

Preceptors' and Faculty's Opinions about the Implementation of Preceptorship In the Diploma Nursing Curriculum in Botswana



Montlennyane Madisa

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Supervisor: Prof B. B. Van Heerden

Co-Supervisor: Ms. Mariette Volschenk

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Declaration

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December 2012

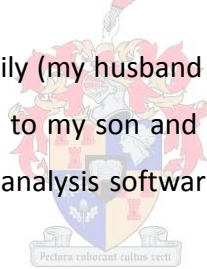
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Without your guidance and support this study would have not been possible

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Summary

Background: Preceptorship refers to a teaching and learning approach through which a well experienced clinician is contracted to provide clinical teaching, supervision, role-modeling of professional and clinical practice skills and assessment of students in a clinical setting. This approach often involves three groups of people, namely: faculty, students, and clinicians (preceptors). The preceptor in this study refers to a registered nurse who supervises and conducts clinical assessment of students in a clinical area, while at the same time is responsible for patient care. The focus of this study was to explore preceptors' opinions regarding the implementation of preceptorship in the diploma in the nursing curriculum diploma in the nursing curriculum in Botswana. Emphasis was placed on seeking information on how preceptorship is implemented, the strengths and challenges regarding its implementation and suggestions as to how it should be strengthened to contribute positively towards teaching and learning of students.

Methodology: A mixed cross-sectional descriptive design, using a survey was used. . The design was adopted because of its ability to provide a broad understanding of the concept under study by allowing participants to share their experiences and opinions about a specified situation. Both the qualitative and quantitative data were collected simultaneously. A standardized self-developed structured questionnaire using both closed ended and few open ended questions and consisting of scaled self-report items and checklists was used to collect data from forty-four (44) preceptors and three (3) third year level coordinators from the three (3) health training institutions. Quantitative data were analyzed using SPSS, while the qualitative data were analyzed for frequency of common themes. Descriptive statistics in the form of frequency tables and charts, as well as measures of central tendencies, were used in the analysis of quantitative data.

Results: The findings revealed that preceptorship program was not well coordinated as there were no preceptorship manuals to guide the implementation of preceptorship program. On the positive side, however, preceptors felt comfortable and competent to supervise and assess students, despite the fact that most of them had not received preceptorship training or

orientation. With regard to preceptor support, it was evident that there was need for major support in regard to improved communication between preceptor and faculty, improved support by the health facility manager and the need for strengthening preceptor training and orientation. The majority of the respondents have recommended for preceptorship orientation /training targeted at addressing some of the following topics: Student and preceptor roles, curriculum requirements, clinical teaching and assessment skills, leadership skills and how to access resources from the health training institutions. A significant number of preceptors felt that it was important to receive feedback about students' progress from faculty and to receive feedback from students regarding their experiences in the clinical internship sites.

Lastly, preceptors also felt that there was need for introducing incentives into the preceptorship program

Conclusion

The key areas that emerged from the study indicated an uncoordinated and unstructured preceptorship program in the diploma nursing curriculum. Preceptor support is limited as evidenced by report of lack of training or orientation of preceptors to their preceptorship role. To ensure sustainability of preceptorship program there is need to improve the following areas: preceptorship training and orientation, and preceptorship support by both the health training institution and the health facility managers. Key words: Preceptors, preceptorship, orientation, socialization, student assessment, and faculty support, clinical teaching, mentor, clinical supervisor.

List of Appendices

1. Preceptor Survey tool
2. Faculty survey tool
3. University of Stellenbosch-RSA Health Research Ethics Committee Approval Letter
4. University of Stellenbosch- department of Health Science Education Cover letter
5. Ministry of Health- Botswana: Health Research and Development- Approval
6. Scottish Livingstone Hospital- Ethics and Research committee approval letter
7. Request letter for data collection in hospitals
8. Requests for data collection letters- Health Training Institutions
9. Participant Information Leaflet and Consent form



Table of Contents

List of Appendices	vi
1. INTRODUCTION	1
1.1 Introduction to the problem	1
1.2 Statement of the Problem	3
1.3 Purpose of the study	4
1.4 Research Question	4
1.5 Research Objectives:	5
2. BACKGROUND	6
2.1: Literature Review	6
2.2 Theoretical Framework	8
2.3 Definition of terms	10
RESEARCH DESIGN AND METHODOLOGY	13
3.1. Research Design	13
3.2 Instrument /Materials.....	13
3.2.1 Preceptor survey tool.....	14
3.2.2 Faculty survey tool	14
3.3 Ethical considerations in research and Quality Control.....	15
3.4 Data collection/Procedure	16
RESULTS: PRESENTATION, ANALYSIS AND DISCUSSIONS	18
4.1. Presentation and Analysis.....	18
4.2. Discussion.....	37
CONCLUSIONS AND RECOMMENDATIONS.....	48
5.1. Conclusions	48

5.2. Recommendations	49
REFERENCES	53
LIST OF APPENDICES	60
Appendix 1: Preceptor Survey Tool	60
Appendix 2: Faculty Survey tool.....	67
Appendix 3 : University of Stellenbosch-RSA Health Research Ethics Committee Approval Letter	72
Appendix 4: University of Stellenbosch- department of Health Science Education Cover letter.....	73
Appendix 5: Ministry of Health- Botswana: Health Research and Development- Approval	74
Appendix 6: Scottish Livingstone Hospital- Ethics and Research committee approval letter	76
Appendix 8: Sample Requests for data collection in Health Training institutions:.....	78
Appendix 9: Participant Information Leaflet and Consent form	79



CHAPTER 1:

1. INTRODUCTION

1.1 Introduction to the problem

Preceptorship refers to a teaching and learning approach through which a well experienced clinician is contracted to provide one to one clinical teaching, supervision, role-modeling of professional and clinical practice skills and assessments of students in a clinical setting (Billay & Myrick, 2008; Reilly & Oerman, 1992). It is a three way approach involving faculty, students, and clinicians (preceptors).

Preceptorship approach is grounded on the andragogical approach to adult learning (Shadeva, 1996) which was developed from the work of Knowles (Atherton, 2009; Forrest III & Peterson, 2006). It is founded on the andragogical approach as this approach requires students to work with minimum supervision, displaying critical thinking and problem solving skills under real life situations.

Preceptorship is a very old concept which can be traced back to the 15th century. It was described to mean tutor or an instructor (Peirce, 1991). It was first used in nursing as a method of clinical teaching around the 60s (Spears, 1986). Since then, the use of preceptors in nursing education has gained popularity and has been endorsed as one of the most important clinical teaching strategies (Myrick & Barrett, 1994). Because of the documented benefits, health training institutions internationally, including Botswana, are feeling pressured to adopt the preceptorship strategy whenever it is appropriate.

In Botswana, preceptorship is used predominantly in the general nursing program. The concept of using preceptors to provide clinical teaching in Botswana has long been adopted since the inception of health training institutions (Serara-Kupe, 1993). However, little is documented about the implementation of preceptorship in the country. The use of preceptors as preceptors increased after the review of the nursing curriculum in 1992, when the curriculum was changed to two years of didactic training and a one year internship (Gasennelwe, 1992). Since then the role of preceptors was extended from that of a mere clinical supervisor to a preceptor with the

power to assess students' performance and contribute to the final academic qualification grades. Despite the documented valuable contribution of preceptorship to the nursing curriculum globally, few or no evaluative studies have been done in Botswana to help contribute towards the strengthening of preceptorship in the country.

Currently in Botswana, preceptorship may be considered mandatory rather than a voluntary service as all nurses with a minimum of 3 years working experience are expected to supervise and assess students in the clinical area. It is a requirement according to the nursing curriculum that all nurses who have worked for three years and above should participate in the clinical teaching and assessment of students, irrespective of whether or not the Preceptor is interested in being a preceptor or not (I.H.S/UB 1995). Employers also consider preceptorship part of the job responsibility of all nurses by virtue of years of clinical experience.

Preceptorship is only offered for third year nursing students who are in their final year of training. There is no monetary remuneration attached to the service offered. Clinical placement of students takes place in hospital, clinics and community settings. Once students are assigned to the clinical area, the Preceptor is expected to provide clinical teaching, to supervise students, to role-model for professional and clinical practice skills and to assess students in a clinical setting. The grades allocated by preceptors currently account for 50% of students' final grade for 3rd year clinical courses (I.H.S/UB 1995).

With regard to training or orientation of preceptors to clinical teaching there was neither documentation of how training is conducted nor guidelines for use by preceptors. Preceptor orientation currently conducted by various health training institutions focuses mainly on the orientation to curriculum requirement and the assessment tools. Orientation is usually less than four hours and this is often offered to senior managers who are in turn expected to pass the information to the nurse clinicians/preceptors in the clinical area. A three day pilot training of preceptors on clinical teaching was conducted about a year ago, but no follow up or evaluation has been conducted to evaluate its effectiveness. The training module (ModCal for clinical training skill) entailed clinical teaching and assessment skills and it was offered by the

Ministry of Health – Botswana (Institute Health Science Coordination unit) in collaboration with Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO).

1.2 Statement of the Problem

Preceptorship in Botswana is currently faced with issues of inadequacy of clinical teaching and compromised quality of clinical assessments. This is probably due to lack of clear guidelines on how preceptorship should be implemented. Ever since the expansion of the preceptor's role, there were concerns about the high clinical performance grades awarded by preceptors. The value and meaning of clinical performance grades allocated by preceptors, versus the students' clinical competence and classroom performance has been questioned in several academic board meetings. The concerns were that high clinical grades awarded by preceptors seemed not to correspond with the students' classroom performance or their clinical competence (National Academic Board (NAB) meeting, 2009). In one of the national academic board meetings, the external examiner voiced concern at the high clinical marks, which were in the range of 80-90%, allocated to all students in all the health training institutions. This grading style resulted in the external examiner questioning the quality of products of the general nursing programs.

In spite of all these concerns about preceptorship in Botswana, there is no record of studies investigating the potential causes or contributory factors to these discrepancies. There is also no documentation or guidelines available about preceptorship in the diploma offering nursing curriculum. According to Sen Gupta, Muray, McDonnell, Murphy & Underhill, (2008), adequate preparation of preceptors could be achieved by availing working guidelines to preceptors, disclosing students' limitations to preceptors, faculty support, training of preceptors on clinical teaching and assessment skills, and ensuring that preceptors have access to information resources.

In an attempt to explore factors contributing to the award of high clinical grades to the third year nursing students by some preceptors, a descriptive survey study was conducted. The critical areas addressed by the survey were to describe and explain the extent to which preceptors felt adequately prepared and supported to engage in the preceptorship process.

Emphasis was placed on perceived barriers to effective preceptorship in the diploma in the nursing curriculum in Botswana. The survey further explored how preceptors were socialized and nurtured into their roles, and how the quality of the role socialization process was related to the way preceptors viewed their roles, as well as their self-report on perceived levels of competence in clinical teaching and student assessment, and their appreciation of the preceptorship process in the clinical learning environment. To validate data collected from preceptors, the survey was further extended to third year level coordinators from participating health training institutions.

1.3 Purpose of the study

Preceptorship is a widely researched topic, but there is not much documentation about the topic in Botswana. The purpose of this study was to describe preceptors' opinions regarding the preparation and implementation of preceptorship, as well as perceived barriers to effective preceptorship, in the diploma in the nursing curriculum in Botswana. The study has attempted to establish preceptors' perceptions of their roles, availability of support systems for preceptors, relevant training needs, level of understanding of curriculum requirements, preceptors' level of comfort with the facilitation of clinical teaching and assessment of students, and as well as to explore the level coordinators' opinion regarding the implementation of preceptorship program. The ultimate goal was to solicit baseline data about the implementation of preceptorship, as well as to identify gaps and barriers that may require interventions to improve preceptorship in the health training institutions in Botswana. The results of the study may ultimately be used to guide the development of a preceptorship orientation package. Secondly, findings of this study may also highlight new perspectives that could later be considered to generate new research topics.

1.4 Research Question

The study was aimed at attempting to answer the following research questions:

1. What is the preceptors' opinion regarding the implementation of preceptorship in the diploma in the nursing curriculum in Botswana?

2. What is the faculty's (level coordinators') opinion regarding the implementation of preceptorship in the diploma in the nursing curriculum in Botswana

The objectives below were used to guide the researcher in attempting to answer the research question.

1.5 Research Objectives:

Major Objective: The rationale was to describe the preceptors' and faculty's experiences and opinions in the implementation of preceptorship program in the diploma in the nursing curriculum in Botswana. Specific objectives of the study were to establish the following:

- Preceptors' understanding of preceptorship and preparations involved to ensure effective preceptorship
- Faculty's (third year level coordinators') opinion regarding processes involved in the implementation of the preceptorship program
- The topics or areas covered during preceptorship orientation and relevance of the content to effective clinical teaching
- The type of and the extent to which preceptors perceive the support received from faculty and staff
- Perceived barriers to effective preceptorship
- Preceptors' views or opinions regarding their levels of competence in student assessment and clinical teaching
- The interpersonal relationship between the preceptors and faculty
- Preceptors' training needs

CHAPTER 2

2. BACKGROUND

2.1: Literature Review

The search strategy covered both the web and library based searches. The researcher used both published and unpublished, peer reviewed and non peer reviewed documents to lower the degree of bias. Unpublished literature, institutional reports, curriculum, academic regulations were used to highlight the significance of the study. For published documents, the researcher conducted library and web based searches. Articles or documents were used in the study if they described preceptorship in Botswana, evaluative studies about preceptorship in any health training institutions regionally or internationally or if the study described benefits of preceptorship or preceptorship intervention programs. Two articles on leadership and education were used to support the discussions and conclusions. In reviewing the literature on issues surrounding preceptorship, about 45 articles were identified for use in the study. The results of the integrated review of the literature revealed that the use of preceptors in health training institutions has gained international recognition (Mantzorou, 2004; Yonge, Ferguson, Myrick & Haase, 2003). Its value toward teaching and learning has been documented (Sen Gupta et al. 2008; Billay & Myrick 2008; Mallette, Loury, Engelke & Andrews, 2005; Myrick & Yonge, 2004; Baker, Dalton & Walker, 2003). The literature has also revealed a wide range of preceptorship benefits amongst all stakeholders directly or indirectly involved in the preceptorship. Benefits for students, preceptors, the clinical settings in which they practice, and as well as for the health training institutions have been highlighted by various researchers.

Benefits gained by students included improved clinical competence, a decreased theory-practice gap (Halabi, Abdalrahim, Person, Hedelmalm & Lepp, 2012; Ashworth & Morrison , 1989), reduced psychological and physical stress often experienced by students during training and hence reduced reality shock (Linn, 1975) (socialization of students to the working environment and exposure to a competent role model (Billay & Myrick, 2008; Mallette et al., 2005; Myrick & Yonge, 2004; Baker et al., 2003). According to Kaviani and Stillwell (2000),

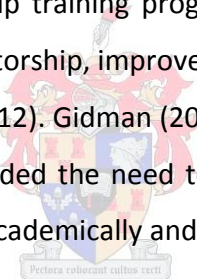
preceptorship, “exposes nursing students to the real world of nursing prior to graduation” (p. 218) and consequently reduces the reality shock as graduates join the work force.

Furthermore, benefits on the part of preceptors have included professional growth of preceptors (Charleston & Happel, 2004; Baker et al., 2003), and professional and personal satisfaction of a preceptor after participating in the growth and development of a student (Wilson, Fegan, Romence, Uhe & Dione, 2011; De Wolfe, Laschinger & Perkin 2010; Reilly & Oerman, 1992). Institutional benefits, emphasized by these and other studies included strengthening of the relationship between academic institutions and health care facilities (Shannon et al. 2006), a reduction in the demand for clinical lecturers in health training institutions, a reduction in strenuous workloads or an increase in staffing as students often bring additional manpower into the clinical area, (Hudson, Weston & Farmer 2011; Wilson et al., 2011; Ashworth & Morrison, 1989), which ultimately contributes positively towards staff retention (Wilson et.al., 2011).

Even with the wealth of benefits mentioned in various studies, various challenges have also been pointed out. The challenges or difficulties mentioned included disadvantages of engaging preceptors in clinical teaching and challenges associated with successful implementation of preceptorship. The disadvantages of engaging preceptors in clinical teaching have included increased practice hours (Taylor, Hasseberg, Anderson, & Knehans, 2010; De Wolfe et al. 2010; Vinson & Paden, 1994) with the cost of decreased productivity as part of preceptors’ time is spent with students (Vinson & Paden, 1994). For instance, according to Taylor et al.’s (2010) study, the increase in practice hours was reported at 18 hours beyond the normal shift hours for a preceptor who is supervising at least two students at a time. Other challenges included preceptor burn-out, role isolation, job dissatisfaction associated with reduced patient contact due to time spent with students (Coates & Gormely, 1997), preceptor discomfort in teaching and student assessment associated with poor support by faculty and health facility managers (Byrd, Hood & Youtsey 1997).

However, studies are also revealing that even though the preceptorship role is reported to make considerable demands on those nurses charged with the responsibility of providing an

environment conducive to learning in a clinical setting (Myrick & Barrett, 1994; Reilly & Oermann, 1992), less attention is paid to whether or not they have adequate clinical teaching skills (Myrick & Barrett, 1994). Considering the fact that the preceptorship approach has been endorsed internationally as one of the practical clinical teaching approaches, critical attention needs to be paid to ensuring that preceptors are well prepared to facilitate the preceptorship process effectively. According to Myrick and Barrett (1994), an adequately prepared preceptor should possess both clinical expertise and clinical teaching skills, otherwise they may have difficulty imparting to students the valuable knowledge and skills that they may have acquired. Myrick and Barrett's hypothesis are supported by Charleston and Happel, (2004)), in their study that revealed a strong positive relationship between the outcome of preceptorship and formal preceptorship training. In their study, formal preceptorship training was associated with the establishment of a positive learning environment for students. In another study on post-intervention evaluation of preceptorship training program, the results revealed an improved competence level in engaging in preceptorship, improved knowledge skill and attitudes towards teaching by preceptors (Halabi et al., 2012). Gidman (2001) revealed that preceptors play a vital role in clinical teaching and recommended the need to have preceptors with adequate adult learning skills and who are competent academically and clinically.



In conclusion, preceptorship, as one of the experiential learning strategies, is crucial to student learning as it effectively blends - the three domains of learning, namely cognitive, psychomotor and affective (Reilly & Oerman, 1992). Engaging students in clinical practice under the guidance of a competent preceptor greatly contributes to their achievement of psychomotor and affective objectives. The higher level cognitive domain also requires clinical practice for someone to effectively apply, analyze, and synthesize concepts learnt in a classroom setting (Reilly & Oerman, 1992).

2.2 Theoretical Framework

Role socialization theory provides a theoretical framework for this study, as it offers a link between positive preceptorship qualities (such as compassion, caring, adequate clinical and teaching skills, role modeling, motivation, critical thinking and analysis and communication

skills) and students' characteristics (Zilembo & Monterosso, 2008). This model proposes that preceptors who are well socialized in their roles usually display a positive attitude towards preceptorship. Role socialization is a "process in which an individual acquires the required knowledge, skills, values, attitude and affective behavior for the purpose of conforming to the norms of a community or an organization (McGraw-Hill Concise dictionary of Modern Medicine, 2002). Lichy and Stewart (2000) have cited various studies that revealed that socialization, if not properly facilitated, could be challenging and agonizing. Their literature review revealed that socialization into a new role could be difficult if performance expectations are not clear; if stakeholders such as faculty and preceptors are not well trained to handle diverse student populations; or if preceptors feel isolated from potentially helpful peers.

According to Klossner (2008) and Lichy and Stewart (2000), socialization is a process that consists of three phases namely; the anticipatory socialization or recruitment phase, entry and induction or professional preparation phase and lastly the continuing socialization and career development phase. The first anticipatory socialization phase includes special training and preparation of individuals for their new role, establishing personal expectations and assuming the new role. This phase is critical during the preceptorship process as it is during this phase that adequately prepared and willing preceptors should be recruited, and that adequate, well-structured training or orientation of preceptors to their role should be facilitated in order for preceptors to function effectively.

The second phase, which is the entry and induction or professional preparation phase, describes a phase whereby the newly recruited preceptors learn the new role and compare it to their previous role. It is during this phase that preceptors require adequate support from faculty, experienced preceptors and staff to help them appreciate their new role. Lack of support may bring uncertainty, misery and ultimately poor performance. The last phase is the continuing socialization and career development phase, which occurs as the newcomer masters the skills, adjusts to the new role and new colleagues, and begins to feel like an insider. This third phase advocates for ongoing support of preceptors to help them appreciate their contribution in a clinical teaching setting. The phase also advocates for preceptors to be

assisted to appreciate themselves as being part of the faculty and their mandate of being required to produce competent graduates.

Role socialization is the key to the success of preceptorship in any training institution. It is through socialization that newcomers are orientated to the values and philosophy of the institution, performance expectations and role definitions (Kowtha, 2008). The benefits of socialization and ongoing support of preceptors are highlighted in a study by Danielsson, Sundin-Anderson, Hov and Athlin, (2009). According to the authors, ongoing support in the form of group supervision of preceptors may result in an improved pedagogical approach by preceptors, change from preceptor-centered teaching to student-centered teaching and lastly an increase in level of comfort/confidence in awarding grades that coincide with the student's clinical excellence. My study has been guided by the three phases of role socialization theory in the design of data collection tools and in the selection of critical themes to be explored. The following critical areas adapted from socialization theory guided the development of the instrument: the recruitment process; the type of training that preceptors received; the perceived support received from faculty and staff; preceptors' perceived skills in facilitating clinical teaching and performing assessments; perceived barriers to preceptorship; and lastly preceptors' training needs.



2.3 Definition of terms

1. Mentoring/Mentorship: process of practical training and consultation offered to ensure a competent health care provider. Usually offered to a student or clinician who has already acquired a given clinical skill but found to be displaying some deficiencies in the clinical skill acquired (WHO, 2006).
2. Clinical Supervision/supervisor: focuses on the conditions required for proper functioning and improved performance of the health facility such as staff and student training, and availability of resources, but does not encompass clinical assessment of students (Goldhammer, Anderson & Krajewski (1993).
3. Preceptorship: The process focuses on practical training of students, proper functioning of the health facility to create an environment conducive for learning and clinical assessment of

students. Preceptors often teach new skills or coach students to improve on the skill already acquired (Billay & Myrick, 2008; Reilly & Oerman, 1992).

4. Preceptor: In this study a preceptor refers to a registered nurse (nurse clinician) with a minimum of 3 years of working experience and had participated in the clinical supervision of 3rd year student nurses who are on internship.

5. Third Year (3rd) Nursing Students: The term 3rd year (Semester 5 and 6) refers to all the nursing students who are in their final year of training and are enrolled in both the old and the new semesterized curriculum. The health training institutions have in the past two years been phasing out the old curriculum and introducing a new semesterized curriculum and this explains why level three and/ or year three will be used interchangeably in the study.

6. VARIABLES

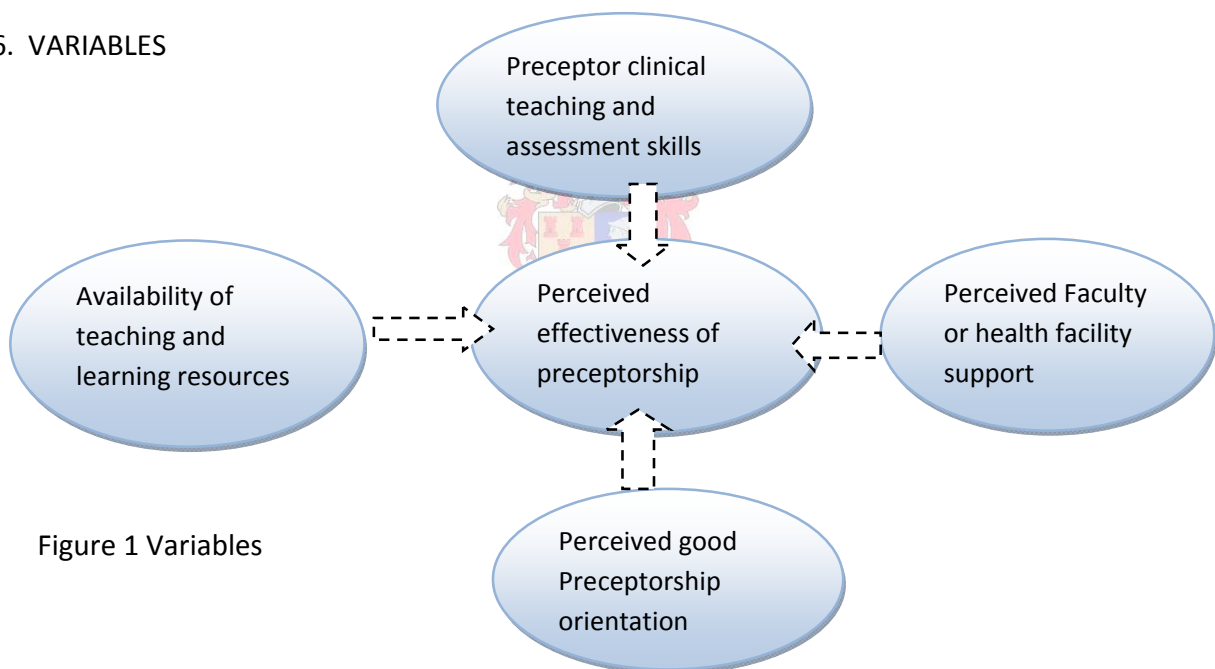


Figure 1 Variables

Figure 1 reflects that the success of an effective preceptorship program is dependent upon various factors such as: the preceptors’ level of clinical teaching and assessment skills, availability and accessibility of teaching and learning resources, the quality of orientation program and availability of support system from health training institutions and health facilities. Table 1 below defines the variables in the study, as reflected in the theoretical framework in figure 1.

Table 1 Definition of Variables

Variable	Indicator that variables are optimally met
Preceptor: Clinical Teaching and assessment skills	Receiving training on clinical teaching skills (demonstration, coaching, giving and receiving feedback, student assessment)
Teaching and learning Resources	Access to internet and library, receiving regular updates in the form of latest articles or in-service lectures
Preceptor orientation	Availability of preceptor orientation package, orientation to program requirements/expectations, perceived clarity of preceptorship roles
Faculty/health facility support	Regular meetings to discuss progress of students, Giving preceptors feedback on end semester course evaluation conducted by students, Report of less work load to accommodate students.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1. Research Design

A cross-sectional mixed descriptive survey was selected for this study. This approach was adopted because of its ability to provide a broad understanding of the concept under study by allowing participants to share their experiences and opinions about a specified situation. (Mouton, 2001). The research was in two parts. The first part was data collection from preceptors from health facilities; while the second part was data collection from year 3 (final year) level coordinators or senior lecturers from health training institutions. The study population comprised of registered nurses involved in preceptorship of third year student nurses who were on internship in the three teaching hospitals servicing the four health training institutions in the southern region of Botswana. Respondents included forty four (44) registered nurses from three health facilities and three level three coordinators from three health training institutions situated in the southern part of Botswana. Year three coordinators were included in the study to validate data collected from preceptors. Registered nurses who have never participated in clinical supervision of students were not included in the study.

In this study, a preceptor is defined as registered nurse (nurse clinician) with a minimum of 3 years of working experience and had participated in the clinical supervision of 3rd year student nurses on internship.

3.2 Instrument /Materials

Two questionnaires with self administered question items were developed and used for this study. The development of the questionnaire was guided by the research question, theoretical framework and the literature review. The first questionnaire (appendix 1) targeted the preceptors. The second questionnaire (appendix 2) was used to collect data from level three coordinators (faculty) from the four health training institutions to help cross-validate data collected from preceptors. The two questionnaires consisted mainly of quantitative questions and a few qualitative questions for the preceptors' questionnaire.

The questionnaire was divided into subsection as follows:

3.2.1 Preceptor survey tool

Questionnaire for Preceptors- See Appendix 1

The first nine (9 .) questions were used to provide general information in the following areas: Preceptors and level coordinators' (faculty) work areas; health training institutions that preceptors were providing clinical teaching for; preceptorship workload; how preceptors were identified and the details of orientation package.

The second part of the questionnaire (question 10) requested respondents to rate their overall experience on 38 declarative statements or items which covered preceptor training, support, resources, self rated competency level and preceptorship skills required. The 5-point likert scale ranged from strongly disagree, disagree, neutral, agree to strongly agree. Respondents were asked to indicate the degree to which they agreed or disagreed with positively worded statements.

The third section (question 11) asked respondents to indicate training needs, by selecting from a list of 5 identified competence-oriented preceptorship skills. The fourth section of the questionnaire (questions 12 -15) consisted of four open ended questions, which requested respondents to identify barriers to effective preceptorship and suggestions as to how preceptorship could be improved.

The last section of the questionnaire asked respondents to provide their demographic information.

3.2.2 Faculty survey tool

Level three Coordinators' (faculty) Questionnaire – See Appendix 2

A similar questionnaire was developed for level 3 coordinators from health training institutions. The questionnaire was to validate information collected from preceptors. The questionnaire was also divided into subsections. Questions 1-12 were similar to the Preceptor questionnaire. The second section of the questionnaire was a likert scale with 14 positively

worded declarative items, which covered areas such as preceptor training, support, resources, clinical assessment and others. Level coordinators were required to rate how they felt preceptorship was implemented in their institution. The third section required level coordinators to indicate the training needs required for effective implementation of preceptorship. The last section was demographic information about level coordinators. There were no open ended questions.

3.3 Ethical considerations in research and Quality Control

To address ethical and quality control measures, the research proposal, including the survey instruments, was approved by the Health Research Ethics Committee, University of Stellenbosch (Appendix 4) and Ministry of Health, Health Research Unit-Botswana (Appendix 5). It was subsequently pilot tested amongst registered nurses who were enrolled for advanced diploma training in Family Nurse Practitioner program at the institute of health sciences-Gaborone. The purpose of pilot testing was to allow the researcher to understand whether respondents understood the questions and to establish for clarity of the questionnaire. The questionnaire was pilot tested among five (5) registered nurses and modified to the current format. Two faculty members were asked to review the questionnaire for clarity of questions which was later revised in-line with their recommendations. Comments from Faculty and registered nurses helped with the establishment of the content validity of the tool. The results of the pilot test were not included in the study as the population was not representative of the population under study.

To comply with the ethical principles of research, a purposeful sampling approach was used to identify all those who were previously involved in preceptorship and willing to participate in the study. The study was explained to all those who volunteered to participate. Volunteers were given a consent form to read and sign, which reiterated the purpose of the study, benefits, the fact that there were no anticipated risks and the respondents' right to withdraw from study at any time. The respondents were also reassured that their responses would remain confidential.

3.4 Data collection/Procedure

After the proposal was approved by the University of Stellenbosch Health Research Ethics Committee and the Ministry of Health – Botswana Health Research Unit (HRU), permission was sought from participating institutions. A cover letter stating the purpose of study, study population, date of data collection and research approval letters from University of Stellenbosch and Ministry of Health -HRU were sent to each participating institution. Copies of the cover letters, permit to conduct research and consent form are attached as appendices “3” – “9”. Respondents were recruited through the managers of the health facilities and health training institutions. A purposeful sampling approach was used to identify all those who were previously involved in preceptorship (clinical teaching and assessment) and willing to participate in the study.. The questionnaires were distributed to each unit in the health facility to be completed by at least 3 respondents per unit. Respondents were requested to sign consent form before they were issued with questionnaires to complete. The questionnaires were distributed in the morning to all those who consented to participate and were collected from each unit in the afternoon or the following day. One participant per unit was assigned by the facility manager to assist with collection of the completed questionnaires, and to store the completed questionnaires in one area. This was so that the researcher could collect them from one person. Data collection per health facility lasted a maximum of 3 days.

On the part of faculty, questionnaires with consent documents were sent through the head of department of the program, who further assisted with the identification of senior lecturers or 3rd year level (internship) coordinators. The names of coordinators who volunteered to participate were communicated to the researcher by phone. The respondents were later followed by telephone to explain the purpose of the study. They were requested to read the consent form and sign before completing the questionnaire. Written consent and questionnaires were completed by the respondents and sent either by fax or collected directly from the health training institutions.

The preceptor survey (appendix 1) was sent out to 62 registered nurses who were employed in a variety of inpatient health care settings (such as surgical, medical, orthopedic, psychiatric unit or recovery unit etc), who served as preceptors to nursing students on internship and had

participated in clinical evaluation of students. Four (4) faculty questionnaires were also sent to four level coordinators in four health training institutions.



CHAPTER 4

RESULTS: PRESENTATION, ANALYSIS AND DISCUSSIONS

4.1. Presentation and Analysis

Data analysis was descriptive in nature and there was qualitative content analysis of data from open ended questions. The steps involved in content analysis were: reading and re-reading of the texts to get a clear understanding of the responses; coding of data or identification of topics that emerged from the scripts; reduction of codes or topics into common themes as generated from the data collection instrument and the theoretical framework and lastly, the conduction of final interpretation of data through word-frequency count of responses. Credibility of the study was established by rereading and recoding of the texts and themes (Lincoln & Guba, 1995).

SPSS version 19.0 was used to perform the analysis of the closed-ended questions. The descriptive statistics included measurement of frequencies, percentages and average means. The survey results were grouped into four sections as follows:

4.1. A. Demographic details (Question 16 for preceptor survey and question 15 for faculty survey)

4.1. B. Basic information about Preceptorship Approach and Orientation Package (Questions 1- 9 for preceptor survey, questions 1-12 for faculty survey)

4.1. C. Preceptors' perceptions on the following areas (Likert-scale question section)

- I. Role Clarity and Preceptorship Training and Orientation
- II. Preceptor Clinical Teaching and Assessment Skills
- III. Preceptor support and availability of resources
- IV. Curriculum implementation issues
- V. Preceptorship benefits

4.1. D. Faculty's' perceptions on the following areas (Likert-scale question section)

- I. Role Clarity and Preceptorship Training and Orientation
- II. Preceptor Clinical Teaching and Assessment Skills
- III. Preceptor support and availability of resources
- IV. Curriculum implementation issues

4.1.E. Preceptors' responses to Open ended questions

The preceptor survey (appendix 1) was sent out to 62 registered nurses who were working in a variety of inpatient health care settings. Forty six (46) preceptors returned completed questionnaires (Response rate of 74.2%). Two (3.2%) of the returned questionnaires were discarded as there was a lot of missing information. Fourteen (22.6%) of the sixty two (62) were sent back not completed, while two (3.2%) were never received from the respondents who volunteered to participate.

With regard to faculty survey, three out of four completed questionnaires were received from level coordinators (75% response rate) and the surveys were all complete. The results after data analysis are presented below:



4.1.A. Demographic Details

A purposeful sample of forty-four (n=44) preceptors from three health facilities in the Southern region of the country participated in the survey. The respondents' age ranged from 25- 48 years with a mean age of 32.3 years. The majority were female accounting for 70. 5% (n=31) of the respondents. The diploma holders accounted for 79.5% (n=35/44) while the remaining 20% (n=9/44) were basic degree holders. There were no Masters Degree holders. The majority (75%, n=33/44) were from the senior nursing level as follows: senior registered nurses were recorded at 40.9% (n=18/44) and principal registered nurses at 34.1% (n=15/44). The lower nursing cadre represented 25% (n=11/44) of the sample. The preceptor designations are reflected on figure 2 below. The preceptor designations are from junior to most senior level.

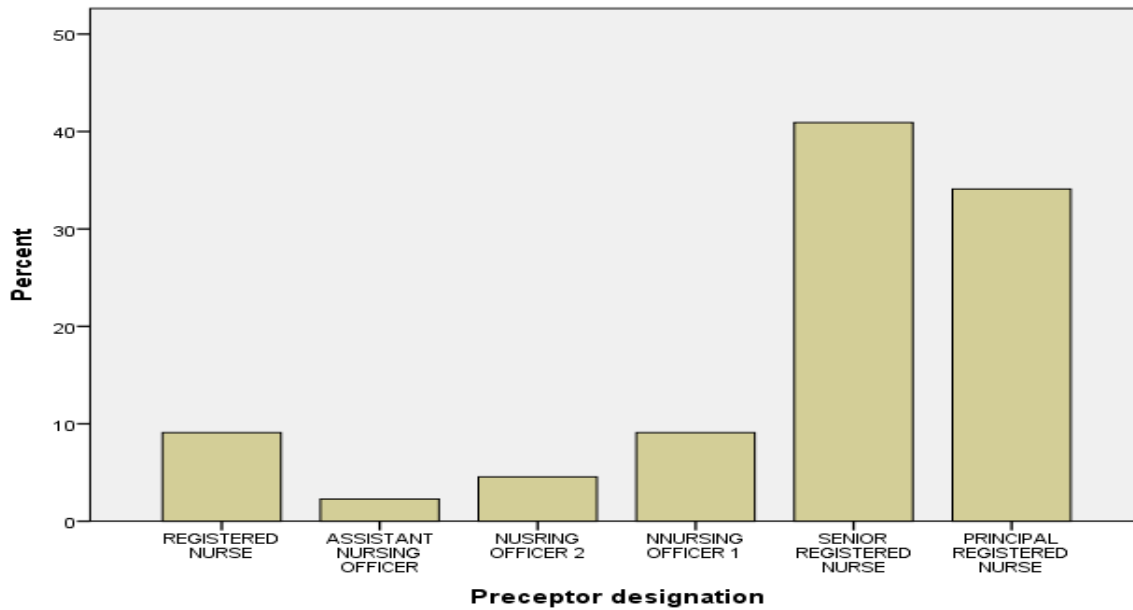


Figure 2 Preceptor Designations

The majority (70.5%, n=31/44) of the preceptors were from two referral hospitals (coded as referral hospital 1 and 2, and the remaining 29.55% (13/44) were from a district hospital, coded “district hospital 3”. See figure 3 below depicting percentage of preceptor distribution per health facility.

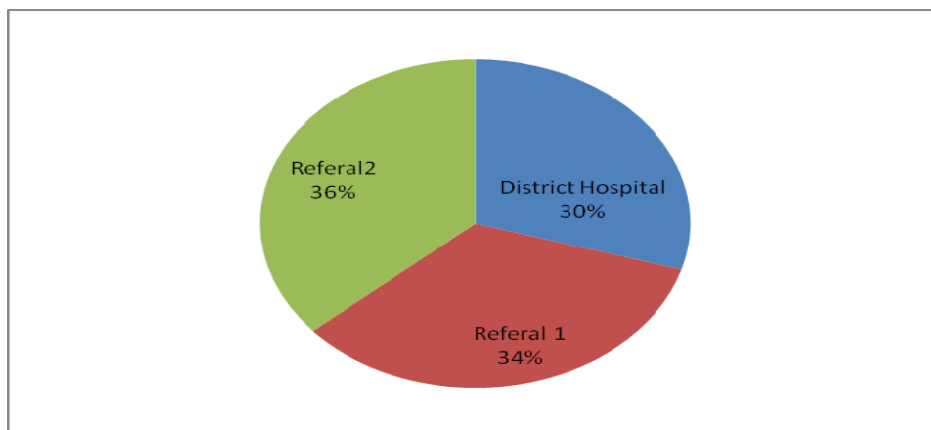
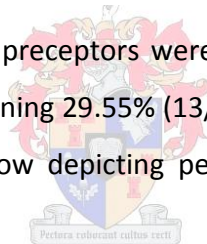


Figure 3 Proportion of preceptor distribution by facility

The data further revealed that referral hospital-2 was used by three health training institutions for mental health nursing, while referral hospital-1 was used by three health training

Institutions for medical and surgical nursing. District Hospital-3 was used by one training institution for both mental health and medical-surgical nursing.

The demographic details for faculty comprised three females with an age range of 33-55 years. Two of the respondents were basic degree holders, while one was a master's degree holder. Two were at the level of senior lecturer, while one was a lecturer.

4.1.B. Basic information about Preceptorship Approach and Orientation Package

In questions 2 – 9 (appendix 1), preceptors were invited to provide information about preceptorship in their facilities. Most of the questions required respondents to select from a list of responses provided in the questionnaire.

On the question (question 2) that requested a list of health training institutions that the clinicians were doing preceptorship for, 47.7% (n=21/44) indicated that they were doing preceptorship for one health training institutions, which was followed by 15.9 % (n=7/44), who were preceptors for students from four (4) health training institutions. The remaining respondents (4.5% (n=2/44), 9.1 (n=4/44) and 4.5%, (n= 2/44)) reported covering 2, 3 and more than 4 health training institutions respectively. There were missing data from 18.2 % (n=8/44) of the respondents. The challenges associated with missing data, is that it affects the quality of inferences derived from the respondents as the sample size was smaller than the original sample size. The missing data is likely to introduced biasness into the estimate as those who did not respond may have different opinions compared to those who responded to the questions. (Becker & Walstad, 1990). In conclusion, a significant number of preceptors (34% n=15/44) indicated to be doing preceptorship for more than 1 health training institutions.

See figure 4 below elaborating the total number of health training institutions serviced by preceptors. .

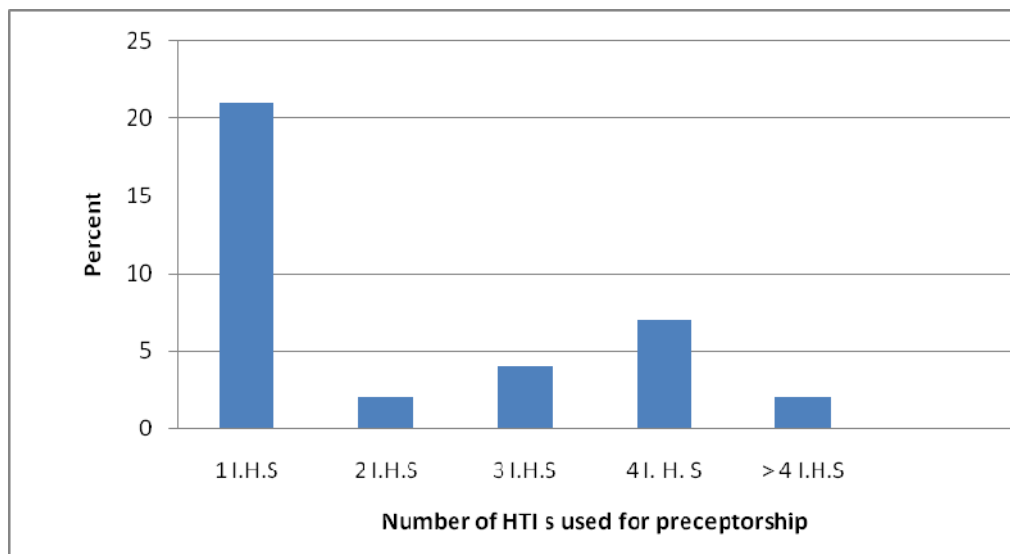


Figure 4 Number of Health Training institutions supervised by preceptors

Similar to responses from some (34%, n=15/44) preceptors, data (appendix 2, Q 7) from all the three faculty members confirmed that preceptors were supervising students for two or more health training institutions.

A survey question (appendix 1, Q 8) about preceptorship training or orientation reveals that 88.6% (n=39/44) had not received training or orientation on preceptorship. Out of the 11.4% (5/44) who reported to have received training, three of the five reported to having been requested to engage in preceptorship by the school or health facility manager while the other two reported to have volunteered and/ or were identified by students. On evaluation of quality of preceptorship training or orientation received by the five preceptors who received training, four of the five (80%) reported that they were not pleased with the training or orientation offered.

Faculty responses about preceptorship training and or orientation (appendix 2, Q 11) confirmed that preceptors received orientation prior to assuming their role and two of the faculty members reported that the last orientation was 2011, while the other one reported 2012 as

the date of training. However, the 2012 date of training was not correct as data were collected in December and the first week of January, 2012.

On the part of faculty questionnaire (appendix 2, Q12) that explored topics covered during preceptor training or orientation, all faculty responses indicated that the training package covered the roles of the preceptor and orientation to the students' clinical assessment tool. Two of the responses reported that training covered additional areas such as orientation to curriculum and school regulations, and how to teach in a clinical area. Only one participant indicated that their orientation also included how preceptors could access resources from school (books, faculty, teaching aids etc).

Preceptor responses to questions on preceptor selection criteria highlighted that the majority (77.3%, n= 34/44) of preceptors were requested by students or volunteered to engage in clinical supervision of students. The remaining 13.6% (n= 6/44) preceptors reported that they were identified by unit manager or school. This question was not completed by 9.1% (n= 4/44) of the respondents. The missing responses may suggest lack of clarity of the question or reluctance of the preceptor to respond to questions. Preceptors who offered to assist students without involvement of faculty, may find it cumbersome to disclose that they have supervised and assessed students with no prior orientation. This missing data is likely to introduce biasness in the interpretation of the results.

Refer to figure 5 below for responses on how preceptors were identified.

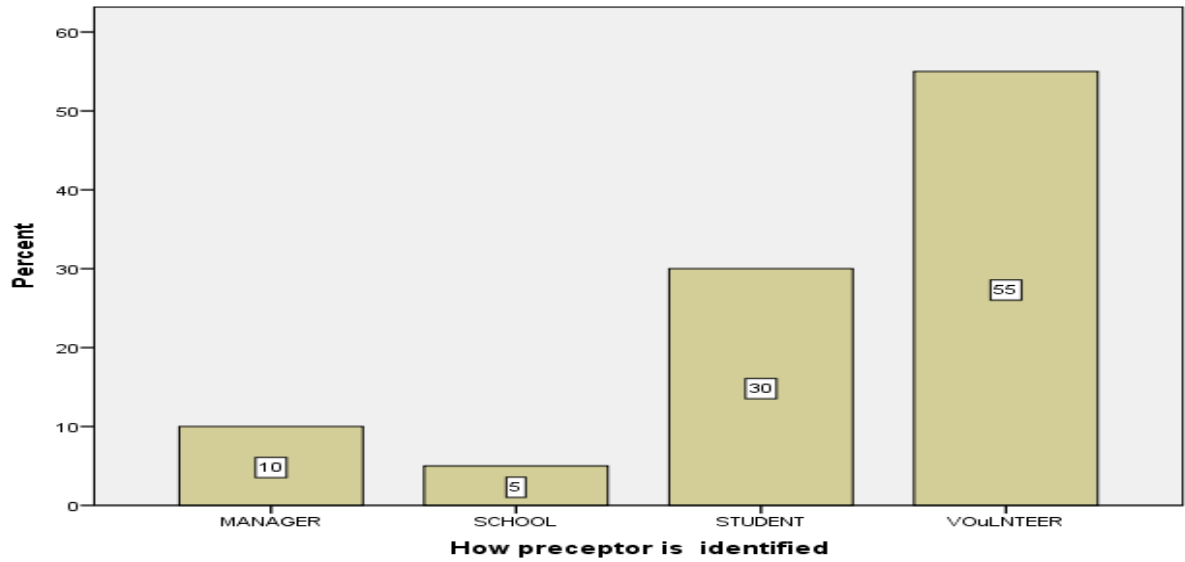


Figure5: Preceptor Responses to How Preceptors Were Identified



Furthermore, data revealed that the period of preceptorship ranged from 1 year to more than 5 years, with the majority (65.9%, n=29/44) reporting years of experience in preceptorship varying between 3 years and more.

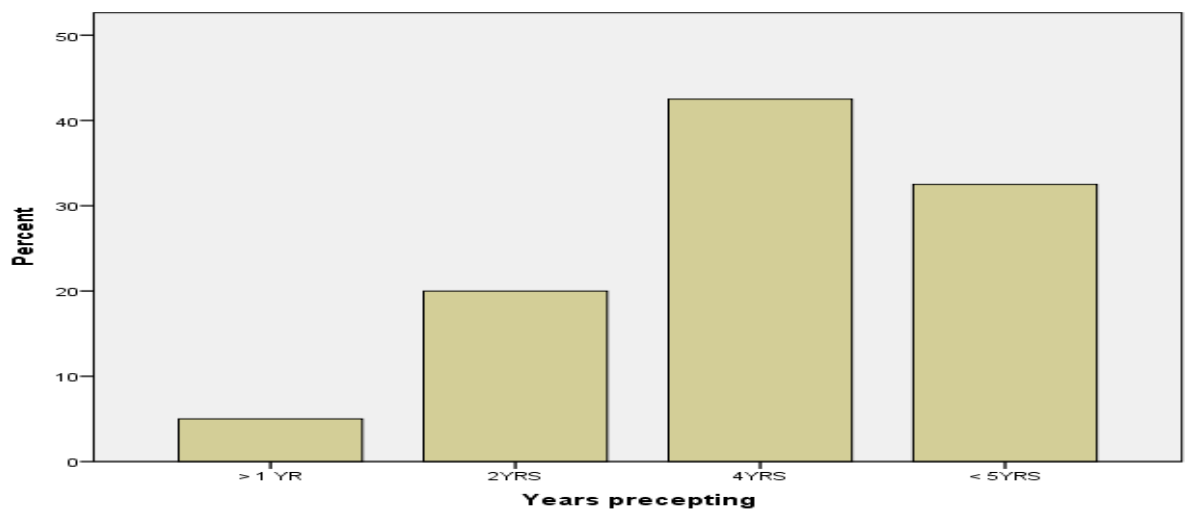


Figure 5: Total number of years preceptors were engaged in preceptorship program

The question on how faculty identified preceptors revealed that preceptors volunteered (2 responses) while the other respondent indicated that the preceptor was identified by the health facility manager. Responses to question 9 (appendix 2), reflected that the institutions have a set criteria for selection of preceptors. .

According to preceptor responses, the students' rotation per unit varied from one week to 4 weeks. The majority (54.5 % n= 24/4) indicated rotation period of 1 week, followed by rotation period of 2 weeks at 36.4% (n= 16/44). Only about 6% (3 respondents) reported a rotation period of up to 4 weeks.

According to faculty, the period of students' attachment to a clinical site/unit is 1-5 days. This correlates well with the majority of the preceptors who reported 1 week rotation to a unit/site.

Preceptor responses to preceptor-student load were reported as follows: 2.3% (n=1/44) reported a preceptor to student load of one preceptor to a student, 50% (n=22/44) reported a preceptor to student load of one preceptor to 3-5 students, 31.9% (n=14/44) reported a preceptor to student load of one preceptor to 6-10 students and a preceptor to student load of one preceptor to 11 students and above was reported by 13.6% (n=6/44) of the responses. . In conclusion the majority (52.3% n=23/44) of responses reflected that the preceptor to student ratio was on an average of around 1 preceptor to 5 students (1: 5).

Figure 6 below reflects preceptor-student ratio.

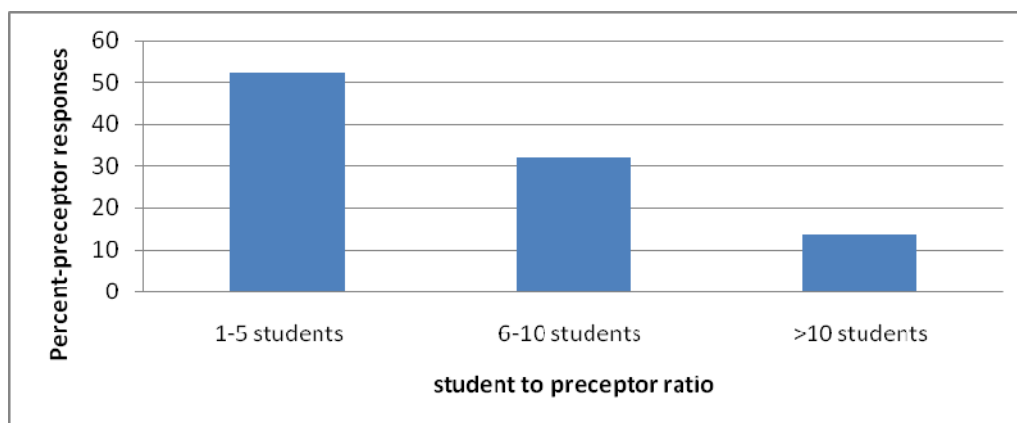


Figure 6 Preceptor responses to Preceptor-Student clinical teaching load

Faculty responses to question requesting for average number of students per internship site reflected that 6-10 students were attached to an internship site at a given period, while the question (Q7, appendix 2), that enquired about the average number of preceptors per internship site reflected an average of 3-4 preceptors to an internship site. This brings down the average ratio of preceptor to student to 1:2. Responses of both preceptors and faculty to preceptor to student ratio have resulted in dichotomous responses as faculty reported an average preceptor to student load of 1 to 2 students, while preceptors reported 1 preceptor to 1-5 students - This could probably be due to factors preceptor such as both the faculty and preceptors losing track of the total number student and preceptors per unit.

Report on the period of preceptorship varied a lot amongst the respondents. Respondents (preceptors) were required to report the periods of preceptorship that they are often assigned students. The preceptorship periods were divided into January – April, May – August and August to November and the results were as follows: January to April and August to November (usual academic semester periods) accounted for 25% (11) responses, followed by August to November at 22.7% (n=10/44), January to April at 11.4% (n=5/44), January – November at 9.1% (n=4/44), May to August at 6.8% (n=3/44) and lastly January to August at 2.3% (n=1/44). Ten respondents (22.7%) did not respond to this question.

Table 2: Period of Preceptorship

	Proportion of responses (% , n=44)
<i>Period of preceptorship</i>	
January - April	11.4 % (n = 5)
January - November	9.1 % (n = 4)
May – August	6.8% (n =3)
January -August	2.3% (n = 1)
August - November	22.7% (n = 10)
January – April and August - November	25% (n = 11)
No response to question	22.7% (n = 10)

According to faculty responses, the period of preceptorship was from August to December and January- April. These responses are in line with clinical teaching months, as May –July is usually a vacation period for most students, however, May to August has also been used by students who have failed to meet clinical requirements during the normal academic period. The faculty responses did not match well with the preceptors' responses who reported May –August as the clinical internship period.

4.1.C. Preceptorship Perceptions (5-point likert scale responses)

This section requested respondents to rate their overall experience on 38 items which covered preceptor training, support, resources, self rated competency level and preceptorship skills required. The 5-point likert scale was in order of strongly disagree, disagree, neutral, agree and strongly agree. On data analysis, the responses were grouped into three main categories as follows: Agree category, which included strongly agree and agree responses; neutral responses and disagree category which covered the strongly disagree and disagree responses. The neutral responses were discussed separately as they may reflect indecisiveness of the preceptors, which may result from factors such as inability to recall information, being

uncomfortable to disclose information or inability of the preceptor to retrieve the information from files or records at the time of data collection to make an opinion (Alwin & Krosnick, 1991).

Data were categorized into five themes, aligned to the theoretical framework and variables as follows: role clarity and preceptorship training and orientation; preceptor clinical teaching and assessment skills; preceptor support and availability of resources; curriculum implementation issues and other preceptorship issues; and lastly, preceptorship benefits.

I. Role Clarity and Preceptorship Training and Orientation

The survey results revealed 56.8% (n= 25/44) of respondents disagreed that they had adequate preparation for their preceptorship role while 13.6% (n=6/44) were neutral to the statement. Neutral response in this case may reflect that the respondents did not want to form an opinion for fear of being judged as not being adequately prepared to engage in preceptorship program. On the other hand neutral responses may depict that the respondents are not sure of their opinions.

On the statement that explored whether the clinicians were satisfied with the quality and relevance of preceptorship training and orientation, majority (72.7 % n= 32) also disagreed with the statement while the remaining respondents were either neutral to the statement (13.6%, n=6/44) or reported to be satisfied (6.8%, n=3/44). The remaining 2.3% (n= 1) did not respond to this question. Similarly the neutral responses may denote respondents' inability to form an opinion about the issue being explored either because they do not have enough information or they are not sure of their opinion.

Questions on role clarity indicated that the majority (54.6% n=24), felt they understood their role as preceptors. Furthermore, preceptors' responses to question that assessed clarity of preceptors' role as an assessor indicated that 50% (n=22) of the respondents felt that their role as student assessors was clear. On another question on role clarity, 70.4% (31) agreed that they understood what students needed to learn in the clinical area. The last question on role clarity explored whether preceptors understood how the material they taught fitted into the nursing curriculum, 40.9 % (n= 18) felt that they understood how it fitted into the curriculum.


II. Preceptor Clinical Teaching and Assessment Skills

This component was evaluated by five questions. The first three questions evaluated preceptors' perception of their competency level on clinical teaching and assessment. The results revealed that of 47.7% (n=21/44) reported that they were well equipped to teach, while on the part of assessment, 54.6% (n=24/44) reported to be equipped to assess students. The questions that evaluated whether respondents were comfortable with the grades they allocated students, 77.3% (n=34/44) were comfortable with the grades that they allocated students. Similarly, 68.2 % (n=30/44) were comfortable awarding a failing mark to a student who did not perform well in the clinical assessment.

The remaining two questions attempted to establish student performance levels. On the question that asked about the outcome of preceptors' assessment, 56.8% (n=25/44) of respondents reported that most of their assessed students pass clinical assessment. When establishing if students that failed were reassessed, 50% (n=22/44) confirmed this.

Preceptors' reflections on clinical competency levels are described in table 2 below:

Table 3 Preceptors' Reflections on clinical teaching and assessment skill competencies



Competencies	Proportion of responses % (n=44)
Well Equipped to teach	47.7 % (21)
Well equipped to conduct assessment	54.6% (24)
Comfortable with clinical grades I allocate	77.3% (34)
Comfortable to allocate a failing mark to students who didn't perform well	68.2% (30)
Conducts reassessment of failing students	50% (22)

III. Preceptor Support and Availability of Resources

The variable on support was evaluated by 10 questions (appendix 1, questions xx to xxvi, xxvii and xxix). Seven of the 10 questions evaluated perceived support from faculty or health training

institutions, while three questions explored support from the health facility. The results on support of preceptors by faculty revealed dissatisfaction with faculty or institutional support in all the seven areas. Only 20.4% (n=9/44) agreed to the statement that that faculty was available to provide mentoring on preceptorship role, while 50% (n=22/44) disagreed with the statement. The remaining data (27.3%, n=12/44) were neutral responses. In another question, 84.1% (n=37/44) disagreed with the statement that they received regular visit from faculty to discuss issues of preceptorship, while 2.3% (n=1/44)) agreed to the statement. The remaining 11.4% (n=5/44) respondents were neutral to the statement.

Responses to questions on whether there was any form of communication about students' performance or learning needs, revealed 2.3% (n= 1) admitted to have received feedback about students progress and clinical performance while 90.9% (n=40/44), denied receiving student progress. Two (4.6%) of the respondents were neutral to the statement. The results on a question that explored whether preceptors received reports about learning needs of students revealed 13.7% (n= 6/44) of the respondents admitting to receiving reports from faculty, while 77.3% (n=34/44) did not receive the reports. The remaining 6.8% (n=3/44) were neutral responses

On the part of health facility support, 37.2% (n=12/44) of the respondents were not happy with the support they received from facility managers, while 47.7% (n=21/44) agreed to the statement that the health facility managers were available to provide support. The remaining 22.7% (n=10/44) of the respondents were neutral to the statement. The co-worker support was reported by 61.3% (n= 27) of the respondents. The question that explored support from other preceptors revealed that 34% (n = 15/44) agreed to receiving support from other preceptors, while 22.8% (n=10) disagreed to the statement and 29.5% of the respondents were neutral to the statement The question on the overall adequacy of contact with or support received from faculty indicated that the majority (68.1% n= 30/44)) were generally not happy with the support received, while 15.9% (n=7/44) were neutral to the statement and 13.6%(n=6/44) agreed that faculty support was adequate .In another question that explored adequacy of resources received from faculty, the majority of respondents revealed that the

resources were not adequate (72.1%, n=32/44), while 18.2% (n=8) had neutral responses to the statement and 6.8% (n=3/44) agreed that the resources were adequate.

A significant number of respondents rated themselves on the neutral scale. These responses have implications on the results of the study. The neutral responses to the question may depict unclear question, fear of being victimized by health facility manager, other preceptors or faculty, lack of enough information to make an opinion or lack of interest in the study. The challenges associated with neutral responses are that the neutral response does not give a clear explanation of what is in the respondents' mind, unless if such questions are followed up an open ended question. On the other hand, neutral responses could be used to generate new studies, to better understand factors that lead to such responses .

Generally the questions on support revealed low support from both faculty and marginal support from health facility and preceptors. A substantial number of neutral responses were noted under the questions that explored health facility manager support and preceptor to preceptor support. The neutral responses in these cases may associate with respondents' fear of disclosing their true opinions to their supervisors and colleagues. The fact that the researcher left the questionnaire with staff members could also have contributed to respondents' reluctance to disclose their opinions.

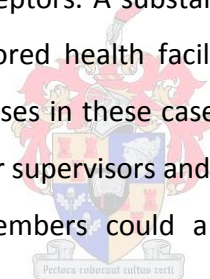
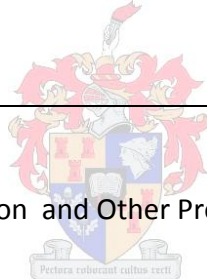


Table 4 Reflections on type of support received by preceptors

Type and availability of support	Proportion of responses satisfied with support (n= 44)
Availability of faculty	20.4% (n= 9)
Availability of health facility supervisors	47.7 % (21)
Co-worker availability	61.3 % (n = 27)
Support from other preceptors	34% (n = 15)
Regular faculty Visits	2.3% (n=1)
Faculty feedback about students' clinical performance	2.3 % (n= 1)
Faculty Reports about students' learning needs	13.7 % (n = 6)
Regular attendance of workshops on preceptorship	2.3 % (n = 1)
Adequacy of contact with or support from faculty	13.6(n= 6)
Adequacy of resources from faculty	6.8 (n= 3)



IV. Curriculum Implementation and Other Preceptorship Issues

There were seven questions (appendix 1, Qx, xii, xxxi to xxxv) that evaluated issues surrounding curriculum implementation. Two of the questions (Qx, xii) evaluated the relevance of assessment tool to clinical care competencies. The results of the two questions revealed a positive response rate of 72.7% (n=32/44) to the question that established whether or not the clinical evaluation tool was adequate to provide guidance on the students' learning objectives. Furthermore, on another question, 56.8% (n=25) indicated that the tool was adequate for assessing the 'clinical competency.

The other four questions evaluated how preceptorship interfered with patient care. The response to these questions revealed that the majority of preceptors 54.5% (n=24/44) felt that time allocated was not enough for them to provide adequate clinical teaching, while on the other hand 45.4% (n=20/44) of the respondents felt that the student-preceptor ratio was high

while 34.5% (n=15/44) disagreed with statement that the student-preceptor load was not manageable. The remaining 13.6% (n=6/44) were neutral to the statement

On the question about preceptor workload, most (59.1% n=26/44) respondents felt that the workload was not manageable. However, most respondents (61.4%, n= 27) denied that preceptorship workload affected the quality of patient care. Furthermore, responses to questions that evaluated whether patient care assignments interfered with preceptorship role revealed that 34.1% (n=15/44) agreed that it interfered with clinical teaching, while 38.6% (n=17/44) disagreed with the statement. Twenty seven point 3 (27.3, n=12/44) were neutral to the statement that patient care assignments interfered with their role as preceptors.

Based on the above responses, issues of concern are short periods allocated for preceptorship, the high preceptor-student ratio and increased preceptor work load, which are likely to impact negatively on the effective implementation of preceptorship program and most importantly on the quality of clinical assessments.

V. Preceptorship Benefits



The last three questions explored how preceptors valued their preceptorship role. The majority (81.8%, n= 36) felt that preceptorship gave them an opportunity to grow professionally and it provided them with personal fulfillment (79.5%, n =35/44). On the question that explored whether preceptors would like to continue with preceptorship, 63.6% (n=28/44) indicated that they would like to continue with the role.

- I. Faculty (n=3) was exposed to 14 questions which evaluated 4 key areas as described in the theoretical framework namely: role clarity and preceptor training and orientation; preceptor clinical teaching and assessment skills; preceptor support and availability of resources; and curriculum implementation issues; Respondents were asked to rate their opinions on a 5-point likert scale, in order of strongly disagree, disagree, neutral, agree, strongly agree. There were no neutral response to all the fourteen questions. Role clarity and preceptor training and orientation

Faculty perception of preceptor training or orientation, revealed that there were no regular seminars or workshops for preceptors (66%, n=2/3 responses); there was no preceptorship resource manual or guideline to guide preceptors and students (100%, n=3/3); faculty believed that preceptors understood students' and program expectations (100%, n=3/3 responses); and lastly, faculty (100%, n=3/3) revealed that preceptors were made to understand students' assessment tool prior to assuming their roles. See table 2 for faculty responses

Table 5: Faculty responses to preceptorship orientation package

Preceptor training	Faculty responses agreeing to the statement: (n =3)
Faculty conducts regular preceptor workshops	1
Preceptor manual is available	0
Preceptors understand student and program expectations	3
Preceptors are made to understand clinical assessment tools prior to assuming roles	2

II. Preceptor clinical teaching and assessment skills. This component was evaluated by three questions (appendix 2, Q v, vi, and viii). The first three questions evaluated whether faculty felt preceptors were well equipped to teach students. The response to this question revealed that preceptors were not well equipped to teach (66.6% n=2/3) responses). On the part that explored whether preceptors had adequate clinical assessment skills, 66.6% (n=2/3) of the faculty felt that preceptors were not well equipped to do assessments. Similarly all the 3 (100%) faculty reported to be uncomfortable with the clinical grades awarded by preceptors.

III. Preceptor support and availability of resources


IV. Responses to the questions that explored the type of support offered preceptors (appendix 2, Qii, ix, x, xiv) , revealed that preceptors had access to health training institution libraries (100%, n=3/4responses); Faculty reported to always be available for support and mentoring of preceptors (100%, n=3/33); Contrary

to the support mentioned above, faculty disagreed to the notion that they created a forum for giving feedback to preceptors about student progress, learning needs and clinical performance (66.6%, n=2/3 responses). On the question that explored whether faculty negotiated for preceptors to be allocated less workload, all disagreed (100%, n=3/3 responses). Curriculum Implementation Issues

There were 2 questions (appendix 2, Qxii, xiii) that evaluated issues surrounding curriculum implementation. The first question assessed whether satisfaction surveys were carried out to help improve preceptorship exercise. The response to this question was that, there were no satisfaction surveys conducted (100%, n=3/3). The second question had attempted to establish whether the preceptor student ratio was manageable. The responses to this question revealed that the preceptor student ratio was manageable (66.65, n=2/3).

4.1.E. Preceptors' responses to open-ended questions

The last section of the preceptor questionnaire were open ended questions. The questions requested respondents to describe the following:

- 
- a. How preceptorship should be conducted to produce competent graduates
 - b. Areas that needs strengthening for smooth running of preceptorship program
 - c. Description the type of support preceptors would like to receive from training institutions and health facilities to enhance effectiveness of performing preceptorship role
 - d. Barriers to effective preceptorship.

The results of the open ended questions (appendix 1, Q 12- 15) are as follows:

The first question (Q12) required respondents to describe how they felt preceptorship program should be implemented so as to produce competent graduates. The most prevalent themes that emerged from this question were: a need for training of preceptors (21 responses),

improved faculty-preceptor interactions (4 responses), availability of faculty in the clinical area (4 responses), allowing preceptors to spend more time with students and reduced workload for preceptor (3 responses), recommendation that students be supervised by one preceptor at a given clinical rotation (2 responses), improved faculty- preceptor feedback (2 responses) improved faculty involvement in clinical teaching (2 responses) , reduced preceptor-student ratio (2 responses) . and lastly, 1 response for each of the following themes were recorded: a need for increased clinical attachment hours and increased total number of preceptors. On the question (Q13) that explored the areas that needed strengthening to ensure smooth running of preceptorship, the following areas were identified (in order of frequency): Strengthening training of preceptors (15 responses); strengthening faculty-preceptor interactions/support/feedback (13 responses); strengthening student assessment (6); Recommendation to have lecturers in the clinical area (2 responses); improved assessment tools (2 responses), sensitization of preceptors about curriculum requirements (2 responses) and lastly, training students about preceptors' role and strengthening student discipline (1 response), strengthening faculty-student-preceptor interactions, improved training resources, strengthening preceptor teaching skills, clarifying the roles of preceptors to students, improving staffing situation in the clinical areas,



The third question (Q14) required preceptors to indicate the support they would like to receive from both the health training institution and the health facility in order to enhance efficiency and effectiveness in performing preceptorship role. The most prevalent themes that emerged from this question were as follows:

- i. Support required from Health training institutions: Respondents requested for Training of preceptors (6); providing teaching aids and preceptor guidelines (5); improved preceptor-faculty interactions (4); Frequent faculty visits to the clinics (4);;. Further responses included the request for faculty to reinforce positive behavior of students; enhancement of faculty-preceptor interactions/feedback; providing incentives for preceptors, and training of preceptors on how to assess and understand assessment tools.

ii. Support required from health facility

The main themes that emerged were: workload for preceptors (15 responses); increasing the number of clinical nurses so that preceptors could cope with patient and student load (4 responses), providing clinical equipment (1 response); and that health facility managers should appreciate preceptors' role.

The last question (Q15) required respondents to describe the perceived barriers to effective implementation of preceptorship. The key barriers identified were excess workload by preceptors (9 responses); lack of training of preceptors (5 responses); poor faculty support (3 responses), The lack of clinical teaching equipment (2 responses), lack of availability of faculty (1 response); students' lack of understanding of preceptors' role (1 response), the use of unskilled preceptors (1 response) and lastly, the lack of support from colleagues (1 response), poor staffing, lack of support from management or faculty and student's unwillingness to learn (1 response each) .

The response rate to open ended question was between 68% (n=44) and 90% (n=39) as some questions were left unanswered. However, some respondents gave more than one answer to a question.



4.2. Discussion

Preceptorship plays a critical role in the integration of nursing students into the “real world” of nursing (Beryl & Wilma, 1981) and as well as attempts to close the theory-practice gap (Halabi, et al., 2012; Altman, 2006) that exists during the implementation of the nursing curricula. Given the purpose of preceptorship as socialization and a clinical teaching strategy, this study therefore was conducted to establish the strengths and the gaps that existed during the implementation of preceptorship in the four health training institutions in some parts of Botswana. The results of the study are discussed below in line with the theoretical framework.

Criteria for Selection of Preceptors

According to Duteau (2012) and Mantzorou (2004), effective implementation of preceptorship is greatly influenced by the careful selection of appropriate preceptors and the availability of

clear criteria or systems for selection of the most competent preceptor. Qualities to be considered in the selection of preceptors include preceptor motivation, being knowledgeable and experienced, a competent role model, having good communication skills, having good teaching skills and good personal characteristics such as enthusiasm (Duteau 2012; Altman 2006; Kaviani & Stillwell 2000; Burke, 1994; Reilly & Oerman 1992). Preceptors and faculty in this study have revealed lack of clarity on how preceptors were identified in the study. The majority (77.3% n = 34) of preceptors' responses revealed that they were either requested by students or they just volunteered to precept without the involvement of faculty or senior facility managers in their selection. The lack of criteria for selection of preceptors and lack of involvement of faculty and health facility managers in the selection of preceptors may result in the use of inexperienced practitioners and hence inappropriate delivery of preceptorship. With reference to both the preceptor and faculty responses on how preceptors were selected, it is justified to conclude that preceptor selection is based on availability and willingness to precept rather on the quality of preceptorship skills. This selection approach is further weakened by the fact that there is minimal faculty follow up to orientate those who volunteered or those requested by students to precept. Selection of a clinically competent preceptor is essential in that the preceptor will be in a position to provide guidance in clinical skill development, and the provision of clinical supervision.

On the other hand, the use of preceptors who volunteered without faculty and health facility managers' influence may be a positive indication that preceptors are highly motivated to teach, are supportive and approachable. Preceptors' involvement in clinical supervision and assessment for students without faculty's involvement in their selection may also be associated with the understanding that registered nurses with three or more years of service qualify to precept. Volunteerism is a sign that the preceptor is approachable and has a good relationship with students.

A good relationship is considered the most important preceptorship quality as it was found to promote learning (Reilly & Oerman, 1992). Just as good preceptor-student relationship supports

learning, good faculty-preceptor collaboration would also provide a supportive environment for the preceptor to effectively assist students and achieve positive outcomes of the programs (Duteau, 2012). Therefore, clear selection criteria promote transparency in the implementation and easy monitoring of the exercise. Volunteering preceptors should be followed up with some form of training to ensure that they have adequate preparation for assuming the preceptorship role and to allow them to offer services in line with the curriculum requirements and lastly, to ensure that they have the required skills to impart knowledge and to assess students. Clear selection criteria and regular screening of those who volunteer provides an opportunity for faculty to identify those persons who are not suitable for preceptorship or are “toxic” clinical supervisors as indicated by Darling (1985) in a special article about the process of mentoring. “Toxic” clinical supervisors or mentors are “those persons who allege to be clinical supervisors but derive energy from oppressive relationships (Barker, 2006, p 58). This includes the “avoiders, dumpers, blockers and destroyers/ critzens.” Good selection criteria will establish whether or not the preceptor is able to screen students according to their learning needs or potential as well as being able to promote autonomy among students (Myrick, Yonge & Billay, 2009).



Preceptorship training or orientation

“Clinical Teaching and supervision is a skill, and it cannot be assumed that by virtue of their knowledge and expertise, practitioners can automatically function as preceptors “(Kaviani & Stillwell, 2000, p 221). Although preceptors’ clinical teaching, assessment and supervision skills are important in the effective implementation of preceptorship, the result of this study demonstrates that preceptors are not getting enough training or orientation before they could assume their role. This requires that health training institutions re-examine their preceptorship orientation plan Respondents both the quantitative and the qualitative questions revealed the preceptors’ need and recommendations for orientation and training on clinical teaching skills. Respondents have cited lack of training and support as the key barriers to effective implementation of preceptorship program.

Equipping preceptors with appropriate clinical teaching skills is essential for the effective implementation of preceptorship (Billay & Myrick, 2008, Yonge et al. 2003) and it is the key to effective socialization of preceptors to their role. Preceptorship training helps equip preceptors with adequate knowledge of the curriculum requirements, so that they will be in a position to identify students' learning needs and be able to apply curriculum requirements into clinical practice (Taylor et. al., 2010; Kaviani & Stillwell, 2000).

Contrary to the preceptors' response, the level coordinators (faculty) had assumed that preceptors had received adequate orientation, even though they (faculty) denied offering regular update seminars for preceptors. Faculty also denied the availability of a preceptorship resource manual, which could be used as a reference guide especially for those who had not received adequate orientation. According to Taylor et al., (2010) on feedback from the report from an institution that had a well structured preceptorship implementation strategy, preceptorship training was reported to have improved awareness and understanding of preceptorship, supported life-long learning and continuing professional development.

Shamian and Inhaber (1985) recommended that effectiveness of the preceptor is influenced by the quality of training or orientation received. Researchers recommended that preceptors require orientation involving a clear description of the preceptor role, expectations, adult learning skills and assessment and the skill of giving feedback to students. Lack of understanding of curriculum requirements often results in preceptors failing to provide clinical teaching that is targeted at addressing the required clinical competencies. Strengthening preceptorship training or orientation, particularly on clinical and assessment skills, curriculum requirements and program objectives, may possibly address the issue of unfair clinical evaluation and the awarding of unrealistic clinical marks (Reilly & Oerman, 1992), a concern that motivated this study to be conducted. Preceptor training would ensure that preceptors demonstrate a high level of integrity, commitment to fairness and appreciation for ethics in learning, which is a skill required for teachers and leaders in the educational field (Johnson & Uline, 2005).

With reference to the quantitative responses, preceptorship orientation should cover training skills, curriculum requirements, assessment skills, faculty-preceptor-student role clarification, clinical assessment tools used and how to discipline students. Ensuring that preceptors are trained and supplied with a preceptorship resource manual will address the reported concern of either lack of training or inadequate preceptorship training (Taylor et.al 2010). In conclusion, the results of the study reveals some form of uncoordinated preceptorship orientation, which could demotivate a lot of preceptors and could negatively affect graduate competencies and the value attached to preceptorship. A low level of satisfaction with the preceptorship process may result in preceptorship burnout and high turnover of preceptors.

Preceptor Clinical teaching and Assessment Skills

Clinical teaching and assessment se skills involves the preceptors' ability to identify student's learning needs, plan with the students how the learning objectives will be achieved, use of various clinical teaching approaches to achieve a desired change in behavior, and assessing students' clinical competence (Reilly & Oerman, 1992). The findings of this study revealed inadequate clinical and assessment skills by some preceptors. Less than 50% (47.7%) reported that there were equipped to teach in the clinical area, while the remaining 52.3% (n=23/44) either reported inadequate clinical teaching skills (25.6%, n=11/44), or remained neutral (27.3%, n=12/44) about their perceived clinical teaching skills. Contrary to the above-mentioned responses was the report that most respondents (77.3%, n=34/44) were comfortable with the grades they awarded students. This dichotomy in respondents' views is probably a reflection of various issues from the study such as: fear of disclosing incompetency or unfairness in the award of grades; or a belief that assessment and clinical teaching and assessment skills acquired over time, from repeated years of preceptorship, were adequate for preceptors to perform effectively in student's evaluations. The majority (65.9%) have been engaged in the preceptorship program for over three years, which may justify why respondents feel comfortable with their assessment practices. However, it is important that further studies be conducted to examine the reasons why respondents reported inadequate clinical and assessment skills, but were comfortable with the grades they allocated students.

In conclusion, the findings have indicated the need to shift from relying on preceptors' experience to selecting preceptors based on clinical training and assessment skills. Clear selection criteria that spell out required minimum preceptor qualities would compel faculty to provide orientation workshops to all those who volunteered or were identified to assist with preceptorship. According to the literature, a competent preceptor is someone who is able to share knowledge and skills with novices, and to provide support to students (Kaviani & Stillwell, 2000). To impart these skills, preceptors require formal preceptorship training and intensive technical support from faculty. Training provides preceptors with confidence and enthusiasm. According to Charleston and Happel, (2004), individuals who completed preceptorship training appreciated that the training had increased their level of awareness of preceptorship expectations. Furthermore, respondents reported an increased level of confidence in accomplishing their role expectations. In a study by Halabi et al., (2012), in which respondents underwent formal preceptorship training, preceptors reported that training had developed their personal and professional growth, increased their level of appreciation and understanding of preceptorship, improved their communication skills, improved their collaborative interactions with faculty and helped decrease the theory-practice gap.

In the current study some preceptors reported that they felt uncomfortable with the grades that they allocated to students, and that this reflects a lack of confidence among preceptors in the assessment of students. The report by some preceptors of their lack of confidence in conducting assessment is supported by Duffy's study (2004), which revealed that poorly prepared preceptors are often reluctant to award a failing grade to poorly performing students. In another study, preceptors reported having awarded a passing grade to students who were not competent because of their lack of experience or competence in conducting clinical evaluations (Luhanga, Myrick & Yonge, 2010). Lastly the use of inadequately prepared preceptor raises questions into the ethical, legal, moral obligation of the preceptor in ensuring competent and safe graduate and patient safety thereafter (Luhanga et al., 2010).

To produce a confident preceptor who possesses all the required competencies, requires that a comprehensive training package be established to address the following: teaching and

assessment skills; processes of identifying students' learning needs; time management; required skills such as: coaching,, leadership, decision making, disciplinary, supervisory skills; and all other necessary tools used in students' assessments (Taylor et.al 2010; Kaviani & Stillwell, 2000). Preceptors "act as the last quality control measure to ensure those nurses who are about to enter the professional work environment are competent to do so" (Yonge, Billay, Myrick, & Luhanga, 2007, p.9). Therefore measures directed at improving preceptors clinical teaching competencies are of paramount importance if training institutions want to produce a competent and clinically safe graduate.

Preceptor Support

The lack of preceptor support is one of the issues that had been identified by the study. Since preceptorship is a triad of preceptor, faculty and students, the success of its implementation is dependent upon strategies that ensure that this learning team stays as one. This could be achieved by strengthening the collaborative relationship between the three, particularly between faculty and preceptor. Collaborative relationship could be strengthened by improving faculty –preceptor interactions. The interactions that could be achieved by preceptor support should be a continual process. Improved preceptor-faculty interactions create an avenue for faculty –preceptor feedback and for faculty to assess preceptor clinical competencies. Nurturing an ongoing collaborative relationship between preceptors and health training institutions helps preceptors feel appreciated and hence reduces preceptor fatigue and turnover. Preceptor support may also in-turn attract more nurses to volunteer to supervise students. Duffy's study (2009) revealed that support from facility managers was associated with a positive impact on preceptors' job satisfaction. In Luhanga, Yonge & Myrick's (2008) study, preceptors reported feeling comfortable awarding a failing grade to unsafe students when there was faculty support and guidance. The researchers further recommended the need for faculty to support preceptors as this creates an enabling environment for preceptors to make critical and challenging ethical decisions about students' clinical competence.

According to Kaviani and Stillwell (2000), the preceptors and preceptees who participated in their study recommended that in order for institutions to overcome challenges associated with

preceptorship, they should provide preceptor support in the form of reduced workload, education and the creation of avenues for preceptors to have regular meetings with their managers to discuss their concerns. Reports of inadequate faculty support may mean that preceptors are left alone to handle the issues of clinical teaching and to make critical decisions about students' performance, yet the effectiveness of clinical teaching is supposed to be a collective responsibility of the faculty, preceptors, health facility managers and students. Regular time should be set aside for preceptors and faculty to come together to examine student work, discuss learning needs and help establish best approaches to address identified needs or problems. According to Luhanga et al., (2008), ongoing faculty–preceptor collaboration ensures that faculty monitors academic progress of students and gets well acquainted with the products produced at the end of internship. Faculty's involvement in monitoring of students on internship is critical particularly, when the preceptor was working with an unsafe or academically challenged student.

In addition to lack of faculty support, the study also revealed lack of preceptor support by health facility managers. The type of support required from facility managers was the need to reduce preceptor workload or redistribute caseload since preceptorship added more load to preceptors' usual daily clinical responsibilities. To achieve this, faculty, as the custodians of teaching and learning process, should take the lead in playing an advocacy role and in negotiations with health facility management for preceptor case redistribution. Faculty should also consider some form of incentives /rewards as incentives also hold value in the provision of support and in motivating preceptors to perform effectively (Wilson et al. 2011 & De Wolfe et al. 2010). According to Wilson et al., (2011), on a study that evaluated preceptor expectations and rewards, findings revealed that rewards such as free continuing education, receiving feedback from students on how preceptors performed, and a simple letter of appreciation were considered highly appreciated by preceptors. This was further supported by De Wolfe et al., (2010) and Ellerton, (2003) studies, that revealed that a personalized thank you letter to appreciate preceptors' contribution to be among the best strategies that help with preceptor support and retention.

Despite the low level of satisfaction with implementation of the preceptorship that was reported in the study, most preceptors were still willing to continue as preceptors and to continue accepting new students. Preceptors' willingness to continue with preceptorship was likely associated with the perceived benefits of preceptorship reported by respondents. Respondents in the study considered preceptorship a rewarding exercise, as it provided an opportunity for preceptors to grow professionally and helped them attain personal fulfillment. This finding is in accordance with reports that revealed personal fulfillment and professional development as intrinsic motivators to participate in preceptorship (Ellerton, 2003). In order for faculty to ensure that preceptors remain motivated faculty should strive towards providing an environment that is supportive and an environment that is conducive for preceptorship program.

In conclusion, preceptor support is a way of creating an environment conducive for student learning and creating an environment within which preceptors feel valued and respected. Johnson and Uline (2005) reported that it is the responsibility of education leaders to create an environment that values and respects students and the other stakeholders engaged in student learning. According to Johnson and Asera (1999), a supportive education leader should be able to provide subordinates with training, teaching resources, guidance and other resources needed to educate students for the attainment of high academic standards. Preceptorship should be considered a strategy that empowers students, faculty and preceptors, rather than a tool that creates confusion amongst faculty, student and preceptors, or a tool for dumping students into the hands of clinicians. Improved preceptor support has been associated with improved preceptor-preceptee relationships. Consequently, poor preceptor-preceptee relationships have been linked to preceptors' lack of confidence in preceptorship (Duffy, 2009).

Curriculum Implementation Issues

The student-preceptor ratio reported by preceptors and faculty contravenes the definition of preceptorship which is considered as a one-to-one teaching and learning approach (Myrick, Yonge & Billay, 2009), in which an experienced clinician imparts clinical skills and role models both the clinical and professional skills for students. According to the study, the reported

student–preceptor ratio of 1-5, given on a limited number of about 5-10 days per student and as well as offered by preceptors who have other clinical responsibilities, defeats the purpose and definition of preceptorship. Attaching a large number of students to a preceptor who is already overburdened by other responsibilities is likely to result in the student being supervised by more than one preceptor in one given rotation, an approach which has been reported to impede student learning. According to Myrick et al.'s study (2009) on how to engage students in authentic clinical practice, they revealed that the use of more than one preceptor in clinical teaching is often challenging to students as individual preceptors will be using differing approaches to learning and hence interfering with consistency in feedback that is often experienced by students when evaluated by one preceptor. These anomalies should be looked into critically if quality of clinical teaching and assessment is to improve.

According to Kim (2007), one of the challenges or barriers to effective preceptorship, is that preceptorship is often defined by clinical contact hours dictated by the curriculum, rather than individual student learning needs. Even though the clinical content hours may not be the determinant of students' clinical competence, the challenges of students being allocated minimal hours to practice and the high preceptor workload, requires that preceptors be equipped with adequate skills, adequate resources and be relieved from other work responsibilities so that they can adequately fulfill preceptorship responsibilities. The importance of equipping preceptors with adequate skills and resources is emphasized by Duteau (2012). According to Duteau (2012), for preceptors to effectively assist students achieve their goals and objectives they should be knowledgeable about appropriate adult learning styles so that they are in a position to select appropriate teaching styles for students. Duteau (2012) further highlighted that the preceptors' qualities alone could not achieve student's professional development, but should be augmented by a supportive non-restrictive environment to allow for successful learning to take place. The restrictive environment in this case would be the limited clinical attachment hours, high student preceptor ratios, unmanageable preceptor workload and lack of teaching and learning resources as reported in the study.

In conclusion the limited clinical contact hours, high student–preceptor ratio and high preceptor workload leaves preceptors with no option but to spend most of their time conducting clinical assessment and little or no time to interact and role model professional and clinical skills for students. According to Greenwood (1993) consequent to inadequate clinical supervision and repeated exposure to clinicians who are always in hurry to teach and assess students because of the limited clinical hours often resulted in producing students who are incompetent, unsafe and desensitized to human needs as they become conditioned to less caring nursing practices.. These perceived consequences strengthen the recommendation for the need to provide an environment conducive to learning, an environment supportive to preceptors during clinical teaching.. According to Knuteson and Wielchowski (1994), short clinical hours limit students from practicing what they learnt from preceptors; leaves preceptors with little time to know the students and to assess students’ progress. That is, students often move to the next clinical area before even adjusting to the clinical environment. Adequate student- preceptor interactions and recognition of students’ contribution in the clinical area are of the utmost importance if student learning has to be maximized (Nolan, 1998). Inadequate clinical contact hours, the use of incompetent preceptors who are already overwhelmed by clinic activities and lack of clinical teaching resources often result in students adopting surface learning approaches rather than t deeper learning approaches. A student who adopts surface learning approach often pays attention to reproduction of the content but less attention to mastering the clinical skill, which may result in students acquiring very high marks which are not commensurate to knowledge and the clinical competencies.

Based on the results of this study, the high clinical grades may be associated with various factors such as preceptors’ lack of confidence in clinical assessment, limited clinical contact hours and the student learning approaches such as surface learning approach. Findings of this study are supported by Luhanga et al., (2008), who also associated the, preceptor’s failure to award a failing grade to borderline students or tendency to award very high marks to lack of preceptor’s experience in clinical assessment, insufficient time allocated for clinical evaluation and reluctance to create extra workload.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

This study has given an insight into the preceptorship process in the general nursing curriculum in some health training institutions in Botswana. On application of the socialization theory as a theoretical framework, the study revealed that the recruitment phase was not well structured, evidenced by some preceptors reporting that they were identified by students rather than by faculty and most preceptors denied ever receiving special training or orientation. The study further revealed that there was no adequate preceptor support from both faculty and health facility managers. This lack of support has been associated with poor performance by individuals who are not well prepared for their role. The second and third phases of the theoretical framework, which are the induction or professional and continuing socialization phase respectively, advocates for training and ongoing support of preceptors. Contrary to that, the results of the study reveal lack of ongoing regular support or evaluative studies to identify gaps in preceptorship. Concerning the socialization or induction of preceptors into their role, it appears that preceptors are disadvantaged by not receiving any training and by not having a strong collaborative relationship with faculty as most have indicated that they have not received training and a denied strong faculty-preceptor interaction.

The positive observation made from the study is that a significant number (54.6, n=24/44) of respondents felt well equipped to assess, however, the fact that the majority (56.85, N=25/44) of respondents had not received training warrants an in-depth study into the level of preceptor competency in student assessment. Data from open-ended questions have risen up critical points that are necessary for the improvement of preceptorship. These suggestions need to be taken into account to ensure the effective and efficient implementation of preceptorship.

The critical points identified from this study are the lack of coordination of the preceptorship program, weak monitoring of the program, poor preceptor support and guidance by faculty and facility managers, and poor collaborative relationships between faculty, preceptors, students and facility managers. Myrick and Barret (1994), recommended that appropriate measures be put in place to intensify the implementation of preceptorship by focusing on monitoring, supporting and improving the relationship between faculty, students and preceptors. A preceptorship resource manual with well established activities that encourage and provide support to preceptors is recommended.

In conclusion, findings emanating from this study reflect the following issues as being very critical for successful implementation of preceptorship program: adequacy in preceptorship orientation or training; provision of a supportive environment; improved attitude of faculty to preceptorship by demonstrating more interest in preceptors and their performance; acquisition of adequate clinical training and assessment skills as well as adult education principles by preceptors; reduced preceptor-student ratios to acceptable levels; adequacy of clinical attachment hours and probably clarity in the objective for clinical attachments. The other key issue on the part of faculty is the capacity to demonstrate educational leadership skills in management and monitoring of preceptorship program and faculty's ability to role model their clinical teaching skills to preceptors. Failure to address the issues identified in the study could result in professionally and clinical incompetent graduates, who are desensitized to human needs, as indicated by Greenwood (1993).

5.2. Recommendations

Practice Recommendations

The findings of this study are consistent with the findings of various other studies conducted about the effective implementation of preceptorship. To ensure an effective and efficient implementation of preceptorship, a number of areas need to be improved. To name a few: Clear strategies on socialization of preceptors should be put in place notably, training of preceptors on their role; clinical teaching and assessment skills; and curriculum requirements. An improvement of communication between the health training institution and the clinical

placement sites is also recommended. Establishing clear criteria for the selection of preceptors, strengthening the support system for preceptors from the health training institutions and the placement site is also a requirement. Resource constraints such as time, use of unqualified preceptors, inadequate staffing by Preceptors, limited clinic attachment hours and limited innovative teaching approaches should be explored and improved. Reducing workload for preceptors so that they can give optimal attention to students is also recommended. The findings point to the importance of a well structured standardized preceptorship model, to allow for consistency amongst stakeholders (Faculty and preceptors).

Developing a preceptorship implementation strategy/guideline and ensuring that all preceptors are trained and receive all the required support, would contribute positively towards producing clinically competent graduates as well as motivating preceptors to continue with preceptorship.

Regular evaluative surveys and preceptor meetings should be introduced as they create an opportunity for faculty to identify preceptorship gaps which may contribute towards the improvement of preceptorship strategies. Regular meetings should be organized to allow for preceptors, health facility managers and faculty to discuss issues of preceptorship.



Furthermore, institutions should consider reducing the number of clinical sites for students and focus on maximizing the period of individual placements to one site or unit and capitalize on acquisition of clinical skills. For example, instead of a student rotating between male medical and female medical wards, the student could be assigned to either one of the two as clinical care is similar. Adequate clinical learning time would allow adequate time for students to get sensitized to the clinical setting and to reduce their anxiety, which may result in deeper learning approaches by students.

The role of preceptors should be formalized by including the preceptors' role in their job descriptions and in their annual performance plans.

The establishment of a preceptorship coordinator (clinical placement coordinator) in each health facility may be of critical importance to help act as a link between all preceptors, faculty

and other professionals in the clinical setting. An in-service coordinator may be considered for this role, as she or he will work hand in hand with faculty to ensure that preceptors receive regular training, teaching and learning resources and to ensure that preceptors receive priority in capacity building workshops on clinical and theoretical concepts and leadership skills, to ensure that preceptors' knowledge level is in line with and even above the student's curriculum requirements. A clinical placement coordinator approach could be bench marked from the Irish Universities (Duffy 2009). A well structured preceptor training program could also be bench-marked from the Swedish –Jordanian international Collaboration Project (Halabi et al., 2012).

Lastly, faculty should be well prepared to lead the preceptorship program (Yonge et al., (2003). Furthermore, faculty as transformational leaders, require some form of training targeted at improving their leadership skills in the management of the learning/educational environment, and nurturing and sharing the vision for learning with all the relevant stake holders (Johnson & Uline, 2005). This kind of training will help faculty appreciate the critical role they play in the achievement of results in the clinical learning environment and to close the theory-practice gaps that is reported to exist in the general nursing curriculum. For faculty to close such gaps, as leaders they must be in possession of adequate leadership skills in the management of teaching and learning environment in addition to the teaching skills that they already have. According to the framework on leading and management developed by World Health Organization (2007) some of the key competencies that may be required by faculty are the faculty's ability to: identify customer needs and priorities; identify best practices for the organization; identify critical challenges; facilitate teamwork; provide staff with feedback and support; be a model of creativity; and innovation and motivation. Training of faculty to address all these features would help faculty to appreciate why it is important to conduct regular satisfaction/ preceptor evaluation surveys, provide support to preceptors, equip preceptors with necessary skills; and strengthen the collaborative relationships between health facilities and health training institutions. Lastly it will also help faculty to appreciate how they (faculty) contribute to the lifelong learning of both the preceptor and student.

Research Recommendations

Future research is recommended to explore the possible differences among other health training institutions and to validate the findings of the current survey study.. Other studies are required to evaluate the effectiveness of preceptorship in assisting the students to acquire the required clinical skills.

An in-depth study is recommended to evaluate why faculty are reluctant to provide preceptors with the required support. For instance in a study conducted by Yonge, Ferguson, Myrick & Haase (2003), the findings associated the lack of preceptor support to faculty's lack of preparedness for the preceptorship program. Evaluation of faculty's level of preparedness in participation and management of preceptorship will be of the utmost importance in strengthening of preceptorship exercise. A participatory action research that introduces formal preceptorship training and support is also recommended.

The limitation of the study is that it cannot be generalized as data collection was not through a random approach and was limited only to a few health training institutions and teaching health facilities. Therefore, the researcher suggests that a similar study that draws a comparison between a number of health training institutions be conducted to allow for validation of results of this study.

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LIST OF APPENDICES

Appendix 1: Preceptor Survey Tool

PRECEPTOR'S OPINIONS ABOUT THE IMPLEMENTATION OF PRECEPTORSHIP IN THE GENERAL NURSING CURRICULUM IN BOTSWANA

Nurse

You are being invited to take part in a research project. Please take some time to read and complete the questionnaire. The questionnaire is designed to take 15-30 minutes of your time. Thank you for agreeing to participate:

1. Name of Facility: (Please tick).

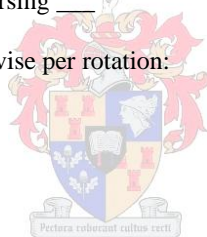
Princess Marina Hospital__ Scottish Livingstone Hospital__, Deborah Retief Memorial Hospital ____,
Athlone Hospital ____, Lobatse Mental Hospital ____

2. Health Training Institutions: Please tick all the institutions where you function as a preceptor at the moment:

Institute of Health Sciences (I.H.S-Gaborone ____, I.H.S. - Molepolole ____, and I.H.S. Lobatse ____,
Deborah Retief Memorial school of nursing ____

3. Average number of students that you supervise per rotation:

- a. 1 Student _____
- b. 2 Students _____
- c. 3-5 students _____
- d. 6-10 students _____
- e. 11 students and above _____



4. How long is the rotation (Length of students' stay in a unit you are working in):

- a. 1 week _____
- b. 2 weeks _____
- c. 3 weeks _____
- d. 4 weeks and above _____

5. Period of preceptorship is from (tick all that applies):

- a. January – April _____
- b. May – August _____
- c. August- November _____

6. How long have you been a preceptor?

- a. Under 1 year _____
- b. 1- 2 years _____
- c. 3-4 years _____
- d. 5 years and above _____

7. How were you identified as a preceptor?

- a. Volunteered _____
- b. Appointed by management: _____
- c. Appointed by school: _____
- d. Requested by student: _____

8. Did you receive training or preceptorship orientation prior to assuming your new role?

Yes ___ No ___

9. If yes to question 8, please answer question 9 (a) , 9(b), 9 (c)

9. (a): When did you receive training? Please indicate the year: _____

9. (b) The preceptorship training or orientation I received covered (please tick all that applies)

- a. ___ My role as a preceptor
- b. ___ Orientation to curriculum and school regulations
- c. ___ How to teach in a clinical area
- d. ___ How to do student assessment
- e. ___ Orientation to students' clinical assessment (evaluation) tool
- f. ___ How to access resources from school (books, faculty, teaching aids, etc.)

9 (c) I am happy with the preceptor training /orientation that I have received

_____ Yes _____ No

10. On a scale from “strongly disagree” to “strongly agree” how would you rate your experience as preceptor? :

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
i. I understand my role as a preceptor					
ii. I feel I have adequate preparation for my role as a preceptor					
iii. I clearly understand what students need to learn*					
iv. I feel well equipped to teach students					
v. I am confident when acting as preceptor for students *					
vi. I feel well equipped to assess students at the end of their clinical rotation					
vii. Students’ clinical assessment tools guide me on what they need to learn					
viii. The grades that students get clearly reflect their levels of clinical competence					
ix. The clinical assessment tool is clear and easy to follow					
x. The clinical assessment tool evaluates the key clinical care competencies as described in the nursing curriculum					

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
xi. I clearly understand my role as an assessor*					
xii. The clinical assessment tool is adequate to assess students' clinical competencies					
xiii. I am usually comfortable with the grade that I allocate to students at the end of their clinical rotation					
xiv. Most of the students I supervise pass their assessments at the end of clinical rotation					
xv. I am comfortable to fail students if their performance is below average					
xvi. I have reassessed students who did not perform well during clinical assessment (as recommended by the general nursing curriculum)					
xvii. I know how the material I teach fits into the overall nursing curriculum*					
xviii. Students know what they need to know to learn*					
xix. Faculty is always available for support and to mentor me in my role as preceptor					
xx.					

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
xxi. My unit supervisor/ manager is always available to support me in my role as a preceptor					
xxii. My coworkers are supportive of the preceptor programme					
xxiii. I receive regular support and mentoring from other preceptors					
xxiv. I receive regular visits from faculty to discuss issues concerning preceptorship					
xxv. I receive feedback from faculty about student progress and clinical performance					
xxvi. I receive report from faculty about the learning needs of students I am to precept					
xxvii. I attend regular workshops or seminars on preceptorship or teaching skills					
xxviii. I am satisfied with the quality and relevance of preceptorship training/orientation I received					
xxix. I have adequate contact with, or support from faculty					
xxx. The resources I receive from faculty is adequate					

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
xxxi. The time I spend with students is enough for me to guide them in the clinical area					
xxxii. The total number of students that I precept per day is manageable					
xxxiii. My workload is appropriate when I function as a preceptor					
xxxiv. My workload as preceptor does not affect the quality of patient care delivery					
xxxv. My workload as a clinician does not affect the quality of student teaching					
xxxvi. I always assist students to plan their daily patient care activities					
xxxvii. Preceptorship gives me an opportunity to grow and develop professionally					
xxxviii. Participating in the growth and development of students provide me with personal and professional fulfillment					
xxxix. I would love to continue being a preceptor for students					

NB: * Reflects questions adopted from article by Baker, Dalton and Walker (2003). Rural General Practitioner Preceptors- How can effective undergraduate teaching be supported or improved. *Rural and Remote Health* 3 (online), 07. Retrieved 29th June, 2009 from www.rrh.org.au/articles/subviewnewsp?articleID=107

11. As a preceptor I require training to develop the following skills

- a. Teaching skills _____
- b. Student assessment _____
- c. Role of preceptor _____
- d. Leadership _____
- e. Technical/professional skill (in the area currently working in) _____

12.. Please describe how you feel preceptorship should be conducted to produce competent graduates:

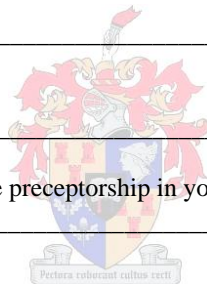
13. What areas should be strengthened to ensure smooth running of preceptorship:

14. Describe the support you want to receive to enhance your efficiency and effectiveness in performing your role as a preceptorship

a. Faculty/ Institutional Support:

b. Health facility manager support:

15. Describe what you see as barrier to effective preceptorship in your unit:



16. Biographical Information

Age _____ Sex: M ___ F __, Designation _____,

Highest level of degree attained: Diploma _____ Degree ____, Masters _____

Thank you for participating in the study.

Appendix 2: Faculty Survey tool

QUESTIONNAIRE

FACULTY’S OPINIONS ABOUT THE IMPLEMENTATION OF PRECEPTORSHIP IN THE GENERAL NURSING CURRICULUM IN BOTSWANA

You are being invited to take part in a research project. Please take some time to read and complete the questionnaire. The questionnaire is designed to take 10-20 minutes of your time. Thank you for agreeing to participate:

Please Tick the work area

1, Health Training Institutions:

Institute of Health Sciences (I.H.S-Gaborone___), I.H.S.- Molepolole___, and I.H.S. Lobatse ___; Deborah Retief Memorial school of nursing ___

2. Name of Facility: (Please tick all facilities that you are utilizing for students’ internship).

Princess Marina Hospital__ Scottish Livingstone Hospital___, Deborah Retief Memorial Hospital___, Athlone Hospital___, Lobatse Mental Hospital ___

3. Total number of students in your internship program (at 3rd year level/ semester 5 and 6):

- a. 10-20 Student _____
- b. 21- 40 Students _____
- c. 41- 60 students _____
- d. 61- 100 students _____



4, For each health facility, the average number of internship sites/units (e.g. male medical ward, Intensive care unit, Theater etc) is :

- a. 1-2 sites/units _____
- b. 3-5 sites /units _____
- c. 6- 10 sites/units _____

5. The average number of days that a student is attached to each internship site/unit (e.g. male medical ward, Intensive care unit, Theater etc) is

- a. 1- 5days _ -----
- b. 6- 10 days -----
- c. 11 days – 15 days -----
- d. 16 days – 20 days -----
- e. 21 days and above -----

6. The average number of students per internship site/unit (e.g. male medical ward, Intensive care unit, Theater etc) :

- a. 1-5 students -----
- b. 6-10 students -----
- c. 11-15 students -----
- d. 16- 20 students -----
- e. 21 and above -----

7. The average number of preceptors per internship site/unit (e.g. male medical ward, Intensive care unit, Theater etc) is

- a. 2 preceptors -----
- b. 4 preceptors -----
- c. 5-6 preceptors -----
- d. 7 and above -----

8. The period of preceptorship often runs from : (tick all that applies)

- a. January – April ___
- b. May – August ___
- c. August- November ___



9. How do you identify preceptors?

- a. Request for Nurses to volunteer ___
- b. Appointed by health facility management: ___
- c. Identified by the academic board: ___
- d. Identified by students: ___

10. Does the school have set criteria for selection of qualifying preceptor

Yes-----, No -----

11. Do your preceptors receive training or preceptorship orientation prior to assuming their new role?

Yes ___ No ___

If yes to question 11, please answer question 12 (a) and 12 (b)

12. (a): When was the last training or orientation conducted? Please indicate the year: _____

12. (b) The preceptorship training or orientation package covered (please tick all that applies)

- a. ___ Roles of a preceptor
- b. ___ Orientation to curriculum and school regulations

- c. ___ How to teach in a clinical area
- d. ___ How to do student assessment
- e. ___ Orientation to students' clinical assessment (evaluation) tool
- f. ___ How to access resources from school (books, faculty, teaching aids, etc.)
- g. Others: _____

13. On a scale from "strongly disagree" to "strongly agree" how would you rate your perception of how preceptorship is implemented ? :

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
i. The program always provides regular workshops or seminars on preceptorship or teaching skills for preceptors					
ii. The program has a preceptorship manual to guide preceptors and students					
iii. Preceptors have access to the library and other learning resources in the institution					
iv. Preceptors understand students and program expectations					
v. Preceptors are well equipped to teach students					
vi. Preceptors are well equipped to assess students at the end of their clinical rotation					
vii. Preceptors are made to understand Students' clinical assessment tools prior to assume their preceptorship roles					
viii. I am comfortable with the grades awarded by					

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
preceptors					
ix. Faculty is always available for support and to mentor preceptors					
x. Faculty always offer regular visits to preceptors to discuss issues concerning preceptorship					
xi. Faculty always create a forum for giving feedback to preceptors about student progress, learning needs and clinical performance					
xii. The program often conducts regular student preceptor satisfaction surveys to advise on how preceptorship could be improved					
xiii. The total number of students per preceptor is manageable					
xiv. Faculty often advocate to clinical supervisors for Preceptors to be given less clinical workload to allow them to cope with preceptorship					

14. To improve on efficiency and effectiveness of the current preceptorship exercise, the program should work towards (please tick all that applies)

- a. Equipping preceptors with clinical teaching skills _____
- b. Equipping preceptors with clinical assessment/evaluation skills _____
- c. Orientating preceptors to their role ----- _____

- d. Providing preceptors with resources for clinical teaching and assessment _____
- e. Providing regular support to preceptors _____
- f. Training preceptor on professional and leadership skills _____
- g. Developing and availing preceptorship orientation package to preceptors
- h. Others: _____

15. Biographic Information


Age _____ Sex: M ___ F___, Designation _____,

Highest level of degree attained: Diploma _____ Degree _____, Masters _____

Thank you for participating in the study.



Appendix 3 : University of Stellenbosch-RSA Health Research Ethics Committee Approval Letter


UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

03 October 2011 MAILED

Ms M Madisa
Centre for Health Sciences Education
1st Floor
Clinical Building
7505

Dear Ms Madisa

"Clinicians' opinions about the implementation of preceptorship in the general nursing curriculum in Botswana."

ETHICS REFERENCE NO: N10/11/359

RE : APPROVAL

At a meeting of the Health Research Ethics Committee that was held on 29 November 2010, the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 28 September 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds) should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit. Translations of the consent document in the languages applicable to the study participants should be submitted.



Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 28 September 2011 Expiry Date: 28 September 2012

03 October 2011 08:36 Page 1 of 2

 **Fakulteit Gesondheidswetenskappe • Faculty of Health Sciences** 

Verbind tot Optimale Gesondheid • Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun • Division of Research Development and Support
Posbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

A.

Appendix 4: University of Stellenbosch- department of Health Science Education Cover letter



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

03 October 2011

MAILED

Ms M Madisa
Centre for Health Sciences Education
1st Floor
Clinical Building
7505

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Approval Date: 28 September 2011

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03 October 2011 08:36

Page 1 of 2



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Posbus/PO Box 19063 • Tygerberg 7505 • Suid-Afrika/South Africa
Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

Appendix 5: Ministry of Health- Botswana: Health Research and Development- Approval

Telephone: (267) 363200
FAX (267) 353100
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD



MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REPUBLIC OF BOTSWANA

REFERENCE NO: PPME 13/18/1 PS V (205)

11 November 2011

Health Research and Development Division

Notification of IRB Review: New application

Montlennyane Madisa
P.O. Box 501378
Gaborone

Protocol Title: NURSE CLINICIANS' OPINIONS ABOUT THE IMPLEMENTATION OF PRECEPTORSHIP IN THE GENERAL NURSING CURRICULUM IN BOTSWANA

HRU Approval Date: 11 November 2011
HRU Expiration Date: 10 November 2012
HRU Review Type: HRU reviewed
HRU Review Determination: Approved
Risk Determination: Minimal risk

Dear Ms Madisa

Thank you for submitting new application for the above referenced protocol.
This approval includes the following:-

1. Application form
2. Protocol
3. Data collection tools

This permit does not however give you authority to collect data from the selected site without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Lemphi Moremi at lamoremi@gov.bw or Tel: +267-3632464

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw. As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kmotlhanka@gov.bw. In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".


Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

Do not hesitate to contact us if you have any questions. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely



P. Khulumani
For Permanent Secretary

Appendix 6: Scottish Livingstone Hospital- Ethics and Research committee approval letter

TELEPHONE: 5908000
FAX: 5915065
TELEGRAM: NGAKA



Republic of Botswana

SCOTTISH LIVINGSTONE HOSPITAL
PRIVATE BAG 001
MOLEPOLOLE

REFERENCE NO: SLH 3/241 (29)

22nd December 2011

Montlenyane Madisa
P.O. Box 501378
Gaborone

**RE: NURSE CLINICIANS' OPINIONS ABOUT THE IMPLEMENTATION OF
PRECEPTORSHIP IN THE GENERAL NURSING CURRICULUM IN BOTSWANA**

This is to inform you that the ethics and research committee reviewed and approved your protocol referenced above.

The study should be conducted within the time limit as approved by the Health Research and Development.

Please ensure that:

1. The Data collection process does not interfere with patient care.
2. Necessary arrangements are in place to avoid interference with the nurses' coverage of their work stations.
3. Submit 2 copies of the findings of the study within three months of completion to the Hospital Management.

A handwritten signature in blue ink, appearing to read 'Japheth Mukaya'.

Dr Japheth Mukaya
Chairperson SLH-REC

cc: Hospital Superintendent - SLH
Matron – SLH

JM/mh

B.

Appendix 7: Request letter for data collection in hospitals

Princess Marina Hospital; Sabrana Psychiatric Hospital ; Athlone Hospital and Scottish Livingstone Hospital; Deborah Retief Memorial Hospital

Gaborone

P. O. Box 501378,

28/11/2011

+267 713 9 8284

montlenyane@gmail.com

Hospital Superintendent

Sabrana Psychiatric Hospital

Att: Research Review Board Coordinator

Re: Request to conduct Research in Partial Fulfillment of the requirements for the degree of Master of Philosophy in Health Sciences Education at Stellenbosch University, South Africa

This serves to request for permission to conduct research from December 5th- 16th 2011. The study will be exploring on the “opinion of nurses about the implementation of preceptorship” for student nurses who are on internship from Gaborone, Molepolole, Mochudi and Lobatse health training institutions. Data will be collected from nurse preceptors and senior lecturers or level coordinators from the following areas: Gaborone- IHS and PMH; Lobatse- IHS, Athlone and SABRANA hospital; Mochudi- DRMSON and DRM hospital; Molepolole- IHS and Scottish Livingstone hospital

The study has been approved by the university of Stellenbosch Health Research Review board and Ministry of Health – Botswana, Health Research Review board.

Please find attached:

Research protocol

Data Collection Tools

Approval letters from

HRU – Ministry of Health, Botswana- Ref #: PPME 13/18/1 PS V (205)

University of Stellenbosch- Research Development and Support- Ethic Reference number: N10/11/359

Consent Form

Thank you in advance for your consideration,

Montlenyane Madisa MSN (FNP), BSc (Nursing), RN

IHS- Gaborone

Appendix 8: Sample Requests for data collection in Health Training institutions:

Institute of Health Sciences- Gaborone; Institute of Health Sciences- Lobatse; Institute of Health Sciences- Molepolole; Deborah Retief Memorial School of Nursing

P. O. Box 501378,

Gaborone

28/11/2011

+267 713 9 8284

montlenyane@gmail.com

Principal

Institute of Health Sciences- Molepolole

Att: Research Review Board Coordinator

Re: Request to conduct Research in Partial Fulfillment of the requirements for the degree of Master of Philosophy in Health Sciences Education at Stellenbosch University, South Africa

This serves to request for permission to conduct research between December 5th and 16th 2011. The study will be exploring on the “opinion of nurses about the implementation of preceptorship” for registered nurses who are on internship from Gaborone, Molepolole, Mochudi and Lobatse health training institutions. Data will be collected from preceptors from teaching hospitals as well as from 1-2 senior lecturers or level coordinators for general nursing students on internship

The study has already been approved by the university of Stellenbosch Health Research Review board and Ministry of Health – Botswana, Health Research Review board.

Please find attached:

Research protocol

Data Collection Tools

Approval letters from

HRU – Ministry of Health, Botswana- Ref #: PPME 13/18/I PS V (205)

University of Stellenbosch- Research Development and Support- Ethic Reference number: N10/11/359

Consent Form

Thank you in advance for your consideration,

Montlenyane Madisa: MSN (FNP), BSc (Nursing), RN

Appendix 9 Participant Information Leaflet and Consent form

**TITLE OF THE RESEARCH PROJECT: Preceptors' and Faculty's Opinions
About the Implementation of Preceptorship In the General Nursing
Curriculum in Botswana**

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Montlenyane Madisa (Student number: 15890686)

ADDRESS: P. O. Box 501378, Gaborone, Botswana

CONTACT NUMBER: +267, 713 98284, + 267 365 5887

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff, **Mrs Montlenyane Madisa or** Health Research Ethics Committee (HREC) at Stellenbosch University, **in South Africa and or the** Health Research Unit in the ministry of Health, Botswana , any questions about any part of this project that you do not fully understand.

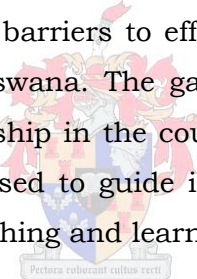
It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University**, in South Africa and the **Health Research Unit in the ministry of Health, Botswana**. It will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

Ms Montlanyane Madisa, a student at the University of Stellenbosch in South Africa would like to get an understanding of how preceptorship is implemented in the general nursing curriculum in Botswana.

The aims of this descriptive study are to describe and explain the preceptors' opinion about the implementation of preceptor-ship in the country and as well as describe what preceptors consider to be the barriers to effective preceptor-ship process in the general nursing curriculum in Botswana. The gaps and barriers that might require interventions to improve preceptor-ship in the country will be identified in the study. The findings would ultimately be used to guide in the development of preceptorship orientation package, to improve teaching and learning in clinical setting.



Why have you been invited to participate?

In Order to improve the teaching and learning in clinical setting, information about the strengths and barriers to the implementation of preceptor ship in the country is required from clinician involved in preceptorship of 3rd year registered nursing students. *You have been invited to participate because you were involved in preceptorship as a clinician.* We would sincerely appreciate your participation in answering the questions. You will be given a questionnaire to respond to questions. The questionnaire will take approximately 10-15 minutes

All that you write on the questionnaire will be treated as confidential. Thank you.

What will your responsibilities be?

- Your responsibility would be to share with us your opinion about preceptorship in the general nursing program in the institute of Health Science Gaborone, Lobatse, Molepolole or Deborah Retief Memorial Hospital.

Will you benefit from taking part in this research?

- There are no personal benefits for participating in this study. However, the information collected from this study would provide a baseline data that will give an insight into how people involved feel about the whole process of preceptorship in the nursing program. The baseline information will guide lecturers in developing preceptorship guideline.
- Benefit linked to this study include improved teaching and learning environment and ultimately, improved quality of care.

Are there any risks involved in your taking part in this research?

- *There are no reasonably foreseeable risks.*



If you do not agree to take part, what alternatives do you have?

- *You are free to withdraw from participating at any time.*

Who will have access to your medical records?

No medical records will be used in the study. However, the following measures will be taken to protect you, minimize possible risk of discomfort or inconvenience:

- I. Data will use coding (no identifiable information like name etc) and will be kept in a safe place under lock.
- II. Anonymity will be ensured throughout.
- III. You will be required to give informed consent prior to participating in the study.

IV. You will be excluded if you refuse to give consent, however you will not be reported to senior management for refusing to participate.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

There are no negative consequences to yourself Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study. And there will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the Stellenbosch University **Health Research Ethics Committee** in the Republic of South Africa at telephone +27 21-938 9075 or Fax number +27 21 931 3352 and ,or the Health Research unit office in Botswana, Ministry Of Health at 363 2500 or 317 0585 if you have any concerns or complaints that have not been adequately addressed by the data collector.

You will receive a copy of the consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled “Preceptors and Faculty’s Opinions About the Implementation of Preceptorship In the General Nursing Curriculum in Botswana”

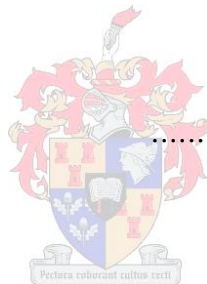
I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) On (*date*) 2011.

.....



.....

Name of Participant

Name of Witness

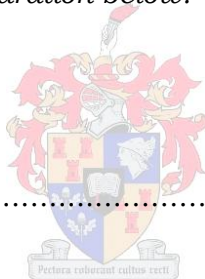
Signature of participant

Signature of witness

Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)



Signed at (*place*) On (*date*)
2010

Name of investigator

Name of witness

Signature of investigator

Signature of witness