinical integration (South Africa, 2012) and is supported by the South African Nursing

Council (SANC) and the Forum of University Nursing Deans in South Africa (FUNDISA). Both have chosen to support a preceptorship model as an educational strategy in an attempt to narrow the theory to practice gap that exists in clinical practice and to improve the standards and quality of nursing care, thereby also meeting higher educational requirements (FUNDISA, 2012: 59). Preceptorship is part of the new clinical model that was suggested to improve the clinical learning of nursing students. This model has various areas that currently are not in full use in the nursing profession. The model advocates the principle of support to preceptors from the nursing education institutions and clinical stakeholders (FUNDISA, 2012: 59).

2.11 RESEARCHER'S REFLECTION ON PRECEPTORSHIP IN PRACTICE

The preceptorship of intensive care students during their clinical placement and training was identified as a gap in research by the researcher. The researcher could find no evidence in the research body of preceptorship of Intensive Care students. Preceptorship of newly qualified or newly appointed staff in ICU has been explored internationally in numerous countries (Ihlenfeld, 2005; Warne et al, 2010). The students who are in the process of obtaining a speciality qualification, work in the ICU environment with the expectation of becoming a specialist leader. These Intensive Care students have a need to develop their own autonomy in their profession, but to do this there needs to be a period of transition. If this transition period does not take place, burnout syndrome comes into play. Burnout amongst younger Intensive Care students leads to higher attrition (Karanikola et al, 2012). Intensive Care students have a clinical facilitator to ensure compliance and obtaining of the outcomes set by the educational institution. The student also needs to be precepted in how to be a self-directed leader, an autonomous leader and practitioner. The expectation of the students upon completion of their studies is to be a competent practitioner and leader. The question to be answered in the South African setting remains, what is the preceptorship availability during clinical placement for the

Intensive Care student and what is the commitment of preceptors towards their role in preceptorship?

2.12 SUMMARY

In this chapter preceptorship was discussed from a literature point of view. Literature introduced the different views of preceptorship and how it is being used in the world and how it has evolved over the years. Different views from around the world on preceptorship and related terms, such as mentorship, were discussed. Preceptorship in the business world and the difference to preceptorship in nursing was discussed. The crucial relationship between the preceptor and preceptee and its context was discussed. Part of the success of preceptorship is the characteristics of preceptors and these characteristics were discussed and made evident as very important to the preceptorship relationship.

The preceptor in relation to benefits, rewards, support and commitment of preceptor to preceptorship were discussed. The preceptee as student and as newly qualified nurse was clarified.

Bringing into account the environment is an added stressor in ICU, difficulties with the environment was discussed. The shortages of nurses play a role in the applicability of preceptorship in ICU and nursing as a whole.

The literature review concluded with a view of preceptorship and the future strategies in South Africa. The development of preceptorship as a model to improve clinical integration, socialisation and quality of nursing care was looked at from the researchers view point.

The next chapter will describe the research method in detail.

CHAPTER THREE

RESEARCH DESIGN AND RESEARCH METHODS

3.1 INTRODUCTION

In this chapter the research design and methods used will be described. A non-experimental, descriptive, correlational and quantitative design was utilised in this study. A survey approach using a questionnaire by Dibert and Goldenberg (1995) was used to collect the data. This chapter illustrates the methods and procedures implemented to achieve the objectives of the study, indicating the means to answer the research questions asked.

3.2 PURPOSE AND OBJECTIVES

The purpose of the study was to examine the relationships amongst preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. The findings will be used to answer the research questions and to make recommendations for improvements of the future role of the preceptor in the clinical practice settings in Gauteng.

The research questions are:

- What is the relationship between the preceptors perception of benefits and rewards associated with this role and their commitment to the role?
- What is the relationship between the preceptors' support for the role and the commitment to the role?

- What is the relationship between the preceptors' years of nursing experience and their: (a) perception of benefits and rewards associated with the preceptor role; (b) perception of support for the preceptor role; (c) commitment to the role?
- What is the relationship between the number of times the preceptor has acted as a preceptor and their: (a) perception of benefits and rewards associated with the preceptor role; (b) perceptions of support for the preceptor role; (c) commitment to the role?

The objectives of the study are:

- to explore, describe and compare the relationships amongst preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role
- to elicit the extent to which years of nursing experience has on the preceptors' benefits, rewards, support and commitment to the preceptor role
- to describe and make recommendations for improvements in the future role of the preceptor in the clinical practice settings in Gauteng.

3.3 RESEARCH DESIGN

The research design in any study is the "blueprint" or "plan." (De Vos et al., 2006:103) The design also ensures the study is done with integrity and within the ethical bounds set out by the ethical principles (Burns & Grove, 2011; De Vos et al., 2006). The design' purpose is to ensure validity of the study by maximising control over the factors that can interfere with the validity. It assists future researchers who would like to duplicate the study to do so within similar context. (Burns & Grove, 2011). To answer the research questions, the research design for this study is a quantitative one. A non-experimental, descriptive, correlational design was used.

3.3.1 Quantitative design

The use of a quantitative design was because there is limited knowledge available regarding the research problem. Quantitative research, according to Burns and Grove (2011: 34), is a "formal, objective, rigorous, systematic process for gathering numerical information." This implies that the data collection was done in a well-structured format. In this study the use of a well-developed, international and peer validated instrument was utilised. Each step was critically examined, quality of data was ensured and contamination minimised (Botma et al., 2010: 39; Burns and Grove, 2011).

3.3.2 Non- experimental design

A non-experimental design was used. This type of design is conducted in the natural setting of the phenomena studied, with minimal interference by the researcher. The researcher wanted to explore the relationship between variables in the natural setting (Brink, 2012). The use of a non-experimental design in this study was appropriate as it took place in the natural setting, which is the unit the participants work in daily. There was also no manipulation of the data collected due to the instrument that was used. The participants completed the instrument, with no influence from the researcher in any way (see ethical considerations) and handed it back.

3.3.3 Descriptive design

The researcher also made use of a descriptive correlational design as very little is known about the problem. A descriptive design was used to describe the perceptions of preceptors on the benefit, reward, support and commitment to preceptorship. The researcher attempted to describe the correlation between the variables that had already occurred (Brink, 2012: 12). A correlation was made between the public and private sector of the various variables to determine the relationship between the two sectors regarding

preceptorship perceptions. A correlation was also made between the demographic data and the benefits, rewards, support and commitment of preceptors (De Vos et al., 2006)

3.4 RESEARCH METHOD

In this study the research method refers to the operational approach of the study which includes methods of data collection, procedure, population, sample and sampling methods and strategies for gathering and analysing the data in the research investigation (Burns & Grove, 2003:51; Polit & Beck, 2012).

3.4.1 Research setting

The research setting describes the actual circumstances surrounding the study when it was conducted. It paints a picture and gives clarity of where and how the study was conducted. The research setting is the natural place where the participant feels comfortable and is accessible, ensuring they feel at ease without any influence to change their behaviour (Polit & Beck, 2012).

The research setting of the study was done in the adult Intensive Care Units at four (n=4) major academic hospitals, in both the public and private sector, in Gauteng Province. These adult Intensive Care Units are responsible for the education and training of Intensive Care nurses through a dynamic partnership with a single public or private nursing college. The ICU's in the private sector are either open or closed units. In closed units, only the Intensivists are allowed to admit a patient into the unit, whereas in open units any physician in the hospital may do admissions. Patients are not screened for suitability to be admitted to the ICU. The public sector has a registrar available to the unit 24 hours a day.

The thirteen (n=13) adult Intensive Care Units of the selected institutions were considered by the researcher to be homogenous as they represented highly specialised private sector Intensive Care Units, which accept critically ill patients from both medical and surgical disciplines. Some of the units accept patients in the cardiothoracic and neurosurgical specialities and others receive only trauma-related injuries. The number of official beds ranged from 8 to 30 Intensive Care beds per unit. Assigned nursing staff to patients generally follows a 1:1 ratio in the acute period of illness. Nurses practicing in these units have access to specialist health care professionals and technical support services on a 24-hour basis.

The public sector had similar units which received neurosurgical, cardiothoracic, trauma and medical related injury patients. The number of beds per unit ranged from 15 to 30. Assigned nursing staff to patients generally follows a 1:1 ratio in the acute period of illness. Nurses practicing in these units have access to specialist health care professionals and technical support services on a 24-hour basis

3.4.2 Population

A population is a gathering of individuals with common characteristics and specifications, who ensure the study is done on the correct group. It also assists future researchers to duplicate the study (De Vos et al., 2004).

In this study all registered nurses working in the adult Intensive Care Units of the chosen institutions were invited to partake in the study. A preliminary record review undertaken in September 2013 indicates there are approximately 100 registered nurses working in the public sector and 98 registered nurses in private sector Intensive Care Units, giving a

combined total population of 198 (N=198) registered Intensive Care nurses in both sectors.

3.4.3 Sample and Sampling Method

The sample is a section of the total population that is representative of the group under study (Brink, 2013:138). All registered nurses working in the adult ICUs of the selected public and private sector settings were invited to participate in the study to ensure a representative sample. The sample size was achieved according to the response rate by participants invited by the researcher. After a discussion with the statistician, a minimum sample size of 70 [n=70] was determined suitable for the study. A non-probability purposive sampling was used, as this method allows the researcher to utilise the available, most suitable participants for the study. (Brink et al, 2013). In the Intensive Care Units, the researcher utilised the staff that met the inclusion criteria. The technique used was purposive sampling, which allows the researcher to select a sample that is familiar with the phenomena. This Sampling method was used to select the widest variety of participants who are typical of the population under study (Brink et al, 2013).

The inclusion criterion for the sample was:

- Intensive Care registered nurses in full time employment
- More than two years of active clinical experience
- Having provided preceptor activities for a new staff member
- Voluntary consent to participate

In terms of the Nurses' Scope of Practice (SANC, 2014) it is an obligation registered nurses have in precepting nursing students, including orientating new staff and/or providing direct support for a new staff member in conjunction with other daily assignments.

3.4.4 Data Collection

Data collection is the process whereby the method deemed appropriate for the study is used to gather the required information by means of the collecting method selected (Polit & Becker, 2012). The purpose is to collect the data with integrity to ensure the research problem can be addressed.

3.4.4.1 Data Collection Instrument

A questionnaire is a set of statements or questions that allow the researcher to elicit a response required form the participants related to the study objectives at hand (Brink, 2013). Questionnaires are one of the methods of obtaining data in a consistent manner as they allow the researcher to have a standardised format for all participants. It is quick and easy if well developed, however the disadvantages are that it is difficult to develop. Participants can manipulate the data by giving answers that are acceptable or by not answering questions. The response rate is generally low (Brink, 2013). A survey instrument developed by Dibert and Goldenberg (1995), identified in the literature by Owens and Tollefson, (1999) was used to achieve the study objectives (see appendix C).

In this study the questionnaire used a Likert scale to measure the participants' perceptions. The Likert scale is frequently used to measure perceptions and consists of a declarative statement and optional responses (Brink, 2013:156). The self-administered questionnaire contains four parts:

- Preceptors Perception of Benefits and Rewards (PPBR)
- Preceptor's Perception of Support (PPS) scale
- Commitment to the Preceptor Role (CPR) Scale

- A demographic sheet.

The PPBR Scale comprises of 14 items rated on a 4-point Likert Scale (1=strongly disagree to 4=strongly agree) concerning rewards and benefits of the preceptor role, followed by the next section, the PPS Scale comprising 17 items that were also rated on the factors contributing to support. The final six questions of this scale were answered if preceptors had experience with either a nurse during orientation (three questions) or had precepted a nursing student (three questions). The CPR scale consists of 10 items rated on a 4-point Likert scale to measure the commitment to the preceptor role.

The fourth section collects demographic data (education, age, gender, experience, type and number of preceptor experiences). After consultation with the statistician and supervisor, a fifth section was added allowing nurse respondents to write any issue relating to the study aims.

3.5 VALIDITY AND RELIABILITY OF DATA COLLECTION INSTRUMENT

Validity refers to the ability of the data collection instrument to measure what it is intended to measure (Brink, 2013). Face validity, a weak type of validity which should always be used with other types, looks at whether the instrument measures what it is supposed to measure. Like content validity, this measures if the instrument measures all the variables possibly involved (Brink, 2013). Face and content validity were tested by the developers in the sample of the original study (Dibert & Goldenberg, 1995) and further tested on a sample of 59 (n=59) preceptors. Reliability analysis of the three scales (PPBR, PPS and CPR) was reported by Dibert and Goldenberg (1995) as having alpha coefficients of 0.91, 0.86 and 0.87, respectively.

Two subsequent independent cross-cultural studies (Hyrkas & Shoemaker, 2007; Usher et al., 1999) were found that utilised this questionnaire on independent samples of preceptors. These authors reported that alpha coefficients of the three scales were similar to the original study.

Permission to use the instrument was sought from the developer (Dibert & Goldenberg, 1995) prior to commencement of the study (see appendix J).

3.6 PILOT STUDY

A pilot study was conducted prior to commencement of the main study, using the collection tool on 10 (n=10) nurse respondents at the study site. A pilot study is a small scale trial run of all the aspects planned for use in the main study. Its purpose is to help the researcher fine-tune the study for the main enquiry and to determine whether the methodology, sampling instruments and analysis are adequate and appropriate (De Vos et al., 2006). The results of the pilot study were not included in the main study.

3.7 PROCEDURE OF DATA COLLECTION

The researcher obtained permission from the four institutions Chief Executive Officer's (CEO) to conduct the study (Refer Appendix I and Appendix H). The researcher then informed the various nursing service managers and selected unit managers of the study to be conducted. The data was collected from 15th March to 7th July 2014.

The researcher visited the respective Intensive Care Units and observed the respective allocation list for selection of participants. The unit managers were also consulted to confirm the participants met the inclusion criteria. Those Intensive Care nurses who

agreed to participate in the study were given an information letter outlining the study and its procedures (refer Appendix A) and a consent form (refer Appendix B). After obtaining consent, the researcher gave the participants the self- administered questionnaire. The participant was given privacy to complete the questionnaire, but the researcher was available to clarify concepts if needed. Due to the nature, the patients with high acuity, fast actions related to critical thinking and an overload of technology of the ICU's, there were instances where the researcher left the questionnaire with the participant and collected it at a later date. Completed self-administered questionnaires were returned in sealed unmarked envelopes provided by the researcher. Where it was necessary to leave the questionnaires with the participants, the relevant unit managers were given an envelope to gather and seal the questionnaires.

3.8 DATA ANALYSIS

Descriptive and inferential statistics were used for analysing the data. Nominal scaled variables are displayed as numbers and percentages (section two and four), interval scaled variables (section one to three) will be reported as mean values and standard deviations. The following statistical tests were used in this study:

- Percentage, mean and standard deviation. The mean scores are not for the purpose of testing but to demonstrate the magnitude of the difference of opinion and the direction of the opinion.
- Statistical tests included the Cronbach's reliability alpha and Pearson's correlation coefficient (r), the Spearman test (rho) and student t-tests. Testing was done on the 0.05 level of significance ($p<0.05$) and ensured a power of at least 95% accuracy of findings. (To determine the direction and strength of interval scaled variables relationships of preceptor's perceptions).

Statistical assistance was sought from a statistician from the Medical Research Council (MRC). Thematic analysis was applied to the qualitative written responses (fifth section of the questionnaire) and verified by the supervisor.

3.9 VALIDITY AND RELIABILITY OF THE STUDY

Reliability refers to the accuracy and consistency of an instrument to the variables (Polit & Beck, 2012). The reliability of the instrument was pre-tested in three previous studies (Dibert & Goldenberg, 1995; Hyrkas & Shoemaker, 2007; Usher et al., 1999). Reliability was maintained by ensuring consistency and accurate recording of data, achieved through compliance by the researcher with the data collection questionnaire.

Being a prospective study, there was no manipulation to the variables and this prevented threats to internal validity. A prospective study also makes it easy to investigate results obtained during the data collection and look at alternative causes that yield the results obtained. External validity on the other hand was ensured by selecting a large sample for the study which was generated from thirteen adult ICUs. This could have been greater if the fifth hospital had participated, nevertheless it was ensured. The characteristics of the sample are representative of those of the population from which it was drawn, thus enhancing generalisability of the results (Polit & Beck, 2012). Face and content validity were ensured by the pilot study that yielded similar results to that of the developers of the instrument (Dibert and Goldenberg, 1995). The pilot study also indicated that the instrument measured what it was supposed to measure. The questions were understandable.

3.10 ETHICAL CONSIDERATIONS

The purpose of research is to generate sound scientific knowledge. This is achieved through the honest conduct, reporting and publication of quality research. Ethical review and clearance before conducting any research is necessary to ensure that the benefits of subjects outweigh the risks and that there is no research transgression (Burns and Grove, 2007). The researcher demonstrated respect to the participants in the following ways:

3.10.1 Self- determination

Participants had the right to self-determination. Participants could decide whether or not they wanted to participate in the study. They had the right to withdraw from the study at any time, to refuse to provide information and to ask for clarification about the purpose of the study. Information regarding the study was provided in writing (Annexure B). Participants were also informed that participation in the study was voluntary and they could decline at any time without incurring penalty.

3.10.2 Protection from harm

No physical harm or discomfort was induced through the conduction of the study. Participants had to complete a self-administered questionnaire. There was also no psychological or social harm, as the topic was not of a nature that would expose the participants to any harm. Furthermore, the identity of the institution was not revealed. The researcher maintained the ethical requirements to ensure the integrity of the data collected as well as the ethical principles and human rights were respected. The ethical requirements were taken into consideration during and prior to the study. The researcher applied for clearance to conduct research to the Committee for Research on Human

Subjects (Medical) of the University of the Witwatersrand. A clearance certificate was received from this committee (refer Appendix F). The researcher also applied for permission to conduct the study from the research operating committee of the private health group. This was obtained and a certificate received (refer Appendix G). The researcher submitted an application for permission to conduct the study to the Hospital Management and Ethics Committee at the public and private hospitals. The various permission letters were received from the four institutions (refer Appendix H and Appendix I).

3.10.3 Anonymity and confidentiality

Anonymity and confidentiality was strictly adhered to. The questionnaire had no identifying criteria. The questionnaires were distributed and the participants were required to return them. The completed questionnaires were only viewed by the researcher. The researcher coded the instruments to maintain the confidentiality of the participants. The completed instruments were protected by being kept in a sealed envelope and then being captured onto an electronic spread sheet that was password protected. (Brink, 2013: 35; De Vos et al., 2006)

The researcher ensured that informed and written consent was obtained from all the participants (refer Appendix A and Appendix B). The consent form was detached from the data collection questionnaire to ensure anonymity of the participants. To further ensure confidentiality and anonymity no names were used during data collection and reporting.

3.10.4 Privacy

Participant's privacy was protected by the researcher not intimidating the participants (Botma et al. 2010:13). The instruments were given and the researcher stepped away. In some instances the researcher was available in the unit should the participants have any questions. There were times the researcher left the instruments with the participants due to the ICU being very busy. This also ensured the participant could complete the questionnaire once they felt comfortable to do so. The researcher's contact details were on the information sheet (refer Appendix A)

3.11 SUMMARY

This chapter consisted of an outlining of the research methodology and the specific design used. The research setting, population, sampling and data collection method was explained. Validity and reliability and ethical considerations were described. The next chapter will discuss data analysis and discussion of the results.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

Data files were set within computer statistical package 'STATA' version 11; data was entered once and then verified during the second direct entry. Descriptive and inferential statistics were used to achieve the study objectives. The descriptive tests (frequency, mean and standard deviation) were used to synthesise nursing participant's demographic and interview schedule. Correlational statistics were employed to describe and synthesise construct scores to compare demographic data of participants with obtained levels of measurements to test for statistical significance. Statistical tests included the Cronbach's reliability alpha and Pearson's correlation coefficient (r), the Spearman test (rho) and student t-tests. Testing was done on the 0.05 level of significance ($p<0.05$) and ensured a power of at least 95% accuracy of findings. Findings will be discussed on construct, scale and item levels. This chapter describes the analysis of data using descriptive and comparative statistical tests and interpretation of findings.

4.2 APPROACHES TO DATA ANALYSIS

Descriptive statistics were used to present interpretation of the demographic data of the participant's gender, age, education, years of experience, years as a preceptor, types and number of preceptor experiences. Frequency distributions and cross tables were used to provide an overall coherent presentation and distribution of the data. Percentages in these findings were taken to the nearest whole number.

The Cronbach's reliability co-efficient alpha was applied to assess the reliability of the summative rating scale (Likert scale) composed of total questionnaire scores for benefits and rewards, support and commitment to the role (construct variables). When comparing items the Pearson's correlation coefficient (r) was applied to test for significance in the frequencies of responses for benefits and rewards, support and commitment to the role. Testing was done on item level to further explore the data. When comparing categorical variables the response was like the latter, the Pearson's correlation coefficient (r) and Spearman (rho) test were used to test for significance or differences in the frequencies of participant responses for benefits and rewards, support and commitment to the role with selected demographic variables (years of preceptor experiences, type and number of experiences). Frequency distributions and cross tables were used to provide an overall summary of the data. When comparing categorical variables the student t-test was applied to test for significance in the frequencies of responses for benefits and rewards, support and commitment to the role and selected demographic variables (age, gender and education). Collapsing of the categories on the Likert scale was done to facilitate presentation of the data, however, it was noted that a larger percentage of participants answered disagree or agree in the itemised analysis. Measurement of central tendency and variation (mean and standard deviation) were used to summarise the data. The level of statistical significance was set at the level of $p<0.05$. A biomedical statistician from the Medical Research Council (MRC) analysed the data using the statistical package 'STATA' version 11.

Because of the homogeneity of the sample the findings may be of interest to other intensive care units, clinical practice and education of Intensive Care nurses.

4.3 RESULTS AND FINDINGS

4.3.1 Demographic Data

This section related to the participant's demographic data, which comprised of eight items. Items included gender, age, education, years of nursing experience, years as a preceptor, type of preceptor experiences and number of preceptor experiences, which were obtained from the participants using a questionnaire. Results of the process are summarised in Table 4.1 for the total sample (n=80). Items were combined to form coherent groups to facilitate discussion of the data.

Table 4.1 Demographic characteristics of participants for the total sample (n=80)

Item	Variable	Frequency				
		n	%	Range	Mean	SD
1.2	Gender					
	Females	68	85.0	-	-	-
	Males	12	15.0	-	-	-
1.3	Age					
	none	5	6.3	-	-	-
	23 – 29	7	8.5	-	-	-
	30 – 39	16	20.0	-	-	-
	40 – 49	27	33.8	-	-	-
	50 >	25	31.3	-	-	-
1.4	Education					
	Hospital certificate	2	2.5	-	-	-
	Diploma	48	60.0	-	-	-
	Bachelor's degree	27	33.8	-	-	-
	Master's degree	3	3.8	-	-	-
1.5	Years of nursing experience	-	-	1 - 49	19.94	10.37

Females accounted for 85.0% (n=68) and males 15.0% (n=12) of the total sample (n=80). The majority (62.3%; n=50) was between the ages of 23 to 49 years and 31.3% (n=25) were in the greater than 50 (>50) age category. It can be extrapolated from these findings that females predominate in the total sample (n=80). However, between age categories indicated opposite higher and lower frequencies in 40 to >50 (65.1%; n=52) and 23 to 39

(28.5%; n=23) age categories implying that in terms of age distribution this is an older population.

The majority (60.0%; n=48) of the total sample held a diploma level nursing education and 33.8% (n=23) had a bachelor degree. Of the total sample (n=80) only 3.8 % (n=3) of the participants had a master's degree. The mean number of years of participants nursing experience was 19.4 (SD 10.37), range varied from 1 to 49 years.

Findings in table 4.1 implies these participants had extensive nursing experience. Findings are shown in Table 4.1

Table 4.2 Participant's preceptorship experiences

Item	Variable	Frequency				
		n	%	Range	Mean	SD
1.6	Years as preceptor	-	-	0 - 30	7.83	7.79
1.7	Types of preceptor experiences with:					
	Newly hired nurses	7	8.75	-	-	-
	New graduates	10	12.50	-	-	-
	Nursing students	7	8.75	-	-	-
	All of the above	46	57.50	-	-	-
1.8	Number of preceptor experiences with:					
	Newly hired nurses	-	-	1-30	3.29	4.51
	New graduates	-	-	1-10	2.61	3.03
	Nursing students	-	-	1-50	5.67	7.30

Of the total sample (n=80), the mean number of years of participant's preceptorship experience was 7.83 (SD 7.79); the range varied from 0 to 30 years. Participant's preceptorship experience with new graduates was 12.5% (n=10) followed by an equal 8.8% (n=7) as newly hired nurses and nursing students. Further, the majority (57.5%; n=46) of these participants indicated experiences with all three categories (newly hired nurses, new graduates and student nurses). Frequencies of preceptor experiences ranged from 1 to 50 (5.57; SD 7.30) in the category of nursing students, followed by 1 to

30 (3.29; SD 4.51) and 1 to 10 (2.61; SD 3.03) in categories of newly hired nurses and new graduates respectively. Findings are show in Table 4.2.

4.3.2 Preceptor's Perceptions of Benefits and Rewards

Participant's perceptions of benefits and rewards formed the next part of the questionnaire (Appendix D), which comprised fourteen (14) questions. Items were combined to form coherent groups to facilitate discussion of the data. Findings are displayed in Table 4.3.

Table 4.3 Preceptor's perception of benefits and rewards

Item	Statement	Participant's responses					
		None		Disagree		Agree	
		n	%	n	%	n	%
2.1	Teach new staff and nursing students	-	-	3	3.75	77	96.25
2.2	Assist new staff and nursing students to integrate into the nursing unit	-	-	1	1.25	79	98.75
2.3	Increase my own professional knowledge base	-	-	-	-	80	100.00
2.4	Keep current and remain stimulated in my profession	1	1.25	3	3.75	76	95.00
2.5	Influence change in my nursing unit	-	-	6	7.50	74	92.50
2.6	Gain personal satisfaction from the role	-	-	5	6.25	74	92.50
2.7	Be recognised as a role model	-	-	3	3.75	77	96.25
2.8	Improve my teaching skills	-	-	4	5.00	76	95.00
2.9	Share my knowledge with new nurses and nursing students	-	-	1	1.25	79	98.75
2.10	Learn from new nurses and nursing students	-	-	5	6.25	75	93.75
2.11	Contribute to profession	-	-	1	1.25	79	98.75
2.12	Increase my involvement in the organisation	1	1.25	7	8.75	72	90.00
2.13	Improve my organisational skills	2	2.50	7	8.75	71	88.75
2.14	Improve my chances for promotion or advancement within the organisation	1	1.25	14	17.50	65	81.25

Items 2.1 to 2.14 on the data collection instrument enquired about how participants perceived the benefits and rewards of the preceptor role. Findings related to item 2.1 revealed 96.25% (n=77) of preceptors responses supported the statement 'Teach new staff and nursing students;' similarly a high response of 98.75% (n=79) of the participants supported the statement 'Assist new staff and nursing students to integrate into the nursing unit' (item 2.2).

Item 2.3 obtained a 100% (n=80) response rate , which supported the statement 'Increase my own professional knowledge base,' whereas 95.00% (n=76) of responses were obtained in support of the statement 'Keep current and remain stimulated in my profession (item 2.4).

Item 2.5 revealed 92.50% (n=74) of the participants responses favoured agreement with the statement 'Influence change in my nursing unit,' whereas only 7.50% (n=6) disagreed to this item. Similarly, item 2.6 revealed 92.50% (n=74) of participants responses were in agreement with the statement 'Gain personal satisfaction from the role,' whereas only 6.25% (n=5) disagreed. Over 96.25% (n=77) of participants responses supported the statement 'Be recognised as a role model' (item 2.7). In item 2.8 majority (95.00%; n=76) of participants responses supported the statement 'Improve my teaching skills'.

Findings related to item 2.9 revealed 98.75% (n=79) of participants responses supported the statement 'Share my knowledge with new nurses and nursing students.' Over 93.75% (n=75) of responses were obtained from the participants that supported the statement 'Learn from new nurses and nursing students' (item 2.10). In item 2.11 98.75% (n=79) of participants responses supported the statement 'Contribute to my profession.' Similarly, in item 2.12, 90.00% (n=72) of participants responses supported the statement 'Increase my involvement in the organisation,' whilst 8.75% (n=7) disagreed.

Findings related to item 2.13 revealed 88.75% (n=71) of participants responses supported the statement ‘Improve my organisational skills,’ whereas 8.75% (n=8) disagreed. Over 81.25% (n=65) of participants responses supported the statement ‘Improve my chances for promotion or advancement within this organisation’ (item 2.14), whereas 17.50% (n=14) were in disagreement.

It can be extrapolated from these findings that participants in this study generally perceived there were benefits and rewards associated with the preceptor role. These findings are shown in Table 4.3.

4.3.3 Participant’s Perceptions of Support

Participant’s perception of support formed the next part of the questionnaire (Appendix C), which comprised seventeen (17) questions. In this part of the questionnaire provision was made for inclusion of six items, particularly for support to new nurses and student nurses. Items were combined to form coherent groups to facilitate discussion of data. Findings are displayed in Table 4.4.

Table 4.4 Preceptor's perceptions of support

Item	Statement	Participant's responses					
		None		Disagree		Agree	
		n	%	n	%	n	%
3.1	I feel I have had adequate preparation for my role as preceptor	-	-	16	20.00	64	80.00
3.2	My goals as a preceptor are clearly defined	1	1.25	18	22.50	61	76.20
3.3	The nursing staff do not understand the goals of the preceptor programme	-	-	31	38.75	49	61.20
3.4	My co-workers on the nursing unit are supportive of the preceptor programme	1	1.25	29	36.20	50	62.50
3.5	My workload is appropriate when I function as a preceptor	2	2.50	34	42.50	44	55.00
3.6	I do not have sufficient time to provide patient care while I function as a preceptor	-	-	37	58.80	33	41.20
3.7	I feel I function as a preceptor too often	-	-	31	38.80	49	61.20
3.8	I feel the nursing coordinates and nursing educators are committed to the success of the preceptor programme	-	-	33	41.20	47	58.80
3.9	Nursing coordinates are available to help me develop in my role as a preceptor	-	-	45	56.25	35	43.80
3.10	Nursing educators are available to help me develop my role as a preceptor	-	-	30	37.50	50	62.50
3.11	There are adequate opportunities for me to share information with other preceptors	1	1.25	24	30.00	55	68.75

Items 3.1 to 3.11 on the data collection instrument enquired about how the participants perceived support for the preceptor role.

Findings related to item 3.1 revealed 80.0% (n=64) of the participants responses supported the statement 'I feel I have adequate preparation for my role as preceptor,'

whereas 20.0% (n=16) disagreed. Over 76.2% (n=61) of responses were obtained for item 3.2 which supported the statement 'My goals as a preceptor are clearly defined.'

Item 3.3 revealed 38.75% (n= 31) of the participants disagreed with the statement 'The nursing staff do not understand the goals of the preceptor programme,' whereas a majority of 61.2% (n=49) agreed with this statement. Similarly, 36.2% (n=29) of the participants disagreed with the statement 'My co-workers on the nursing unit are supportive of the preceptor programme,' whereas the majority (62.5%: n=50) agreed with this statement (item 3.4). Item 3.5 revealed equally divided responses from the participants to the statement 'My workload is appropriate when I function as a preceptor,' 55.0% (n=44) agreed to this item, whilst 42.5% (n=34) disagreed.

Findings related to item 3.6 revealed that 58.8% (n=37) disagreed with the statement 'I do not have sufficient time to provide patient care while I function as a preceptor,' whereas 41.2% (n=33) agreed with this statement. Item 3.7 revealed 61.2% (n=49) of participants agreed with the statement 'I feel I function as a preceptor too often,' and 36.8% (n=31) disagreed. The results indicated that 58.8% (n=47) of responses supported the statement 'I feel the nursing coordinators and nursing educators are committed to the success of the preceptor programme,' whereas 41.2% (n=33) of the responses indicated disagreement (item 3.8). Item 3.9 yielded 56.2% (n=45) of preceptors responses to the statement 'Nursing coordinates are available to help me develop my role as a preceptor,' whereas, 43.8 (n=35).

The results indicated that 62.5% (n=50) of participants responses supported the statement 'Nursing educators are available to help me develop my role as a preceptor' and 37.5% (n=30) disagreed (item 3.10). Item 3.11 revealed 62.5% (n=50) of participants responses supported the statement 'There are adequate opportunities for me to share information with other preceptors,' whilst 37.5% (n=30) disagreed.

It can be extrapolated from these findings that the preceptor's perception of support for the preceptor role reflected varied responses. The item scores in this section are low because a number of participants did not respond to all the items in this section. Findings are show in Table 4.4**.**

Table 4.5 Preceptor's perceptions of support to new staff member

Item	Statement	Participant's responses					
		None		Disagree		Agree	
		n	%	n	%	n	%
3.12	The nursing coordinator provides support by helping me to identify preceptees' and orientees' performance problems	15	19.48	10	12.50	55	68.75
3.13	The nursing coordinators spend too little time with the new student	15	18.75	20	25.00	45	56.25
3.14	The guidelines clearly outline the responsibilities of the nursing coordinator in relation to my preceptor role	14	18.18	10	12.50	54	70.00

Items 3.12 to 3.14 on the data collection instrument enquired about the preceptors perceptions of support to a new staff member.

Findings related to item 3.12 revealed the majority (68.75%; n=55) of responses were in agreement to the statement 'The nursing coordinator provides support by helping me to identify preceptees and orientees performance problems,' whereas 12.50% (n=10) disagreed. The results indicated that 56.25% (n=45) of participants responses supported the statement 'The nursing coordinators spend too little time with the new student,' whereas 25.0% (n=20) disagreed with this statement (item 3.13). Item 3.14 revealed 70.00% (n=54) of participants responses supported the statement 'The guidelines clearly outline the responsibilities of the nursing coordinator in relation to the preceptor role,' whereas 12.50% (n=10) disagreed.

It can be extrapolated from these findings that the participants were generally in agreement that new staff members were adequately supported by nursing faculty. Findings are shown in Table 4.5.

Table 4.6 Preceptor's perceptions of support to nursing student

Item	Statement	Participant's responses					
		None		Disagree		Agree	
		n	%	n	%	n	%
3.15	The nursing faculty member provides support by helping me to identify a student's performance problems	18	23.38	5	6.25	57	71.25
3.16	The nursing faculty member spends too little time with the nursing student	16	20.78	5	6.25	59	73.75
3.17	The guidelines clearly outline the responsibilities of the nursing faculty member in relation to my preceptor role	16	20.78	9	11.25	55	68.75

Items 3.15 to 3.17 on the data collection instrument enquired about the preceptors perceptions of support to a nursing student.

Findings indicated the majority (71.25%; n=57) supported the statement 'The nursing faculty member provides support by helping me to identify a student's performance problems.' The results indicated that 73.75% (n=59) of participants responses supported the statement 'The nursing faculty member spends too little time with the nursing student,' whilst 6.25% (n=5) disagreed (item 3.16). Item 3.17 revealed 68.75% (n=55) supported the statement 'The guidelines clearly outline the responsibilities of the nursing faculty member in relation to my preceptor role,' whereas 11.25% (n=9) of participants disagreed.

It can be extrapolated from these findings that the participants were generally in agreement that nursing students were adequately supported by nursing faculty. Findings are shown in Table 4.6.

4.3.4 Preceptor's Commitment to Preceptor Role

Participant's commitment to the preceptor role formed the last part of the questionnaire (Appendix D), which comprised ten questions. Items were combined to form coherent groups to facilitate discussion of data. Findings are displayed in Table 4.7.

Table 4.7 Preceptor's commitment to preceptor role

Item	Statement	Participant's responses					
		None		Disagree		Agree	
		n	%	n	%	n	%
4.1	I am willing to put in a great deal of effort beyond what is normally expected in order to help the preceptee be successful	-	-	7	8.75	73	91.25
4.2	I am enthusiastic about the preceptor programme when I talk to my nursing colleagues	-	-	10	12.50	70	87.50
4.3	I feel very little loyalty to the preceptor programme	-	-	59	73.75	21	26.25
4.4	I find that my values and the values of the preceptor programmes are very similar	-	-	12	15.00	67	83.75
4.5	I am proud to tell others I am a preceptee	1	1.25	9	11.25	69	86.25
4.6	It would take very little change in my present circumstances to cause me to stop being a preceptor	2	2.50	32	40.00	47	58.75
4.7	There is not much to be gained by continuing to be a preceptor	1	1.25	56	70.00	22	27.50
4.8	I really care about the fate of the preceptor programme in hospital	2	2.50	11	13.75	68	85.00
4.9	Deciding to be a preceptor was a definite mistake on my part	1	1.25	69	86.25	10	12.50
4.10	Being a preceptor really inspires me to perform my very best	1	1.25	6	7.50	73	91.25

Items 4.1 to 4.10 on the data collection instrument enquired how the participants commitment to the role.

Findings revealed 91.25% (n=73) supported the statement 'I am willing to put in a great deal of effort beyond what is normally expected in order to help the preceptee be successful' (item 4.1). The results indicated that 87.50% (n=70) of participants responses supported the statement 'I am enthusiastic about the preceptor programme when I talk to my nursing colleagues,' whereas 12.50% (n=10) disagreed (item 4.2). Item 4.3 indicated 73.75% (n=59) of participants disagreed to the statement 'I feel very little loyalty to the preceptor programme,' whilst 26.25% (n=21) were in agreement.

Findings revealed in item 4.4 reflected 83.75% (n=67) of participants were in agreement with the statement 'I find that my values and the values of the preceptor programmes are very similar.' The results indicated that 86.25% (n=69) of participants responses supported the statement 'I am proud to tell others I am a preceptee' (item 4.5). Item 4.6 indicated 58.75% (n=47) of participants agreed to the statement 'It would take little change in my present circumstances to cause me to stop being a preceptor,' whereas 40.00% (n=32) disagreed. This suggests participants were divided in their response to this item.

Findings revealed in item 4.7 reflected that 70.00% (n=56) of participants disagreed with the statement 'There is not too much to be gained by continuing to be a preceptor,' whereas 27.5% (n=22) supported this item. Over 85.00% (n=68) of participants responses supported the statement 'I really care about the fate of the preceptor programme in this hospital' (item 4.8), whereas 13.75% (n=11) disagreed. Item 4.9 indicated 86.25% (n=69) of participants disagreed to the statement 'Deciding to be a preceptor was a definite mistake on my part,' whilst 12.50% (n=10) agreed to this item. Over 91.25% (n=73) of participants responses supported the statement 'Being a preceptor really inspires me to perform my very best' (item 4.10), whereas 7.50% (n=6) disagreed.

It can be extrapolated from these findings that the participants were generally committed to the preceptor role. Findings are displayed in Table 4.7.

4.3.5 Rank-Order of Mean Scores

Table 4.8 Rank-ordered mean scores for items from preceptor's perceptions of benefits and rewards

Item	Statement	Mean	SD
2.3	Increase my own professional knowledge base	3.69	0.47
2.9	Share my knowledge with new nurses and nursing students	3.66	0.50
2.11	Contribute to my profession	3.61	0.56
2.2	Assist new staff and nursing students to integrate into the nursing unit	3.60	0.52
2.7	Be recognised as a role model	3.59	0.61
2.8	Improve my teaching skills	3.54	0.64
2.1	Teach new staff and nursing students	3.50	0.57
2.5	Influence change in my nursing unit	3.48	0.67
2.6	Gain personal satisfaction from the role	3.45	0.76
2.10	Learn from new nurses and nursing students	3.36	0.60
2.12	Increase my involvement in the organisation	3.30	0.77
2.13	Improve my organisational skills	3.21	0.81
2.14	Improve my chances for promotion or advancement within the organisation	3.08	0.85

Table 4.8 presents rank ordered mean responses for items 2.1 to 2.14 of the preceptors' perceptions for the benefits and rewards scale.

Findings showed high consistency amongst participant's total mean score (3.69; SD 0.47) for the statement 'Increase my own professional knowledge base' (item 2.3) and in item 2.9, reflected as 'Share my knowledge with new students and nursing students' (3.66; SD 0.50). Similarly a close total mean score of 3.61 (SD 0.56) and 3.60 (SD 0.52) for the statement 'Contribute to the profession' and 'Assist new staff members to integrate into the nursing unit,' respectively.

The mean rank score of 3.59 (SD 0.61) was obtained for the statement ‘Be recognised as a role model’ (item 2.7), whereas a mean rank score of 3.54 (SD 0.64) was obtained for item 2.8 reflected as the statement ‘Improve my teaching skills,’ and a total mean score of 3.50 (SD 0.57) for the statement ‘Teach new staff and nursing students’ (item 2.1).

Findings showed a mean rank score of 3.48 (SD 0.67) was obtained for the statement ‘Influence change in my nursing unit’ (item 2.5), whereas a mean rank score of 3.45 (SD 0.76) was obtained for item 2.6, which reflects the statement ‘Gain personal satisfaction from the role.’

In item 2.10, the mean rank score of 3.36 (SD 0.60) was obtained for the statement ‘Learn from new nurses and nursing students,’ whereas the mean rank score of 3.30 (SD 0.77) was obtained for the statement ‘Increase my involvement in the organisation’ (item 2.12) and the mean rank score of 3.21 (SD 0.81) was obtained for the statement ‘Improve organisational skills’ (item 2.13).

The mean rank score of 3.08 (SD 0.85) amongst participants was lowest for the statement ‘Improve my chances for promotion or achievement within this organisation’ (item 2.14).

It can be seen from these findings that the mean rank score was highest amongst the participants in item 2.3, followed closely by items 2.9, 2.11, 2.2, 2.7, 2.8, 2.1, 2.5, 2.6, 2.10, 2.13 and lowest in item 2.14. Findings are shown in Table 4.8.

Table 4.9 Rank-ordered mean scores for items from preceptor's perceptions of support

Item	Statement	Mean	SD
3.1	I feel I have had adequate preparation for my role as preceptor	3.08	0.73
3.2	My goals as a preceptor are clearly defined	3.00	0.81
3.11	There are adequate opportunities for me to share information with other preceptors	2.75	0.80
3.7	I feel I function as a preceptor too often	2.69	0.76
3.3	The nursing staff do not understand the goals of the preceptor programme	2.66	0.69
3.8	I feel the nursing coordinators and nursing educators are committed to the success of the preceptor programme	2.63	0.75
3.4	My co-workers on the nursing unit are supportive of the preceptor programme	2.61	0.80
3.10	Nursing educators are available to help me develop my role as a preceptor	2.58	0.81
3.12	The nursing coordinator provides support by helping me to identify preceptees and orientees' performance problems	2.48	1.34
3.5	My workload is appropriate when I function as a preceptor	2.48	0.98
3.15	The nursing faculty member provides support by helping me to identify a student's performance problems	2.43	1.47
3.9	Nursing coordinators are available to help me develop in my role as a preceptor	2.39	0.74
3.16	The nursing faculty member spends too little time with the nursing student	2.36	1.31
3.14	The guidelines clearly outline the responsibilities of the nursing coordinator in relation to my preceptor role	2.34	1.20
3.17	The guidelines clearly outline the responsibilities of the nursing faculty member in relation to my preceptor role	2.34	1.31
3.6	I do not have sufficient time to provide patient care while I function as a preceptor	2.27	0.86
3.13	The nursing coordinates spends too little time with the new student	2.25	1.39

Table 4.9 presents rank ordered mean responses for items 3.1 to 3.17 of the preceptors' perceptions of support for preceptor role scale.

Findings showed high consistency amongst participants total mean score (3.08; SD 0.73) for the statement 'I feel I have adequate preparation for my role as preceptor' (item 3.1) and in item 3.2, reflected as 'My goals as a preceptor are clearly defined' (3.00; SD 0.81).

Similarly, a mean rank score of 2.75 (SD 0.80) was obtained for the statement ‘There are adequate opportunities for me to share information with other preceptors’ (item 3.11), followed by mean rank scores of 2.69 (SD 0.76), 2.66 (SD 0.69), 2.63 (SD 0.75) and 2.61 (SD 0.80) for the statements ‘I feel I function as a preceptor too often’ (item 3.7), ‘The nursing staff do not understand the goals of the preceptor programme’ (item 3.3), ‘I feel the coordinators and nursing educators are committed to the success of the preceptor programme’ (item 3.8) and ‘My co-workers on the nursing unit are supportive of the preceptor programme’ (item 3.4), respectively.

The mean rank score of 2.58 (SD 0.81) was obtained for the statement ‘Nursing educators are available to help me develop my role as a preceptor’ (item 3.10), whereas a lower mean rank score of 2.48 (SD 1.34) and 2.48 (SD 0.98) was obtained for the statements ‘The nursing coordinator provides support by helping me identify preceptees and orientees performance problems’ and ‘My workload is appropriate when I function as a preceptor,’ respectively, Similarly the mean rank score of 2.43 (SD 1.47) was obtained in item 3.15, reflected as the statement ‘The nursing faculty member provides support by helping me to identify a student’s performance problems.’ The mean rank score of 2.39 (SD 0.74) was obtained for the statement ‘Nursing coordinators are available to help me develop in my role as a preceptor’ (item 3.9).

Findings showed lower consistency amongst participant’s total mean rank score of 2.36 (SD 1.31) for the statement ‘The nursing faculty member spends too little time with the nursing student’ (item 3.16) and in item 3.14 reflected as ‘The guidelines clearly outline the responsibilities of the nursing coordinator in relation to my preceptor role’ (2.34; SD 1.20). In item 3.17, the total mean rank score of 2.34 (SD 1.31) was obtained for the statement ‘The guidelines clearly outline the responsibilities of the nursing faculty member in relation to my preceptor role’ and a mean score of 2.27 (SD 0.86) was obtained for the

statement ‘I do not have sufficient time to provide patient care while I function as a preceptor’ (item 3.6).

The mean score of 2.25 (SD 1.39) for statement ‘The nursing coordinater spends too little time with the new student’ (item 3.13) was the lowest consistency amongst participants total mean rank score.

It can be extrapolated from these findings that the mean rank score was highest amongst the participants in item 3.1, followed closely by items 3.2, 3.11, 3.7, 3.3, 3.8, 3.4, 3.10, 3.12, 3.5, 3.15, 3.9, 3.16, 3.14, 3.17, 3.6 and the lowest in item 3.13. Findings are shown in Table 4.9.

Table 4.10 Rank-ordered mean scores for items from preceptor’s commitment to the preceptor role

Item	Statement	Mean	SD
4.1	I am willing to put in a great deal of effort beyond what is normally expected in order to help the preceptee be successful	3.30	0.70
4.2	I am enthusiastic about the preceptor programme when I talk to my nursing colleagues	3.08	0.65
4.6	It would take very little change in my present circumstances to cause me to stop being a preceptor	3.04	0.85
4.9	Deciding to be a preceptor was a definite mistake on my part	2.99	0.75
4.5	I am proud to tell others I am a preceptee	2.98	0.76
4.7	There is not much to be gained by continuing to be a preceptor	2.54	0.86
4.4	I find that my values and the values of the preceptor programmes are very similar	2.17	0.65
4.8	I really care about the fate of the preceptor programme in this hospital	2.13	0.93
4.10	Being a preceptor really inspires me to perform my very best	1.69	0.80
4.3	I feel very little loyalty to the preceptor programme	1.26	0.44

Table 4.10 presents rank ordered mean response for items 4.1 to 4.10 of the preceptors' perceptions for commitment to the role of preceptor scale.

Findings showed high consistency amongst participant's total mean score (3.30; SD 0.70) for the statement 'I am willing to put in a great deal of effort beyond what is normally expected in order to help the preceptee be successful' (item 4.1) and in items 4.2 and 4.6, the mean rank score of 3.08 (SD 0.65) and 3.04 (0.65) was obtained for the statements 'I am enthusiastic about the preceptor programme when I talk to my nursing colleagues' and 'It would take very little to change in my present circumstances to cause me to stop being a preceptor,' respectively.

The mean rank score of 2.99 (SD 0.75) and 2.98 (SD 0.76) was obtained for the statements, reflected as 'Deciding to be a preceptor was a definite mistake on my part' (item 4.9) and 'I am proud to tell others I am a preceptee' (item 4.5), respectively. Whereas a mean rank score of 2.39 (SD 0.74) was obtained for the statement 'Nursing coordinators are available to help me develop my role as a preceptor' (item 4.9).

Findings showed high consistency amongst participant's total mean score (2.17; SD 0.65) for the statement 'I find that my values of the preceptor programmes are very similar' (item 4.4). The mean rank scores of 2.13 (SD 0.93) and 1.69 (SD 0.80) was obtained for the statement 'I really care about the fate of the preceptor programme in this hospital' (item 4.8) and 'Being a preceptor inspires me to perform my very best' (item 4.10), respectively. The lowest mean rank score of 1.26 (SD 0.44) was obtained for the statement 'I feel little loyalty to the preceptor programme' (item 4.3).

It can be concluded from these findings that the mean rank score was highest among the participants in item 4.1, followed closely by items 4.2, 4.6, 4.9, 4.5, 4.7, 4.4, 4.8, 4.10 and lowest in item 4.3. Findings are shown in Table 4.9.

4.3.6 Comparative statistics

Construct scores and item scores were of interest for further analysis to compare the results with the categorical variables. Cronbach's alpha summative rating scale was used and the sum of the construct scores and individual scores were used. Results of the process are summarised in Table 4.10**.**

Table 4.11 Summary Cronbach's reliability coefficient for items Q2.1 to Q2.14, Q3.1 to Q3.17 and Q4.1 to Q4.10

Test	Items included	Reliability coefficient
Test 1	Q2.1; Q2.2; Q2.3; Q2.4; Q2.5; Q2.6; Q2.7; Q2.8; Q2.9; Q2.10; Q2.11; Q2.12; Q2.13; Q2.14	0.850
Test 2	Q3.1; Q3.2; Q3.3; Q3.4; Q3.5; Q3.6; Q3.7; Q3.8; Q3.10; Q3.11; Q3.12; Q3.14; Q3.16; Q3.17	0.755
Test 3	Q4.1; Q4.2; Q4.3; Q4.4; Q4.5; Q4.6; Q4.7; Q4.8; Q4.9; Q4.10	0.832

Findings were based solely on the reliability coefficient and some items (Q3.9 and Q3.15 in test 2) were omitted to maximise reliability of the coefficient alphas. Findings yielded Cronbach alphas of 0.850 to 0.832 (test 1 and test 3) for construct and total questionnaire scores. These findings meet the standard 0.75 to 0.85 for reliability (Burns & Grove, 2012; Polit and Beck, 2012), they suggest a positive relationship exists between the variables and the total item scores. Results of this process are summarised in Table 4.12.

Measurement of central tendency and variation (mean and standard deviation) were used to summarise the data. The mean scores are not for the purpose of testing, rather they are used to demonstrate the magnitude of the difference of opinion and the direction of the opinion. Summary of the mean scores for difference of the preceptor's opinion for benefits and rewards, support and commitment to the role are provided in Table 4.12.

Table 4.12 Summary of mean total scores for comparison of preceptor's perceptions of benefits and rewards, support and commitment to the role

Construct	n	Mean	SD
Benefits and rewards	80	48.61	5.82
Support of preceptor role	80	43.45	7.50
Commitment to the role	80	27.27	3.41

Table 4.12 presents the summary of total mean scores for comparison of construct scores for benefits and rewards, support and commitment to the preceptor role. Of the total sample (n=80) the mean total score obtained for benefits and rewards was 48.61 (SD 5.82), with the mean total score of 43.45 (SD 7.50) for support of the preceptor role and 27.27 (3.41) for commitment to preceptor role.

The data were then further explored using the approaches advocated by Dibert and Goldenberg (1995) which were mainly correlational in orientation. Primarily this would allow for comparability of the results in the interval scaled variables. The relationship between the preceptor's perception of benefits and rewards associated with the preceptor role and the commitment to the role was determined using Pearson product correlation coefficient r. This is the correlations between the two scales when calculated. Findings showed that the more the preceptors perceived there was benefits and rewards associated with the preceptor role the more they were committed to the role (n=80, r=0.39, p=0.000).

The relationship between the preceptors' perception of support for the preceptor role and their commitment to the role was o determined by using Pearson's correlation between the two scale scores producing significant positive results for both newly hired nurses and nursing students and commitment to the role (n=80, r=1.00, p=0.000).

Table 4.13 Correlations between preceptor's perception of support and commitment to the preceptor role

Perceptions of support	n	r	p-value
Number of times as preceptor	80	0.37	0.001
Number of times preceptoring newly hired nurses	80	0.05*	0.660
Number of times preceptoring graduate nurses	80	0.32	0.004
Number of times preceptoring a nursing student	80	0.06*	0.573

Key: r=Pearson's correlation coefficient

A positive relationship was found when preceptor's perception of support for preceptoring newly hired nurses was analysed separately from perceived support for preceptoring nursing students. These weak correlations suggested that preceptor's perceptions of support to the role were positively related to the commitment to the role. Table 4.13 summarises these findings.

Spearman's rank-order correlation co-efficient (rho) was calculated between the preceptor's years of nursing experience and the score for preceptor's perception of benefits and rewards, support to the role and commitment to the role. None of the correlations reached statistical significance, implying that years of nursing experience were not related to preceptor's perceptions of benefits, rewards and support not commitment to the role.

Spearman rank-order correlation coefficients (rho) were further calculated between the number of times the preceptor had acted as a preceptor and the scores for the preceptor's perceptions of benefits and rewards, support of the role and commitment to the role. No relationships were found between the number of preceptor experiences, the preceptor's perception of benefits and rewards and the preceptor's perception of their role. A moderate association was found between the number of preceptor experiences and the

preceptor's perception of commitment to the preceptor role. Findings are shown in Table 4.14.

Table 4.14 Correlations between frequency of preceptor experiences and commitment to the preceptor role

Frequency of experiences	n	rho	p
Number of times as preceptor	80	0.34	0.002
Number of times preceptoring newly hired nurses	80	0.27	0.016
Number of times preceptoring a graduate nurse	80	0.12	0.279
Number of time preceptoring a nursing student	80	0.27	0.017

Key: rho =Spearman rank order correlation coefficient

Based on the observed difference in the mean scores in the sub-groups for nursing education, the total construct scores were then tested to determine whether they were significant or not. A cut off point was set statistically and education in diploma and degree groups was considered for further analysis. The t-test was employed to analyse the data by sub-categorical variables. The student t-test was used to determine these calculations.

Table 4.15 Summary for t-test for frequencies obtained for benefits and rewards, support and commitment to the role by nursing education

Construct	Nursing education						p-value
	Diploma			Degree			
	n	M	SD	n	M	SD	
Benefits and rewards	49	48.1	6.8	31	49.4	3.8	0.367
Support for role	49	42.1	7.3	31	45.6	7.5	0.039*
Commitment to preceptor role	49	26.7	0.48	31	27.9	0.61	0.191

Key: *=statistical significance

Table 4.15 presents the summary of total mean scores for comparison for benefits and rewards, support for role and commitment to preceptor role by nursing education. Of the

total sample (n=80) the mean score obtained for benefits and rewards was 48.1 (SD 6.8) for participants categorised as diploma, with contrast of 49.4 (SD 3.8) for responses in degree group. This is an observed difference of 1.3. Similarly the mean score obtained for support for role was 42.1 (SD 7.3) for participants categorised as diploma, with contrast of 45.6 (SD 7.5) for responses in the degree group: an observed difference of 3.5. The mean score obtained for commitment to preceptor role was 26.7 (SD 0.48) for participants categorised as diploma, with contrast of 27.9 (SD 0.61) for responses in the degree group: an observed difference of 1.2. Using the t-test, there was significant (p=0.039) correlation found between diploma and degree participants in support for preceptor role. Findings are shown in Table 4.15.

Based on the observed difference in the mean scores in the sub-groups for age, the total construct scores were then tested to determine whether they were significant or not. A cut off point was set statistically and the age groups <39 years of age and >40 years of age were considered for further analysis. The t-test was employed to analyse the data by sub-categorical variables. The student t-test was used to determine these calculations. Findings are show in Table 4.16.

Table 4.16 Summary for t-test for frequencies obtained for benefits and rewards, support and commitment to the role by age

Construct	Age						p-value
	< 39 years			>40 years			
	n	M	SD	n	M	SD	
Benefits and rewards	28	48.9	5.0	52	48.5	6.2	0.754
Support for role	28	43.3	7.6	52	43.5	8.7	0.886
Commitment to preceptor role	28	27.6	3.2	52	26.9	4.4	0.482

Table 4.16 presents the summary of total mean scores for comparison for benefits and rewards, support for role and commitment to preceptor role by age. Of the total sample (n=80) the mean score obtained for benefits and rewards was 48.9 (SD 5.0) for participants categorised as <39 years of age, with contrast of 48.5 (SD 6.2) for responses in >40 years age group. This is an observed difference of 0.4. Similarly, the mean score obtained for support for role was 43.3 (SD 3.2) for participants categorised as <39 years of age, with contrast of 43.5 (SD 8.7) for responses in the >40 years of age group. This is an observed difference of 0.2. The mean score obtained for commitment to preceptor role was 27.6 (SD 3.2) for participants categorised as <39 years of age, with contrast of 26.9 (SD 4.4) for responses in the >40 years age group. This is an observed difference of 0.7. The differences were not significant using the t-test and there was no significant correlation found between age of the participants and the scores of the benefits and rewards, support of the role and commitment to the role. Findings are show in Table 4.16.

Based on the observed difference in the mean scores in the sub-groups for gender, the total construct scores were then tested to determine whether they were significant or not. A cut off point was set statistically and age in females and male groups was considered for further analysis. The t-test was employed to analyse the data by sub-categorical variables. The student t-test was used to determine these calculations. Findings are shown in Table 4.17.

Table 4.17 Summary for t-test for frequencies obtained for benefits and rewards, support and commitment to the role by gender

Construct	Gender						p-value
	Female			Male			
	n	M	SD	n	M	SD	
Benefits and rewards	68	48.6	5.6	12	48.4	7.2	0.900
Support for role	68	43.4	7.3	12	43.6	8.7	0.947
Commitment to preceptor role	68	27.3	3.2	12	26.9	4.4	0.695

Table 4.17 presents the summary of total mean scores for comparison for benefits and rewards, support for role and commitment to preceptor role by gender. Of the total sample (n=80) the mean score obtained for benefits and rewards was 48.6 (SD 5.6) for participants categorised as female, with contrast of 48.4 (SD 7.2) for responses in the male group. This is an observed difference of 0.2. Similarly the mean score obtained for support for role was 43.4 (SD 7.3) for participants categorised as females, with contrast of 43.6 (SD 8.7) for responses in the male group. This is an observed difference of 0.2. The mean score obtained for commitment to preceptor role was 27.3 (SD 3.2) for participants categorised as females, with contrast of 26.9 (SD 4.4) for responses in the male group. This is an observed difference of 0.6. The differences were not significant using the t-test, there was not significant correlation found between gender of the participants and the scores of the benefits and rewards, support of the role and commitment to the role. Findings are shown in Table 4.17.

4.3.7 Response from open ended question

One open ended question enquired whether the participants wished to make additional comments. Findings indicated that 21% of participants suggested there was a need for a formal preceptor programme, which should be of a nature to allow others to join. A formal preceptor programme was said, would lead to an improvement in patient care, standards and clinical practice in the Intensive Care Units. Participants said there is no financial gain for the preceptor role, formally appointed preceptors salary was reduced when a preceptor role was entered formally. Some participants felt preceptoring was difficult in the ICU, as patient's needs were high which made teaching unpredictable especially when managing an unstable patient. Also the subcategories, inclusive of enrolled nurses and newly qualified staff, make it difficult to teach because of their lack of knowledge of critically ill patients and the Critical Care situation. In addition, other participants felt the workload of

the preceptor was demanding and becomes more so with additional non-preceptoring activities, i.e. meetings they are expected to attend. However, the findings in this study are not unique and have been reported in similar more recent studies (Hallin and Danielson, 2008; Martensson et al, 2013; O' Brien el al, 2013; Usher et al, 1999) conducted in other institutions. It is the intention of the researcher to incorporate these findings into the recommendations arising from the study.

4.4 DISCUSSION OF MAIN FINDINGS

The purpose of the study was to examine the relationship among preceptor's perceptions of benefits, rewards, supports and commitment to the preceptor role.

In this study, the first part of the questionnaire elicited participant's perceptions of the benefits and rewards of the preceptor role. Fourteen items supported the results and discussion of findings in this part of the questionnaire. Participant's perceived the benefits and rewards of the preceptor role with high positive responses. These ranged from 100.0% to 81.25%. Six items scored greater than 95% (>95%), with a similar six items scoring greater than 90% (>90%) and two items less than 90% (<90%).

The second part of the questionnaire elicited participant's perceptions of the support of the preceptor role. Seventeen items supported the results and discussion of findings in this part of the questionnaire. Participant's perceived support for the preceptor role with lower positive responses ranged from a high 80% to a lower 41.20%. Two items scored greater than 70% (>70%), followed by five items greater than 60% (>60%), two items greater than 50% (>50%) and two items greater than 40% (>40%). In this part of the questionnaire provision is made for inclusion of six items, particularly for support to new nurses and student nurses. Participant's perceived support to new nurses was lower than support to

student nurses, whereby support for new nurses ranged from 70% to 56% and 68% to 73% for student nurses.

The third part of the questionnaire elicited participant's perceptions of commitment to the role. Ten items supported the results and discussion of findings in this part of the questionnaire. Ten items supported the results and discussion of findings in this part of the questionnaire. Participant's perceived commitment to the preceptor role more positively. These ranged from 91.25% to 85.0% for agreement, contrasting with 86.25% to 73.75% in disagreement items. There appears to be a divided response amongst participants in one item (item 4.6) in this construct.

In this study, rank order of the mean scores was done. Findings showed high consistency amongst participant's total mean score for the benefits and rewards scale, support of preceptor scale and commitment of preceptor role scale. This finding is similar to the original study by Dibert and Goldenberg (1995). Hyrkas and Shoemaker (2007) and Usher et al (1999) found good consistency between the mean scores and the benefits and rewards scale, support of preceptor scale and commitment of preceptor role scale. Hyrkas and Shoemaker, (2007) showed higher mean scores if the benefits and rewards were also ranked higher.

Of the total sample (n=80), the mean total score obtained for benefits and rewards was 48.61 (SD 5.82), with the mean score of 43.45 (SD 7.50) for support of preceptor role and 27.27 (SD 3.41) for commitment to preceptor role. Hyrkas and Shoemaker, (2007) found results with a higher mean total score obtained for benefits and rewards was 68.84 (SD 9.34) with the mean score of 62.67 (SD 12.62) for support of preceptor role and 48.65 (SD 6.87) for commitment to preceptor role. Usher et al., (1999) found the mean score for the benefit and reward was 62.9 (SD 8.37) with the mean score for support of 50.0(SD 6.99) and the commitment to the role mean score of 41.9(5.67).

Findings showed that the more the preceptors perceived there were benefits and rewards associated with the preceptor role, the more they were committed to the role (n=80, r=0.39, p=0.000). These findings are consistent with Dibert and Goldenberg (1995) who found the more preceptors perceived there were benefits and rewards associated with the role, the more committed they were. In this study, a correlation coefficient of r=0.39, p=0.000, n=80 was calculated, replicating Dibert and Goldenberg's findings of a statistically significant association between benefits and commitment to the preceptor role. Hyrkas and Shoemaker, (2007) found preceptor's perceptions of preceptor benefits and rewards have increased form the original study by Dibert and Goldenberg (1995).

Similarly, the findings showed the relationship between the preceptor's perception of support for the preceptor role and their commitment produced significant positive results for commitment to the role (n=80, r=1.00, p=0.000). These findings are consistent with Dibert and Goldenberg (1995), who found there to be a positive relationship between the preceptor's perceptions of support and commitment to their role (n= 30, r= 04664, p= 0.0010). Hyrkas and Shoemaker, (2007) further support this finding in their study (n=134, r= 0.42, p= 0.01) with positive results, but not as positive as in this study or that of Dibert and Goldenberg (1995).

In this study, a positive relationship was found when preceptor's perception of support for precepting newly hired nurses was analysed separately from perceived support for precepting nursing students. The weak correlations suggested that preceptor's perceptions of support for the role were positively related to the role. This is similar to the results by Dibert and Goldenberg (1995) and Usher et al, (1999).

The years of nursing experience in this study were not related to preceptor's perceptions of benefits, rewards and support commitment to the role. Findings are consistent with Dibert and Goldenberg (1995), Hyrkas and Shoemaker (2007) and Usher et al, (1999).

The differences in nursing education were significant. Using the t-test there was significant (p=0.039) correlation found between diploma and degree participants in support for preceptor role. This finding was not found in other studies.

The differences were not significant using the t-test and there was no significant correlation found between gender of the participants and the scores of the benefits and rewards and support of and commitment to the role.

4.5 SUMMARY

This chapter discussed the descriptive and correlational statistics used to describe and analyse the data collected. The data and interpretation of findings were presented. The following chapter will discuss the limitation of the study, summary of research findings, conclusions and recommendations for further research.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This concluding chapter of the research report presents the summary of the study, conclusions are discussed and the limitations described. This is followed by recommendations for clinical nursing practice, education and the institution and future research based on the findings of the study.

5.2 SUMMARY OF THE STUDY

5.2.1 Purpose of the Study

The purpose of the study was to examine the relationships among preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The findings were used to answer the research questions and make recommendations for improvements of the future role of the preceptor in the clinical practice settings in Gauteng.

5.2.2 Objectives of the Study

The objectives of the study were:

- to explore, describe and compare the relationships among preceptors' perceptions of benefits, rewards, support, and commitment to the preceptor role.
- to elicit the extent to which years of nursing experience has on the preceptors' benefits, rewards, support and commitment to the preceptor role.

- to describe and make recommendations for improvements in the future role of the preceptor in the clinical practice settings in Gauteng

5.2.3 Methodology

The Human Research Ethics Committee (Medical) of the Witwatersrand (protocol 131197, Appendix F) granted ethical clearance before commencement of the study. Other permissions form the CEO's of both public (appendix H) and private sector (appendix I) institutions was obtained as well as from the private hospital group research operating committee (appendix G.)

Thirteen adult Intensive Care Units at both public and private sector institutions combined were utilised in the study. A statistician was consulted prior to data collection and deciding sample size, which was achieved according to the response rate. After discussion with the statistician, a minimum sample size of 70 was determined suitable for the study. Non-probability purposive sampling was used and the total sample for this study was 80 (n=80) participants.

Significance testing by means of Cronbach's alpha test yielded alphas of 0.850 to 0.832 (test 1 and test 3) for construct and total questionnaire scores. These findings meet the standard 0.75 to 0.85 for reliability (Burns & Grove, 2012; Polit & Beck, 2012), the findings suggest a positive relationship exists between the variables and the total item scores. Measurement of central tendency and variation (mean and standard deviation) indicated the direction of the opinion of the participants were overall positive in nature.

To test feasibility of the study, understanding of the information letter, informed consent form and questionnaire a pilot study was conducted. A pilot study was conducted prior to commencement of the main study and consisted of 10 (n=10) participants at the study

site. The findings of the pilot study was not included in the study. The pilot study indicated the instrument was well understood and interpreted. No changes were made to the original instrument.

A survey instrument developed by Dibert and Goldenberg (1995), as identified in the literature of Usher et al. (1999) and further validated by Hyrkas and Shoemaker (2007), was used to achieve the study objectives. The self-administered questionnaire comprised four parts: Preceptors Perception of Benefits and Rewards (PPBR), Preceptor's Perception of Support (PPS) scale, Commitment to the Preceptor Role (CPR) Scale and a demographic sheet. To elicit suggestions and comments one open ended question was included at the end of the questionnaire.

5.3 SUMMARY OF MAIN FINDINGS

The purpose of this study was to examine the relationships among preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The findings were used to answer the research questions and make recommendations for improvement of the future role of the preceptor in the clinical practice settings in Gauteng.

In this study, a survey was conducted using a validated and reliable questionnaire from Dibert and Goldberg (1995), which had been used in three previous studies (Dibert & Goldberg, 1995; Hyrkas & Shoemaker, 2007; Usher et al., 1999).

The first objective of the study was to explore, describe and compare the relationships among preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. There was a definitive result that preceptors perceived there to be benefits for the preceptor in preceptorship. The benefits and rewards were material and non-material in nature. The commitment of preceptors, if they perceive to be rewarded and

being part of a beneficial goal, was seen as a positive response with all participants' responses being above 90%. The study indicates participants are more committed if they perceive there to be benefits and rewards to preceptorship.

The study also found that if the preceptors perceive there to be support for their role as preceptor, their commitment to the role of preceptorship increases. The preceptors were also more committed to their role if the support was increased. Support from nursing education to support the development of the preceptor was perceived as important. Support related to workload is also important, as this was addressed in the second section of the questionnaire and also in the open question. Preceptors felt a great need to be able to both care for their patient and meet the needs of the preceptee. The nature of ICU, with high acuity patients and demands, increases the need of the preceptor for support.

The second objective of the study was to elicit the extent to which years of nursing experience has on the preceptors' benefits, rewards, support and commitment to the preceptor role. This study found no significant relationship between the two. The preceptors are committed to preceptorship and their experience is not relevant. What is relevant, is the benefit, rewards and support by the institution, education and their colleagues. It was evident the preceptors had numerous years of experience. The age and gender of the participants also had no significant effect on their perceptions.

The third objective of the study was to describe and make recommendations for improvements in the future role of the preceptor in the clinical practice settings in Gauteng. The study found that if preceptors perceive their role to be of benefit and rewarded, they are more committed to their role. Similarly if they perceive to be well supported their commitment increases. These findings underpin the importance of continuous provision of benefits, rewards and support to the preceptors. This will ensure sustained commitment to their role.

5.4 LIMITATIONS OF THE STUDY

The researcher acknowledges the following as limitations in this study:

- The sample size was significantly influenced, as permission to conduct the study at a fifth intended site could not be obtained in time and had to be removed from the study. This limited the sample size by possibly 30 participants.
- The type of instrument being quantitative in design limits answers that participants wished to pose. The response rate was generally low as seen in this study. The participants also failed to answer some questions. The nature of a questionnaire is limited and the researcher was unable to understand why the sections were not answered, due to respect for the participants. The researcher did not want to intimidate the participants and they in turn did not always ask for clarification of sections.
- Reluctance of nursing staff to participate in the study. The nature of the work in ICU and the workload of the participants limited the researcher in collecting data. The researcher had some difficulty in distributing the questionnaire and also found the participants could not complete the questionnaires due to their responsibilities towards their patients. If the researcher approached the participants during a break, some resistance was experienced as they did not want to be disturbed during their break. This led to participants taking the questionnaire home leading to a decreased return rate. The researcher could not visit every site at regular intervals due to her own responsibilities, which also led to decreased response rate.

5.5 CONCLUSION

Results of the study have supported the existing evidence on the preceptor's perceptions on the benefit, rewards, support and commitment to the preceptor role. This study is based on the original study of 59 participants by Dibert and Goldenberg (1995), who were the developers of the instrument on the preceptor's perceptions on the benefit, reward, support and commitment to the role as preceptor. The results of the study by Dibert and Goldenberg (1995), showed if the preceptors perceived the benefits and rewards to be increased, there was greater commitment to the role as preceptor, which is supported by the researcher's study which yielded similar results. Dibert and Goldenberg (1995) found that if the support increases so does the commitment to the role as preceptor. This again was similar to the researchers study. There was no significant relationship between the years of experience and the commitment to the role. Dibert and Goldenberg (1995) highlight that the higher the frequency of the preceptor experiences the greater the commitment to the role as preceptor. The researcher found no relationship between the years' experience and the commitment to preceptorship. This study also found there were high incidences of participating in preceptor activities, but this did not positively relate to commitment to the role.

5.6 RECOMMENDATIONS OF THE STUDY

The researcher concluded the following recommendations based on the findings of the study:

5.6.1 Recommendations for education

- The importance of continuous support by means of preceptor development for the role of preceptor is of high importance. The need for the development of a

continuous professional development programme for preceptors is needed. The need for development in the role as preceptor is needed.

- The implementation of the preceptor clinical model needs to be done with a plan that will equip the preceptor to understand and support the programme.
- Continuous support from academic institutions is needed. The preceptor needs to be able to have open communication with the academic staff who in turn need to be more visible in the clinical setting.

5.6.2 Recommendations for nursing practice

- The role and the function of the preceptor need to be supported with commitment from management. The commitment to give the preceptor adequate time to prepare to meet the needs of the preceptee's.
- The workload of the preceptor also needs to be considered. It is recommended that for the ICU environment, the preceptor has supernumerary status. This will allow the preceptor to assist the preceptee without compromising patient care.

5.6.3 Recommendations for nursing research

- Research on the implementation of the proposed clinical model in a multi sectorial study is needed.
- Research on the implementation of a preceptor development model is needed. This study needs to be both qualitative, to obtain data from the experiences of the preceptor and preceptee's and quantitative to determine the effect of preceptorship on the quality outcome of preceptee's.
- Qualitative research on the preceptor's perceptions of the benefit, reward, support and commitment is needed.

5.6.4 Recommendations for the health care institutions

- The implementation of a preceptorship programme is recommended as it benefits the patient, staff, profession and the institution.
- There is a need from the preceptors to be recognised for their role in the quality of care provided by means of their role as preceptor. It is recommended that institutions offer support by means of a clear role clarification. The importance of their role and authority of the role should be clarified.
- Financial support to allow this role to be taken without having to decrease financial benefits, should be reviewed. Financial support in the form of development of the preceptor for their role should be implemented.
- Support in the form of time management should be supported by means of a policy. Preceptors need to have time to prepare for their role in the support of the preceptee's. Preceptors need time to update and develop their own knowledge base, to ensure they remain experts in their field.
- The researcher recommends that the institution have a long term commitment towards preceptorship and the support thereof.

5.7 RESEARCHER'S REFLECTIONS

The researcher reflected on the two and a half year journey of completing this study. One of the complexities the researcher found, was to define the actual problem. Preceptorship is such a broad essential component for quality clinical assurance, which has so many facets. Once the researcher was able to agree with her supervisor on the problem, the journey was a fascinating one. The researcher could identify with the literature found that the need for supervision in the clinical setting was a great need in the nursing profession. There is a loss of knowledge and expertise in the nursing profession, which leaves the newly qualified and new students exposed and having to cope on their own. This sudden

increase in responsibility, without supervision and support, leads to many qualified but inexperienced nurses leaving the profession due to burn out.

Having been a preceptor herself, the researcher could identify with the benefits and rewards of preceptorship. The lack of support by the institution in relation to financial gain and time management was a lived experience for the researcher. The researcher could reflect on and found that commitment without support and rewards goes to waste. The commitment of preceptors is fading fast due to the feeling of not being able to change the situation in nursing.

One of the more difficult issues the researcher dealt with was the lack of interest by participants to be part of the study. The researcher could identify with the feeling of not wanting to be disturbed during your only break on a day filled with various demands by the patient and their next of kin. With ICU being such a high pace and demanding environment it was understandable. The researcher had to remain positive and motivated to complete the study. The support from her supervisor and colleagues was a determining factor. The unexpected support from participants, whom have also done their masters, was surprising and highly welcomed.

Through all of this, the researcher could see the need for a formal preceptor programme in the various units. The silent shouts for the need for more experienced staff and in some instances, just more staff and the need for leadership and mentorship was evident in both the public and private sector. The preceptor model is an effective way to assist and guide the profession to new quality heights.

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APPENDIX A

NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

INFORMATION SHEET

Dear Colleagues,

My name is Alida Viljoen and I am currently registered as a student at the University of the Witwatersrand, in the Department of Nursing Education for the degree of Master of Science in Nursing. I hope to conduct a research project and would like to invite you to participate and kindly consent to your inclusion in my sample of Intensive Care registered nurses, which I hope to study in the clinical practice setting.

The aim of this study is to examine the relationships between preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The findings will be used to make recommendations for improving the future role of the preceptor in clinical practice settings.

Should you consent to participate, I will ask you to complete a questionnaire consisting of thirty-five questions, known in literature, to evaluate preceptorship in the clinical practice settings. The questions are mostly closed ended with Likert scales (agree and disagree) and should not take more than 15 to 20 minutes to complete. I will obtain permission from your unit manager to enable you to complete the questionnaire during your on duty time and I will personally bring you the questionnaire. Completed questionnaires will be placed in unmarked sealed envelopes.

Participation is entirely voluntary. You may choose not to participate or withdraw from the study at any time, which will have no effect on you personally or the services you may provide in this institution. Anonymity and confidentiality will be ensured by using code numbers instead of your real name and no personal information will be reported throughout the study to avoid your identification.

I appreciate you will derive no direct benefits from participating in this study however, I hope the completed study will make recommendations on how preceptors should effectively fulfil their role in the clinical practice setting. Results of the study will be given to you should you so wish.

The appropriate people and research committees of the University of the Witwatersrand, Gauteng Department of Health, Netcare Private Hospital Group and institutions (Chris Hani Baragwanath Academic Hospital (CHBAH), Charlotte Maxeke Johannesburg Academic Hospital (CMAH), Unitas, Milpark, Sunninghill and Pretoria East) have approved the study and its procedures.

Thank you for taking the time to read this information letter. Should you require any further information regarding this or your rights, you are free to contact me in the Department of Nursing Education, or on the following telephone number - 082 334 2768.

APPENDIX B

NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

CONSENT FORM

I _____ (name)

I have read and understood the content of the information sheet and have been given the opportunity to ask any questions I might have regarding the study and my consent to being included.

Date: _____ Signature: _____

Witness: _____

APPENDIX C

NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORTS AND COMMITMENT TO THE PRECEPTOR ROLE IN INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

DATA COLLECTION TOOL

SECTION 1: DEMOGRAPHIC DATA

1.1 Research Code Number

1.2 Gender

Female	Male

1.3 Age (years)

1.4 Education

Hospital certificate	
Diploma	
Bachelor's degree	
Master's degree	

1.5 Years of Nursing Experience

1.6 Years as preceptor

1.7 Types of preceptor experiences with:

Newly hired nurses	
New graduates	
Nursing students	

1.8 Number of preceptor experiences with:

Newly hired nurses	
New graduates	
Nursing students	

APPENDIX C

SECTION 2: PRECEPTOR'S PERCEPTIONS OF BENEFITS AND REWARDS

Please consider each statement with reference to your experience as a preceptor.

Item	Statement	strongly disagree	disagree	agree	strongly agree
2.1	Teach new staff and nursing students				
2.2	Assist new staff and nursing students to integrate into the nursing unit				
2.3	Increase my own professional knowledge base				
2.4	Keep current and remain stimulated in my profession				
2.5	Influence change on my nursing unit				
2.6	Gain personal satisfaction from the role				
2.7	Be recognised as a role model				

2.8	Improve my teaching skills				
2.9	Share my knowledge with new nurses and nursing students				
2.10	Learn from new nurses and nursing students				
2.11	Contribute to my profession				
2.12	Increase my involvement in the organisation within this hospital				
2.13	Improve my organisational skills				
2.14	Improve my chances for promotion or advancement within this organisation				

APPENDIX C

SECTION 3: PRECEPTORS' PERCEPTION OF SUPPORT

Please consider each statement with reference to your experience as a preceptor

		strongly disagree	disagree	agree	strongly agree
3.1	I feel I have had adequate preparation for my role as a preceptor				
3.2	My goals as a preceptor are clearly defined				
3.3	The nursing staff do not understand the goals of the preceptor programme				
3.4	My co-workers on the nursing unit are supportive of the preceptor programme				
3.5	My workload is appropriate when I function as a preceptor				
3.6	I do not have sufficient time to provide patient care while I function as a preceptor				
3.7	I feel I function as a preceptor too often				
3.8	I feel the nursing coordinators and nursing				

	managers are committed to the success of the preceptor program				
3.9	Nursing coordinators are available to help me develop in my role as a preceptor				
3.10	Nursing educators are available to help me develop in my role as a preceptor				
3.11	There are adequate opportunities for me to share information with other preceptors				

APPENDIX C

Please answer questions 3.12 to 3.14 if you have been a preceptor to a new staff member

3.12	The nursing coordinator provides support by helping me to identify preceptees an orientees's performance problems				
3.13	The nursing coordinator spends too little time with the new student				
3.14	The guidelines clearly outline the responsibilities of the nursing coordinator in relation to my preceptor role				

Please answer questions 3.15 to 3.18 if you have been a preceptor to a nursing student

3.15	The nursing faculty member provides support by helping me to identify a student's performance problems				
3.16	The nursing faculty member spends too little time with the nursing student				
3.17	The guidelines clearly outline the responsibilities of the nursing faculty member in relation to my preceptor role				

APPENDIX C

SECTION 4: COMMITMENT TO PRECEPTOR ROLE

Please consider each statement with reference to your experience as a preceptor

		strongly disagree	disagree	agree	strongly agree
4.1	I am willing to put in a great deal of effort beyond what is normally expected in order to help the preceptee be successful				
4.2	I am enthusiastic about the preceptor program when I talk to my nursing colleagues				
4.3	I feel very little loyalty to the preceptor programme				
4.4	I find that my values and the values of the preceptor programmes are very similar				
4.5	I am proud to tell others I am a preceptee				

4.6	It would take very little change in my present circumstances to cause me to stop being a preceptor				
4.7	There is not much to be gained by continuing to be a preceptor				
4.8	I really care about the fate of the preceptor programme in this hospital				
4.9	Deciding to be a preceptor was a definite mistake on my part				
4.10	Being a preceptor really inspires me to perform my very best				

APPENDIX C

SECTION 5: OPEN RESPONSE

Is there anything else you wish to add

Please write this in the space provided below.

THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS STUDY

APPENDIX D

Alida Viljoen.
Department of Nursing Education,
Faculty of Health Sciences,
University of the Witwatersrand,
7 York Road,
Parktown.
2193

The Chief Executive Officer,
Charlotte Maxeke Johannesburg Academic Hospital,
5 Jubilee Road,
Parktown.
2193

Dear Mrs Mogopodi-Bogoshi,

RE: REQUEST TO CONDUCT RESEARCH AT CHARLOTTE MAXEKE JOHANNEBSURG ACADEMIC HOSPITAL (CMJAH)

My name is Alida Viljoen and I am currently a registered student at the University of the Witwatersrand in the Department of Nursing Education. I hereby ask for permission to undertake research titled “Nurse preceptors’ perceptions of benefits, rewards, support and commitment to the preceptor role in the Intensive Care Units of five major academic hospitals in Gauteng,” at Charlotte Maxeke Johannesburg Academic Hospital.

The preceptorship model is widely used in undergraduate and postgraduate nursing education. Primarily, preceptors engage in this activity to share knowledge, obtain recognition and achieve job satisfaction. However, the same preceptors are also facilitating integration of newly hired staff in Intensive Care settings and these experiences are relatively unknown. Preceptors are highly qualified and valued staff, who undertake this role in addition to their nursing responsibilities and the risk of burnout exists if they are required to assume additional obligations without appropriate rewards and support.

The aim of this study is to examine the relationship between preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The findings will be used to make recommendations for improvement in the future role of the preceptor in clinical practice settings.

I wish to assure you the name of the institution and the personnel involved will not be divulged in the report. Informed written consent will be obtained from all the research participants. A copy of the report will be available to you if so requested.

Once my study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand, I hope to conduct my research in the adult Intensive Care Units (trauma, cardiothoracic, coronary care, neurosurgery and multi-disciplinary units).

Yours sincerely,

Alida Viljoen

MSc (Nursing) student

Date:

APPENDIX E

Alida Viljoen.

Department of Nursing Education,

Faculty of Health Sciences,

University of the Witwatersrand,

7 York Road,

Parktown.

2193

[redacted]

Dear [redacted]

RE: REQUEST TO CONDUCT RESEARCH AT [redacted]

My name is Alida Viljoen and I am currently a registered student at the University of the Witwatersrand in the Department of Nursing Education. I hereby ask for permission to undertake research titled “Nurse preceptors’ perceptions of benefits, rewards, supports, and commitment to the preceptor role in the Intensive Care Units of five major academic hospitals in [redacted]

The preceptorship model is widely used in undergraduate and postgraduate nursing education. Primarily, preceptors engage in this to share knowledge, obtain recognition and

achieve job satisfaction. However, the same preceptors are also facilitating integration of newly hired staff in intensive care settings and these experiences are relatively unknown. Preceptors are highly qualified and valued staff who undertake this role in addition to their nursing responsibilities and the risk of burnout exists if they are to assume additional obligations without appropriate rewards and support.

The aim of this study is to examine the relationship between preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The findings will be used to make recommendations for improvement in the future role of the preceptor in clinical practice settings.

I wish to assure you the name of the institution and the personnel involved will not be divulged in the report. Informed written consent will be obtained from all the research participants. A copy of the report will be available to you if so requested.

Once my study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand, I hope to conduct my research in the adult Intensive Care Units (trauma, cardiothoracic, coronary care, neurosurgery and multi-disciplinary units).

Yours sincerely,

Alida Viljoen

MSc (Nursing) student

Date:

APPENDIX E

APPLICATION FOR NON-MEDICATION RELATED TRIAL TO BE CONDUCTED IN A

Name of Applicant Alida Hettie Viljoen

Contact details:

Land line (012) 644 4917 **Cellular Phone** 082 334 2768

Email address: Alida.Viljoen@netcare.co.za

Research protocol forms part of an extended programme: No

Reference number of protocol (if any) _____

Title of the research / protocol applied for here:

Nurse preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role in the intensive care units of five major academic hospitals in Gauteng

_____ _____

Signature of Applicant Date of application

APPENDIX F

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M131197

NAME: (Principal Investigator)	Mrs Alida Viljoen
DEPARTMENT:	Nursing Education University of the Witwatersrand
PROJECT TITLE:	Nurse Preceptors' Perceptiosns of Benefits, Rewards, Supports and Commitment to the Preceptor Role in the Intensive Care Units of Five Major Academic Hospitals in Gauteng
DATE CONSIDERED:	29/11/2013
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Shelley Schmollgruber
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 24/02/2014

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature M131197Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX G

RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2014-0014

Mrs A Viljoen

E mail: Alida.Viljoen@netcare.co.za

Dear Mrs Viljoen

RE: NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

[redacted]

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information with regards to Company will be treated as confidential.

iii) Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements with regards to patient rights and confidentiality will be complied with.

v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability

vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist

vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)

viii) Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from as well as a FINAL REPORT with

reference to intention to publish and probable journals for publication, on completion of the study.

ix) A copy of the research report will be provided to Company once it is finally approved by the tertiary institution, or once complete.

x) Company has the right to implement any Best Practice recommendations from the research.

xi) Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.

xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully

[redacted]

[redacted]

This letter has been anonymised to ensure confidentiality in the research report.
The original letter is available with author of research

APPENDIX H

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:
Ms.M. Ndlovu
Office of the Chief Executive Officer
(011): 488-3792
(011) 488-3753
5th March 2014

Mrs. Alida Viljoen
Nursing Education
University of Witswatersrand

Dear Mrs. Veljoen

RE: "Nurse Preceptors' Perceptions of Benefits, Rewards, Support and Commitment to the Preceptor Role in the Intensive Care Units of Five Major Academic Hospitals in Gauteng"

Permission is granted for you to conduct the above research as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Approved / not approved

pp

Ms. G. Bogoshi
Chief Executive Officer

APPENDIX H

Dear Alida Viljoen,

Re _ NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORTS AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG

iv) That the Hospital/Site/Division Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / Netcare or should the researcher not comply with the conditions of approval.

We wish you success in your research.
Yours faithfully

APPENDIX I

[redacted]

26 November 2013

Alida Viljoen
Milpark Hospital

Dear Alida

Title of Research: Nurse Preceptors – Perceptions of Benefits, Rewards, Supports and Commitment to The Preceptor Role in The Intensive Care Units of Five Major Academic Hospitals In Gauteng

[redacted]

We wish you every success with your project

Please forward all findings and Interim and Final Reports to the Ethics committee for review

Sincerely

[redacted]

[redacted]

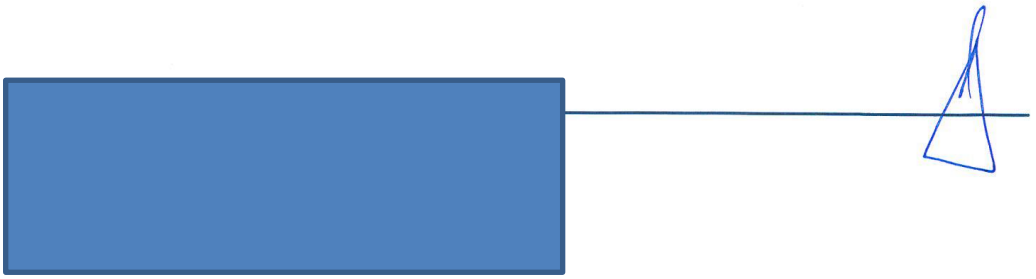
APPENDIX I

31 October 2013

LETTER CONFIRMING KNOWLEDGE OF CLINICAL MEDICATION RELATED TRIAL OR CLINICAL NON-MEDICATION RELATED TRIAL RESEARCH TO BE CONDUCTED IN THIS NETCARE FACILITY

Dear Alida Viljoen,

RE: NURSE PRECEPTORS 'PERCEPTIONS OF BENEFITS, REWARDS, SUPPORTS AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG



APPENDIX J

PERMISSION TO USE INSTRUMENT

From: Dolly Goldenberg <dollygold@rogers.com>
Date: 21 October 2013 at 15:55:51 SAST
To: Shelley Schmollgruber <Shelley.Schmollgruber@wits.ac.za>
Subject: Re: expressed interest in work

Thank you for your email, and congratulations on your work and proposed study.
I will forward your request to the secretary at the research department at our university, as she has a copy of that tool.

Good luck to you and your student with your study.

Dr. Dolly Goldenberg
----- Original Message -----
From: Shelley Schmollgruber
To: dgoldenb@uwo.ca
Sent: Monday, October 21, 2013 8:45 AM
Subject: FW: expressed interest in work

Dear Professor Goldenberg

My name is Shelley Schmollgruber. I am the Postgraduate Coordinator in the Department of Nursing Education of the University of the Witwatersrand in Johannesburg, South Africa. I am currently supervising a research study and my MSc student has interest in an aspect of your work. It is entitled “Preceptors’ perceptions of benefits, rewards, supports and commitment to the preceptor role” Journal of Advanced Nursing, vol 21, pp 1144-1151.

On behalf of myself and my student I would like to request your permission to use the instrument as we are conducting a similar study in our South African context. Would it be possible to send us a copy of the instrument along with your permission to use the instrument. If you are in agreement we can forward a copy of the proposal to you once

our ethics committee has approved the study. We anticipate that the study will be completed by mid 2014. .

I am looking forward to your response.

Kind regards
Shelley Schmollgruber
Senior Lecturer: Intensive and Critical Care Nursing
Postgraduate Coordinator

APPENDIX K

Gill Smithies

Proofreading & Language Editing Services

59, Lewis Drive, Amanzimtoti, 4126, Kwazulu Natal

Cell: 071 352 5410 Email: moramist@vodamail.co.za

Work Certificate

To	Alida Viljoen
Address	Wits Dept of Nursing Education
Date	3/9/2014
Subject	Thesis: Foreward and Chapters 1 – 5 NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG
Ref	SS/GS/02

I, Gill Smithies, certify that I have proofed and language edited:

Thesis: Foreward and Chapters 1 – 5

NURSE PRECEPTORS' PERCEPTIONS OF BENEFITS, REWARDS, SUPPORT AND COMMITMENT TO THE PRECEPTOR ROLE IN THE INTENSIVE CARE UNITS OF FIVE MAJOR ACADEMIC HOSPITALS IN GAUTENG, by Alida Viljoen

to the standard as required by Wits Dept. of Nursing Education.

Gill Smithies

31/8/2014