Student-centered Teaching in a Non-student-centered World:

Clinical Nurse Educators' Lived Experience

By

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Abstract

The growing complexities and dramatic changes in the contemporary health care system require nurses to practice successfully with essential professional knowledge and skills required for safe and competent practice. The implication is that nurse educators are confronted with the challenge to redefine effective teaching strategies appropriate to prepare nurses for the complexities of the current practice demands. To this end, student-centered teaching (SCT) has emerged in many undergraduate nursing curricula as a tool to develop essential practice skills in nursing students. A lack of understanding of how nurse educators experience SCT may hinder its success and sustainability. This qualitative study explored the lived experience of clinical nurse educators (CNEs) using SCT in the practice settings. Ten CNEs who self-identified as using SCT volunteered to participate. Data were collected using a semi-structured interview guide and audio recorder. Additional data source included a demographic survey and a reflective journal. Analysis of the CNEs' perspectives revealed an overarching theme entitled "SCT in a non-student-centered world" with a variety of meanings of SCT from a humanistic point of view. Participants identified individual, staff, and contextual factors including policy issues that hinder successful implementation of SCT in the practice settings. The study also unveiled that a successful paradigm shift to SCT may not be the sole responsibility of the CNEs but a joint endeavor by all stake-holders within the health care delivery system. Findings of this study may be used by nursing and health sciences faculty and administrators to guide policy and program planning that incorporates student-centered clinical education.

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Dedication

This thesis is dedicated to the ten clinical nurse educators who participated in this study to acknowledge their commitment to the nursing profession.

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Chapter One: Background to the Study

This chapter provides a backdrop that forms the foundation for the statement of the

research question and its significance. The researcher's assumptions about the topic are shared as

well as definitions of key constructs. The chapter concludes with a summary statement of the

research problem, the study's purpose, and the overarching research question.

The concern about the quality of nursing education in the 21st century is a global

challenge, particularly with the practice demands of the modern health care delivery system.

Traditionally, nursing education was based on an apprenticeship model that introduced students

to nursing concepts and clinical skill sets through a series of teacher-centered approaches

(Arundel & Cioffi, 2005; Phillips & Vinten, 2010). Curricula were designed to promote learning

through repetition, memorization, and recitation of a standardized dataset (Candela, Dally &

Benzel-Lindely, 2006). Although, these passive rote learning approaches of the traditional

model may have served earlier generations of nursing students, evidence suggests that these

approaches are not sufficient in preparing today's nurses for practice (Doyle, 2011).

Neuroscience provides a logical explanation to support the above argument. Evidence suggests

numerous physical changes occur in the brain during learning process and how passive learning

styles, could not only delay learning, but negatively affect a person's intellectual functional

capacity (Miller & Cohen, 2001). Nursing scholars have expressed particular concerns for the

traditional model of nursing education, arguing that it lacks the critical thinking component

required for optimal nursing care (Banning, 2008), and how reliance on a traditional model could

compromise the quality of nursing care (Banning, 2008; Spouse, 2001).

With the increasing changes and complexities within the current health care system, there

is a critical need for nurses to be educated to practice with a high degree of competency and

professional knowledge (Gipson & Richards, 2011). Modern nursing practice is characterized by the complex barriers of technological advances and patients with complex health care needs (Yuan, Williams & Fan, 2008). Therefore, the demands of practice are such that a professional nurse must constantly engage in learning and be able to integrate knowledge, skilled know-how, and ethical comportment (Benner, Sutphen, Leonard & Day, 2010). Competent practice requires that nurses use clinical reasoning and critical thinking skills required for the assessment, analysis, and synthesis of complex clinical situations while providing client care (Candela et al., 2006; Yuan et al., 2008).

According to Raterink (2012), critical thinking is composed of cognitive skills, confidence, creativity, inquisitiveness, intuition, open mindedness, and a capability for analyzing and transforming knowledge. The tendency is that each of these components could be used to enhance the quality of nursing care provided to patients, when combined with application of knowledge and expertise in clinical situations (Banning, 2008). Conversely, patients' lives may be in jeopardy if a nurse is lacking or unable to use critical thinking skills appropriately in numerous clinical situations (Benner, 2012). Candela et al. (2006) asserted that the means of achieving the goal of safe nursing practice go beyond memorization of instructional content or execution of nursing procedures as dictated. The recent challenge in nursing, therefore, has been on how to transform nursing education from traditional teacher-centered approaches to SCT (Tanner, 2006).

The majority of literature in nursing education has focused on teaching approaches that promote cognitive skills and intellectual capacity through active engagement in higher order skill activities as opposed to passive absorption of information (Lapkin, Levett-Jones, Bellchambers, & Fernandez, 2010). The push for transformation is also reflected in position statements and

keynote speakers' presentations at conferences (Institute of Medicine [IOM], 2010; National League for Nursing [NLN], 2008; Western & North-Western Canadian Association of Schools of Nursing [WNCASN], 2014). However, the quality of nursing education in meeting the complex practice demands remains a global concern.

Purpose of the Study

Many educational administrators and faculty have incorporated student-centered curricula and pedagogy to optimize undergraduate nursing students' learning experiences (Rideout et al., 2002; Waters, Rochester & McMillan, 2012). Additionally, nurse educators are incorporating evidence-based SCT strategies such as reflective thinking, case-study analysis, and inquiry-based learning to develop critical thinking in nursing students at all levels (Raterink, 2012). However, there is limited evidence about the experiences of the Clinical Nurse Educators (CNEs) who are using Student-centered Teaching (SCT) in the practice settings.

Student-centered pedagogy incorporates a number of strategies that focus on students' learning needs with the aim of promoting complex higher order skills and a deep learning experience (Colley, 2012). Fullan (1991) indicates that failure to understand how people experience change in contrast to how it is intended is the major cause of lack of success of most social reforms. Fullan's statement can be applied to the realm of educational reform. Since student-centered pedagogy is a paradigm shift from the traditional mode of teaching nursing knowledge (Walsh-Brennan & Sullivan-Marx, 2012), it is important to examine how nurse educators implementing the pedagogy experience the change.

This interpretive phenomenology explored the lived experience of SCT from the perspective of CNEs. The study was guided by the five conceptual domains of learner-centered teaching, a model proposed by Weimer (2013): (1) balance of power, (2) function of content, (3)

role of the teacher, (4) responsibility for learning, and (5) purpose and process of evaluation. The next chapter provides a more detailed description of the five conceptual domains, under the study's guiding framework.

Research Questions

This study was designed and conducted to answer the following research questions:

1. What characterizes the day to day experience of the CNEs while incorporating SCT in the practice settings?

2. What meanings do the CNEs attribute to SCT?

Significance of the Study

Clinical education is recognized as signature pedagogy in the discipline of nursing or in other words, it is a form of education that defines how nurses are prepared for practice (Shulman, 2005). Clinical education is also regarded as an essential and experience-based component of nursing programs that serves as a bridge between theory and practice (Higgs & McAllister, 2005). Through clinical experiences, students are provided with opportunities to develop the competencies to function in the real world of nursing practice.

Despite the fact that clinical activities form the heart of nursing education where theoretical principles are applied and used in practical situations, literature indicates that these areas are the least explored of all nursing educational activities (Phillips & Vinten, 2010; Yonge et al., 2005). For example, only 4.4% of nursing education studies focused on clinical teaching compared to 16.6% that encompassed classroom instruction (Yonge et al., 2005).

While student-centered philosophy has been widely researched in recent years in classroom and laboratory settings (Avdal, 2012; Candela et al., 2006; Choi, Lindquist & Song, 2014; Colley, 2012; Diefenbeck, Hayes, Wade & Herrman, 2011; Tiwari, Lai, So & Yuen, 2006;

Tseng et al., 2011; Zavertnik, Huff & Munro, 2010), there is a paucity of research evidence

pertaining to SCT in practice settings (Phillips & Vinten, 2010). As CNEs are the ones who are

intended to help students learn how to bridge the gap between classroom theory and clinical

practice, the success of clinical education rests on the shoulders of the CNEs (Higgs

& McAllister, 2005). Analysts noted that people construct their own reality and meanings from

how they experience a particular situation, and that many educational reforms failed due to lack

of awareness of what the implementers are facing (Fullan, 1991, cited in Nolan & Meister,

2000). Moreover, Williams and Beattie (2008) found that CNEs' understanding of the concept of

SCT largely influenced its implementation in the practice settings. A study examining SCT from

the perspectives of CNEs is necessary to fill the gap in nursing knowledge about SCT in practice

settings and provide exemplars for effective clinical teaching.

This study aimed to:

1. Contribute to existing knowledge by providing valuable insight into the CNEs'
    meaning and experiences of SCT in practice settings.

2. Identify individual and contextual factors that impact the implementation of SCT in
    practice settings.

3. Add to the limited knowledge base about SCT for health sciences faculty and
    administrators who strive to incorporate SCT.

4. Assist faculty and health services administrators in various health care disciplines in
    planning clinical education curriculum that incorporates SCT.

Assumptions

A philosophical assumption in phenomenology is that a researcher may have background

knowledge and experience about the phenomenon under study. Flood (2010) contended that the

researcher does not enter the project without prior beliefs and preconceived ideas that influence the researcher's perception of the subject of inquiry. However, these preconceptions need to be explicated before beginning the research process. According to Streubert and Carpenter (2011), the purpose of explicating personal beliefs and preconceived ideas is to identify potential judgments that could influence data collection and data analysis based on the investigator's beliefs rather than the participants' voice. In interpretive phenomenology, the researcher is regarded as part of the research in the world of the participants (Wimpenny & Gass, 1999).

As the researcher seeks to understand the participants' world of significance through immersion in their experience and meanings of SCT, it is impossible to completely ignore the background knowledge that led to exploring the subject in the first place (Flood, 2010; Heidegger 1962, cited in Paley, 2013; Munhall, 2012).The researcher is a member of a nursing faculty that is currently implementing a student-centered philosophy, and has worked with culturally diverse students with various learning styles in the classroom and practice settings. Moreover, being a graduate student also provides the researcher with a double lens with which to see SCT from both the teachers' and students' perspectives. The experiences of the researcher while teaching and trying to meet the learning needs of individual students provided a solid foundation for this study.

The researcher recognized that, while the goal of a student-centered teacher is to encourage students to be self-regulated, self-directed, self-confident, and risk takers, implementing SCT in clinical settings in this regard could be challenging. The researcher recognized that it is essential for a teacher to acknowledge the value of independent thinking and decision-making in students. However, when a student is confronted with barriers of having to make appropriate decisions in regard to safe client care, the teacher is faced with the dilemma

and ethical responsibility of having to intervene when a client's safety is at risk. This intervention may require that the CNE dictates what the student should implement and direct them as to how to problem solve. The researcher also recognizes that power sharing may become particularly challenging when students realize that being empowered means taking more responsibility for learning. In most cases, the researcher has observed that students are willing to share control but tend to hesitate with regard to additional personal responsibilities that come with being empowered.

The researcher's assumptions originated from personal experience in implementing SCT. Rather than making efforts to ignore previous knowledge and experiences regarding SCT, it was necessary for the researcher to identify and document how these assumptions shape the research process. Being aware of attitudes, beliefs and conceptions was helpful for the researcher to focus on the participants' perspectives of SCT rather than the researcher's interpretations. The following are the researcher's assumptions:

1. Multiple realities exist among CNEs regarding SCT in practice settings.

2. Transitioning from traditional teaching approach to SCT in practice settings has barriers.

3. CNEs require the supports of staff and administrators (both in academic and practice settings) to accomplish SCT.

4. Due to individual and contextual factors, CNEs may not be able to incorporate SCT in some instances in practice settings

Definitions of the Main Constructs

Qualitative researchers suggest a clear definition of the main terms in order to avoid a misunderstanding of con construct, and for the purpose of clarifying meanings

(Vivar, McQueen & Amaryor, 2007). Moreover, clarification of the meaning of the key

constructs ensures transparency of the study and allows the researcher to understand the specific

context of the phenomenon under study. Main constructs are defined in this section.

Clinical nurse educator. In this study, a CNE refers to a nursing faculty member, who is

often described in the literature as clinical tutor, clinical facilitator, clinical teacher, or clinical

instructor. This faculty member is responsible for providing the primary elements of experiential

education for small groups of undergraduate nursing students in the practice settings. The CNE

plays a key role in students' assessment, skill acquisition, and evaluation.

Deep learning. Deep learning refers to a learning approach that is associated with

intrinsic motivation, whereby a learner focuses on understanding the meaning of the learning

material with the purpose of connecting previous knowledge and new ideas to everyday life

experiences.

Higher-order skill. Higher-order skill is the ability to analyze, synthesize, and transform

facts and ideas into new knowledge for the discovery of new meanings or for problem solving

Pedagogy. The term "pedagogy" was originally defined as the theoretical basis for

teaching and learning in children (Knowles, 1975). Currently, pedagogy is used to describe the

art of teaching and designing teaching methods including the aims of education and the ways in

which such goals may be achieved (Young & Paterson, 2007). The root word "agogy" was

derived from the Greek word "dywyog" which means "leading" or "guiding" (van Manen,

2014). This forms the basis for SCT in which the teacher guides students in learning rather than

dominating or controlling students' learning.

Practice settings. Practice settings refer to hospital or community environments where

students practice communication techniques, decision-making, teamwork, and psychomotor

skills, while learning how to provide real-life and professionally competent care to individuals, families, or communities. In the context of this study, practice settings include acute care hospital units such as surgery, medicine, mental health, labor and delivery, as well as long-term care facilities such as personal care homes, or a community agency where students in an undergraduate nursing program in Manitoba are assigned.

Student-centered teaching. This term refers to a combination of various teaching approaches focused on the needs and active involvement of the student in the teaching-learning process. The aim is to promote metacognitive skills (Colley, 2012). In the context of this study, SCT is the incorporation of the SCT tenets into clinical teaching as described by Weimer (2013).

Chapter Summary

In this chapter, the background to the study was introduced with a brief overview of pertinent evidence supporting the significance of exploring the lived experience of CNEs using SCT in practice settings. In response to the call for transformation of nursing education from the traditional, teacher-centered approach to more relevant pedagogy, scholars and researchers have directed their attention to SCT. However, researchers have mainly examined and tested SCT in classroom settings; few studies have explored CNEs' use of SCT in practice settings. The purpose of the study and its overarching research question were stated. The significance of the study was described. Additionally, the chapter provided the researcher's assumptions undergirding the study. Finally, main constructs were defined for the purpose of clarity of meanings.

Chapter Two: Review of the Literature

This chapter provides a review of the literature that forms the basis for this study. In order to justify the need for the study, it was important to perform an analysis of existing literature for identification of gaps in knowledge about the meaning and experience of SCT. A rigorous literature review also provides a clearly defined logic for a research study, and helps to establish a firm background for the research question being investigated (Sandelowski & Barroso, 1995). Therefore, the review focused on the conceptualization of SCT in the literature, SCT methods relevant to clinical education in practice settings, and empirical studies on SCT in undergraduate nursing programs.

The University of Manitoba library online system was used to access electronic databases in the search of the literature. The structured searches of database platforms included Ovid, EBSCO host, Google Scholar, Education Resources Information Center (ERIC), PubMed, Scopus and the Cumulative Index for Nursing and Allied Health Library (CINAHL). Due to a plethora of literature evidence on SCT methods, the search focused on published research manuscripts written in English language and those published in peer reviewed journals within the last 10 years. The key words and subject headings used in each database search were: "learner-centered education," "learner-centered pedagogy," "creative teaching," "experiential learning," "collaborative teaching," "student-centered teaching," "self-directed learning," "problem based learning," "team based learning" AND "clinical nursing". The initial search yielded approximately 160 articles. Titles and abstracts were reviewed to identify primary sources of research. Some publications involving graduate nursing education, conceptual papers, position papers or editorial publications were eliminated. Subsequently, a "snowball" approach was used to identify relevant studies cited within the located articles. Thirty four empirical

studies related to SCT in undergraduate nursing programs were critically reviewed. An annotated

bibliography was constructed (see Appendix A) to facilitate a critical review of relevant

literature.

The need for clarity of concepts in research study cannot be over emphasized. McEwen

and Wills (2007) discussed the crucial importance that scholars define concepts clearly and

distinctly so that the readers may thoroughly and accurately comprehend what is discussed.

Walker and Avant (2005) also emphasized that it is important to know how a concept is defined

for the purpose of clarifying vague or ambiguous meanings so that everyone subsequently using

the term has the same understanding of the concept. The following section provides an overview

of various definitions and how SCT is conceptualized in the literature.

Student-centered Teaching Defined

A review of publications revealed different opinions and unresolved issues regarding the

conceptualization and meaning of SCT. There is ambiguity and lack of an explicit definition in

the way the term is used to label teaching strategies, teachers, classes, programs, departments, or

institutions (Weimer, 2013). The lack of a clear definition is also demonstrated in the divergence

among its many meanings by various authors. In an effort to provide a definitive

conceptualization of SCT, some authors attempted to define the term in connection with related

terms or pedagogical strategies, such as problem-based learning, collaborative learning, active

learning, or self-directed learning (Aspelin, 2011; Boyd, McNeil & Sullivan, 2006; Bruner,

1966; Stanley & Dougharty, 2010). A clear meaning of SCT is important in understanding its

significance in relation to clinical nursing, and to how the CNEs use the concept in their

teaching. The following section provides the themes that emerged in the various definitions of

SCT.

Active participation in teaching-learning process. A number of early theorists described SCT as the active involvement of students in the teaching-learning process (Bruner, 1966; Dewey, 1966; Piaget, 1973; Vygotsky, 1978, as cited in Huitt & Hummel, 2003). This definition evolved from the point of view of constructivists, who believed that learning occurs when the individual learner is an active participant in the teaching-learning process, and is able to integrate new information with their existing knowledge to engage in innovative procedures or create new understandings.

Constructivism favors unique experiences and beliefs of the learner in determining what to learn and how to achieve the learning goals. Furthermore, constructivists argue that successful learning occurs when the student actively participates in the process that leads to the achievement of the goals (Huitt & Hummel, 2003). Moreover, the ability to recognize the uniqueness of each student and adapt teaching strategies to meet the needs of an individual student has been identified as one of the learner-centered characteristics of nurse educators (Greer, Pokorny, Clay, Brown, & Steele, 2010).

Integration of previous knowledge and experience. In addition to students' involvement in the teaching and learning process, constructivists also encourage the integration of information generated from previous experiences. According to Huitt and Hummel (2003), constructivism emphasizes the role of practical experience, experimentation, purposeful learning, autonomy, and social interactions in promoting learning and knowledge construction.

A constructivist considers education not only as a means to gain content knowledge or acquire pre-determined skills, but also as a means of learning about one's full potential and using that potential for self-development. A constructivist supports a purposeful students' engagement in direct experience and self-reflection with the

aim of increasing knowledge, clarifying values and developing skills and capacity (Huitt &

Hummel, 2003).

      Sense of inquiry. Another important element of SCT commonly described in the

literature is the development of a sense of inquiry in the student. Huitt and Hummel

(2003) believed that learning is a discovery of new knowledge which requires a step by step

process through participation, modification, and transformation of information into operational

knowledge. Vigotsky (1978) also recognized the ability of an individual student to inductively

discover knowledge and transform information. He referred to acquisition of new knowledge as

being dependent on previous learning, as well as the availability of instruction and the belief that

cognitive function is optimized through practical activities within a social environment.

      Similarly, scholars such as Stanley and Dougharty (2010) are in support of contemporary

instructional designs and SCT methods. These scholars based their arguments on the pioneering

works of the aforementioned constructivists. Stanley and Dougharty (2010) maintain a

constructivist view in agreement with the notion that students are knowledge seekers, with real

world experience and pre-existing ideas rather than just the passive recipients of information.

      Empowerment and independence. Empowerment is a theme not explicitly described by

some authors but implied in their description of SCT. Student-centered teaching is described as a

holistic approach to promote students' personal responsibility for autonomy in determining

learning needs (Sweeney, 1986). This definition implies that students should be empowered with

the freedom to act or make independent decisions about learning. A nurturing environment

conducive to questioning, exploring, and experimenting is crucial to promoting knowledge

seeking behaviors in students.

In her concept analysis, Hawks (1991) identified a nurturing and caring environment as an antecedent to empowerment. A nurturing environment that promotes trust, openness, honesty, communication, positive interpersonal relationships, mutual respect, acceptance of people as they are, value for others, and a shared vision is paramount in promoting optimal learning. Students' empowerment is facilitated by: motivation to take initiative in diagnosing learning needs, formulating learning goals, as well as identifying human and material resources for students' learning. Nurse educators empower students by guiding them in choosing and implementing appropriate learning strategies, and evaluating learning outcomes (Klunklin, Viseskul, Sripusanapan & Turale, 2010).

Mutual relationships and working as a team. A number of authors describe SCT as a learning process in which social relationships are encouraged, whereby students interact not only with the teacher but also with peers to share ideas and experiences for the purpose of constructing new knowledge (Boyd et al., 2006; Bruner, 1966; Gillespie & McFetridge, 2006; Greer et al., 2010; Weimer, 2013). Bruner (1966) maintained a relational view that learning is a social and interactive process whereby students are guided in selecting information, constructing hypotheses, and making decisions with the aim of knowledge discovery. Several authors also identified contact between faculty and student as an important component of effective SCT that motivates student learning and participation (Al-Hussami, Saleh, Hayajneh, Abdalkader & Mahadeen, 2011; Anaya & Cole, 2001; Lundberg & Schreiner, 2004; Rugutt & Chemosit, 2009).

Lonser (2006) supports role modeling, facilitating a climate of mutual respect, providing supportive encouragement, giving responsibility and independence to students, creating opportunity to practice tasks and providing feedback, collaboration, and

supervision as strategies for maintaining contact with students. Evidence also suggests that

sound and trusting interpersonal relationships between clinical teachers and learners are

crucial to achieve optimal learning outcomes. Mannix, Faga, Beale and Jackson (2005) found

that lack of opportunity for trusting learning relationships to develop between facilitator and

student can result in conflict between facilitator and student.

In agreement with Bruner (1966), several contemporary researchers also associate SCT

with interpersonal relationships. These researchers found that through relational teaching, faculty

members were better able to connect students with knowledge (Boyd et al., 2006; Gillespie &

McFetridge, 2006; Greer et al., 2010; Weimer, 2013). These authors claim that rather than a

hierarchical teacher-student relationship, mutual understanding and a sense of community

between students and teachers should be maintained to promote learning. Boyd et al. (2006)

conclude that a partnership relationship promotes a trusting atmosphere for risk-taking in

learning, and serves as a means to hold both teacher and students accountable

for learning. Al Hussami et al. (2011) and Aspelin (2011) also express the view that partnerships

between faculty and students promote mutual respect and sharing of knowledge.

Brown, Kirkpatrick, Mangum, and Avery (2008) are optimistic that partnerships in

learning would be more effective in meeting students' learning needs in today's

world. Generally, SCT is seen not only as a relationship between the teacher and the learner but

also as an approach to teaching that facilitates collaborative and co-operative learning among

students who are working in concert to achieve a common goal (Wijnia, Loyens & Derous,

2011). Positive relationships between students and educators also are connected with self-

confidence and increased critical thinking in students (Roberts & Chandler, 1996; Wijnia et al.,

2011). Researchers indicate that a positive relationship between the faculty member and students

tend to promote confidence and sense of control, and responsibility for learning among students (Rugutt & Chemosit, 2009).

Gillespie and McFetridge (2006) found that a positive relationship not only allows the teacher to share thought process with students, but creates opportunity for thought-provoking questioning and critical thinking activities for real world application. Gillespie and McFetridge (2006) suggest that, the teacher should look for opportunities to engage students in teaching-learning activities that are stimulating to their intellectual ability and challenging enough to move students forward in their learning. However, Gillespie and McFetridge (2006) emphasize the need for faculty to provide sufficient support in order to remove anxiety, and gradually reduce the amount of support until students become confident to practice at higher levels of competence.

In the previous section, a review of the literature was provided with descriptions of the various meanings of SCT and its underlying tenets. A number of themes found in the literature served to define SCT as "students' active participation (involvement) in the teaching-learning process," "building on students' previous experience as a fundamental component to learning," "empowerment of students in their learning" and "facilitating sense of inquiry in students and creating trusting teacher-student and student-student relationships". In the following section, commonly used SCT methods are discussed.

Student-centered Teaching Methods

Although it is essential to understand the concept of SCT, it is equally important to be familiar with the pedagogical methods that transform students from passive to active learners. This section provides a review of some SCT methods that engage students in active learning in practice settings.

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Active learning. Felder (2011) defines active learning (AL) as any form of course-related activities in which students are learning through engagement with the learning materials, rather than watching, listening, or taking notes. A teacher implementing AL engages students in problem solving, critical questioning, and formulating questions of their own, discussing, explaining, debating, brainstorming, or critiquing during the class or course session. Felder and Brent (2004) suggest effective ways to engage students in AL such as "think-pair-share". Think-pair-share is a method that is relevant in practice settings and can be used during a post-conference debriefing where students share barriers or cases encountered during practice.

Active learning methods are known to be effective in engaging students in critical thinking and problem solving. These methods also promote greater learning, collaboration, and knowledge sharing among students, helping them to realize that there are multiple approaches to problem solving (Felder & Brent 2004). Other AL strategies include "concept mapping" and "think aloud problem-solving" (Felder & Brent, 2004). Concept mapping are embraced in nursing as an effective teaching method that promotes critical thinking (Abel & Freeze, 2006; Chen, Liang, Lee & Liao, 2011; Wilgis & McConnell, 2008) and helps students to apply theory to practice (Veo, 2010). "Think aloud problem solving strategy" are also adopted in nursing to enhance clinical reasoning and decision-making skills in students (Banning, 2008). In using a think-aloud protocol, the CNE encourages students to verbalize cognitive processes while making clinical decisions and prioritizing patient care.

Problem-based learning. This strategy was originally introduced into medical education many years ago at McMaster University in Canada (Neville, 2009). Problem-based learning (PBL) consists of carefully designed problems that challenge students to use problem-solving techniques, self-directed learning strategies, team participation skills, and disciplinary knowledge

(Schmidt, Rotgans & Yew, 2011). PBL is similar to AL but the problem presented in PBL is more complex than in AL (Felder, 2011). Students are required to work in collaboration with peers to solve complex problems.

The goal of PBL education is to help students develop effective problem solving, self-directed learning, collaborative learning skills, and intrinsic innovation skills (Schmidt, Rotgans & Yew, 2011). PBL strategy follows constructivist perspectives in that the role of the teacher is to facilitate students' learning through self-discovery, self-direction, and independent learning, or to build on previous knowledge. PBL is a SCT approach that is receiving attention with several scholars recommending that CNEs incorporate PBL (Chan, 2013; Farid, Farah & Naz 2012; Nevin, 2014; Oja, 2011). PBL is compatible with the nursing process model, in which students are required to conduct comprehensive and holistic client assessment, cluster data and formulate nursing diagnoses, identify priority nursing diagnoses, and design a nursing care plan.

Self-directed learning. Self-directed learning (SDL) is described as a learning process in which students take the initiative to determine their learning needs, set goals, identify necessary resources for learning, choose and implement appropriate learning strategies, and evaluate the outcome (Knowles, 1975). The theoretical root of SDL method is found in Dewey's (1966) theory that every individual possesses inherent potential for cognitive development, which should be allowed to unfold naturally; and that teachers are to facilitate and guide students.

Personal responsibility is central to SDL, in that the students must be willing to assume ownership of their own thoughts and actions as well as the consequences (Williams, 2001). Self-directed learning is integral to nursing education and competent nursing practice (College of Registered Nurses of Manitoba [CRNM], 2013; International Council of Nurses [ICI], 2006).

SDL has been adopted in many nursing education programs (Choi et al., 2013; Zhang, Zeng & Chen, 2012). Knowles (1975) identifies several advantages associated with SDL such as an increase in motivation among students, enhanced retention of what has been learned, and an ability to learn more effectively. Avdal (2012) reports an association between SDL approach and successful student outcomes when the teacher facilitates an environment that is supportive to learning. According to Williams (2001), creating environments that support learning involves effective facilitation of students' activities, assisting students in diagnosing their own learning needs, assisting them in setting learning goals, and evaluating learning outcomes in a way that promotes self- reflection and peer review among students. Avdal (2012) discusses the importance of examining the learning styles of students for effective use and successful outcomes of SDL approach.

Case-based learning. Case based learning (CBL) is an instructional method within the context of SCT (Kadoura, 2011). CBL facilitates students' learning and independent decision-making through the use of case studies (Yoo & Park, 2014). CBL provides a rich basis for developing students' problem-solving and decision-making skills. CBL curriculum is based on application of problem-solving skills, in which case studies are presented to help students synthesize, evaluate, and apply information and concepts learned in the classroom and textbooks (Yoo, Park & Lee, 2010). CBL is relevant to clinical nursing education because graduates of nursing programs often experience clinical problems on a daily basis; their ability to competently deal with such problems is critical to safe nursing practice (Yoo et al., 2010). Moreover, CBL has been shown to be effective in both medical and nursing education programs (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013; Yoo & Park, 2014). Practice settings provide rich environments for students to learn how to problem-solve, the CNE can apply CBL

by describing a real practice scenario in which a problem is presented with its complexities and dilemmas for students to analyze and make decisions regarding the resolution.

Collaborative learning. Collaborative learning (CL) involves students and faculty working together to build knowledge with the goal of developing students' independent thinking (Gillespie & McFetridge, 2006). The teacher's responsibility is to become a joint member of the learning community with students, in search of knowledge (Gillespie & McFetridge, 2006). The role of the teacher is crucial to create a learning environment that promotes students' participation and interaction between students and faculty (Slavich & Zimbardo, 2012). According to Greer et al. (2010), a key role of the learner-centered teacher is to model a positive attitude and creativity in incorporating teaching strategies that promote interaction among students, students and teacher, students and content, and peer-to-peer learning. Collaborative learning is consistent with clinical nursing education in that it promotes collaboration among students, and between students and nurse educators (Yang, Woower & Mathews 2012). This process allows students to engage in problem-solving and critical thinking to build knowledge related to nursing care and complex clinical cases.

The ambiguity surrounding SCT is evident in the literature, where the concept has been treated both as pedagogical approach, as well as a label for educational programs, with no clear conceptualization. Indeed, in spite of applicability of SCT methods to a wide range of educational programs, no tangible definition of SCT exists. The next section of this review is based on a critical analysis of research about SCT in nursing education.

Empirical Evidence About Student-centered Teaching in Nursing Education

The scope of empirical evidence on SCT in nursing focuses on describing and testing various teaching methods used in undergraduate programs. The studies used designs that include descriptive surveys (Avdal, 2012; Colley, 2012; Cooper & Caver, 2012; El-Gelany & Abusaad, 2012; Hoke & Robbins, 2005; Kaddoura, 2010; Klunklin et al., 2010; Kocaman, Dicle & Ugur, 2009; Ozbicakci, Bilik, & Interpeler, 2012; Phillips & Vinten, 2010; Schaefer & Zygmont, 2003), mixed methods (Dearnley & Meddings, 2007; Diefenbeck et al., 2011; Jeffries, Rew & Cramer, 2002; Lau & Wang, 2013; Regan, 2003; Tiwari et al., 2006), program evaluation (Yang, et al., 2012), a systematic review (Yuan et al., 2008), qualitative approaches (Greer et al., 2010; Klunklin, Subpaiboongid, Keitlertnapha, Viseskul & Turale, 2011; Lekalakala-Mokgele, 2010; Lerret & Frenn, 2011; Moore, 2009), quasi-experimental (Baumberger-Henry, 2005; Choi et al., 2014; Clarke, 2010; Kalam-Salminen, Valkonen, Aro & Routasalo, 2013; Rideout et al., 2002; Shin, S., Ha, Shin, K. & Davis, 2006; Tseng et al., 2011; Zhang et al., 2012), and experimental projects (Brydges, Carnahan, Rose & Dubrowski, 2010; Lin et al, 2010). Two major themes emerged from a critical review of 34 studies pertaining to SCT in nursing education. These themes were student outcomes of SCT and faculty experiences of implementing SCT methods.

Student outcomes. Most studies that examined the effects of SCT reported positive student learning outcomes. According to the reports of Avdal (2012), Brydges et al. (2010), Cheng, Lou, Tsai and Chang (2013), Diefenbeck et al. (2011) and Hoke and Robbins (2005), SCT methods such as SDL, co-operative learning techniques, and team-based learning were consistently reported as leading to enhanced problem-solving and analytical skills in students. Several other studies comparing various SCT methods with conventional methods reported

enhanced critical thinking and clinical decision-making skills in nursing students. For example, Tseng et al. (2010) examined PBL and concept mapping in comparison with traditional methods in an undergraduate nursing program; they found that PBL and concept mapping promoted critical thinking skills, personal accountability and autonomy, and clinical reasoning among students. Yoo et al. (2010) also examined the effects of case based learning (CBL) on the problem-solving ability of nursing students. Ability to problem-solve was found to be higher among students who received CBL when compared to a control group. Furthermore, CBL was found to enhance decision-making and create curiosity in students. Consistently, researchers also identified student satisfaction (Lin et al., 2010; Rideout, 2002; Zhang et al., 2012) and motivation for SDL (Klunklin et al., 2010; Kocaman, Dicle, & Ugur, 2009) as positive outcomes of SCT.

Contrary to the positive trend reported in the above studies, some researchers claim there is no difference in the outcome of SCT when compared to student outcomes of traditional teaching. For instance, Jeffries et al. (2002) compared the effectiveness of an interactive SCT approach with traditional lectures and demonstrations between two groups of nursing students (70 sophomore and 50 junior baccalaureate students) in a baccalaureate program. Although more satisfaction with learning was indicated, the study reported no significant difference in the basic laboratory skills for both groups. Choi et al. (2013) and Lin et al. (2010) examined SCT in connection with outcomes such as critical thinking, problem-solving, and self-directed learning of nursing students receiving PBL as compared to those receiving traditional lecture. No significant difference was found between the learning outcomes in the PBL group and those in the traditional lecture group. Moreover, according to Yuan et al. (2008), a systematic review of

empirical literature on the effects of PBL could not identify any supportive evidence to indicate improved critical thinking ability in nursing students.

The inconsistency identified in research regarding the effects of SCT teaching on student learning is noteworthy. None of those studies that claimed positive outcomes, such as increased critical thinking and problem-solving skills, documented how SCT was implemented. Although Yoo and Park (2014) reported significant difference in outcomes; their report was only based on a 15 minutes analysis of video case scenario of students' performance. Moreover, most studies conducted among students were either cross-sectional studies of self-reported outcomes (Avdal, 2012; Hoke & Robbins, 2005) or quasi-experimental studies (Brydges et al., 2010; Cheng et al., 2013; Clark et al., 2008).

Faculty Experience. The majority of studies on faculty experience were conducted in the United States (Colley, 2012; Dearnley & Meddings, 2007; Greer et al., 2010; Johnson-Farmer & Frenn, 2009; Lerret & Frenn, 2011; Moore, 2009; Phillips & Vinten, 2010; Regan, 2003; Schaefer & Zygmont, 2003). Most researchers describe a number of factors that influence the effective use of SCT methods. Among the key barriers identified are the lack of understanding of the basic principles of SCT and the need for more knowledge regarding the philosophical roots of the approaches. For example, Colley (2012) explored faculty's perceptions of adopting a SCT philosophy. Understanding the philosophical concepts by faculty and students, administrative support, and peer sharing were identified as key facilitators for effective implementation and sustainability of SCT model.

Dearnley and Meddings (2007) and Lekalakala-Mokgele (2010) also describe faculty's experience and impact of SCT on learning. While these studies examined different aspects of SCT, their results consistently indicated inadequate understanding of SCT pedagogy, and the

need for significant preparation of both students and faculty in order to achieve successful

implementation of SCT. Similarly, Greer et al. (2010) examined the SCT characteristics among

self-identified nurse educators who reported using SCT at least 50% of the time in their teaching.

Factors such as administrative issues, student issues, and lack of understanding of SCT also

emerged in Greer et al.'s study as key barriers to the implementation of SCT. Although Johnson-

Farmer and Frenn (2009) and Lerret and Frenn (2011) conducted their studies on teaching

excellence, both studies emphasized the need for knowledge and faculty preparation for

sustaining teaching excellence. The four themes emerging from their study describe an excellent

teacher as enthusiastic, knowledgeable, student-centered, and one who knows and honors

students (Lerret & Frenn, 2011).

A common recommendation in all the studies was the need for faculty development in

order to prepare nursing faculty for the adoption of SCT. Studies also showed that faculty

members face barriers in adapting to the change process and the need for organizational

support (Lerret & Frenn, 2011; Moore, 2009; Ozbicakci et al., 2012; Phillips & Vinten, 2010;

Regan, 2003). Although studies widely documented faculty's experiences of using SCT in the

classroom and simulation laboratory settings in places like the United States and United

Kingdom (Arundell & Cioffi, 2005; Colley, 2012; Greer et al., 2010; Johnson-Farmer & Frenn,

2009), no studies described the experiences of CNEs using SCT in the practice settings in

Canada.

The Conceptual Framework for Student-centered Teaching - Weimer's Model

This section provides a detailed description of the conceptual framework for the

study. A conceptual framework is used in research to provide a structure for examining

relationships between concepts relevant to the phenomenon under study (Vivar, McQueen & Amaryor, 2007).

This study used Weimer's (2013) model as a suitable guiding framework with which to examine the relationship among the concepts central to SCT. From her work on learner-centered teaching, Weimer presented teaching as student-centered when there is a paradigm shift in instructional activities. She described teaching with more focus on the quality of students' learning rather than the technical "know how" of teaching. In the model, there is more consideration for learner-related factors such as the condition under which students are learning, whether students are retaining and using learning, and how current learning positions students for future learning. Weimer further defined student-centered teaching by five conceptual domains: (a.) power dynamic; (b.) instructional content, (c.) responsibility for learning, (d.) role of the teacher, and (e.) purpose and process of evaluation.

Figure 1. Model of learner-centered teaching (Weimer, 2013)
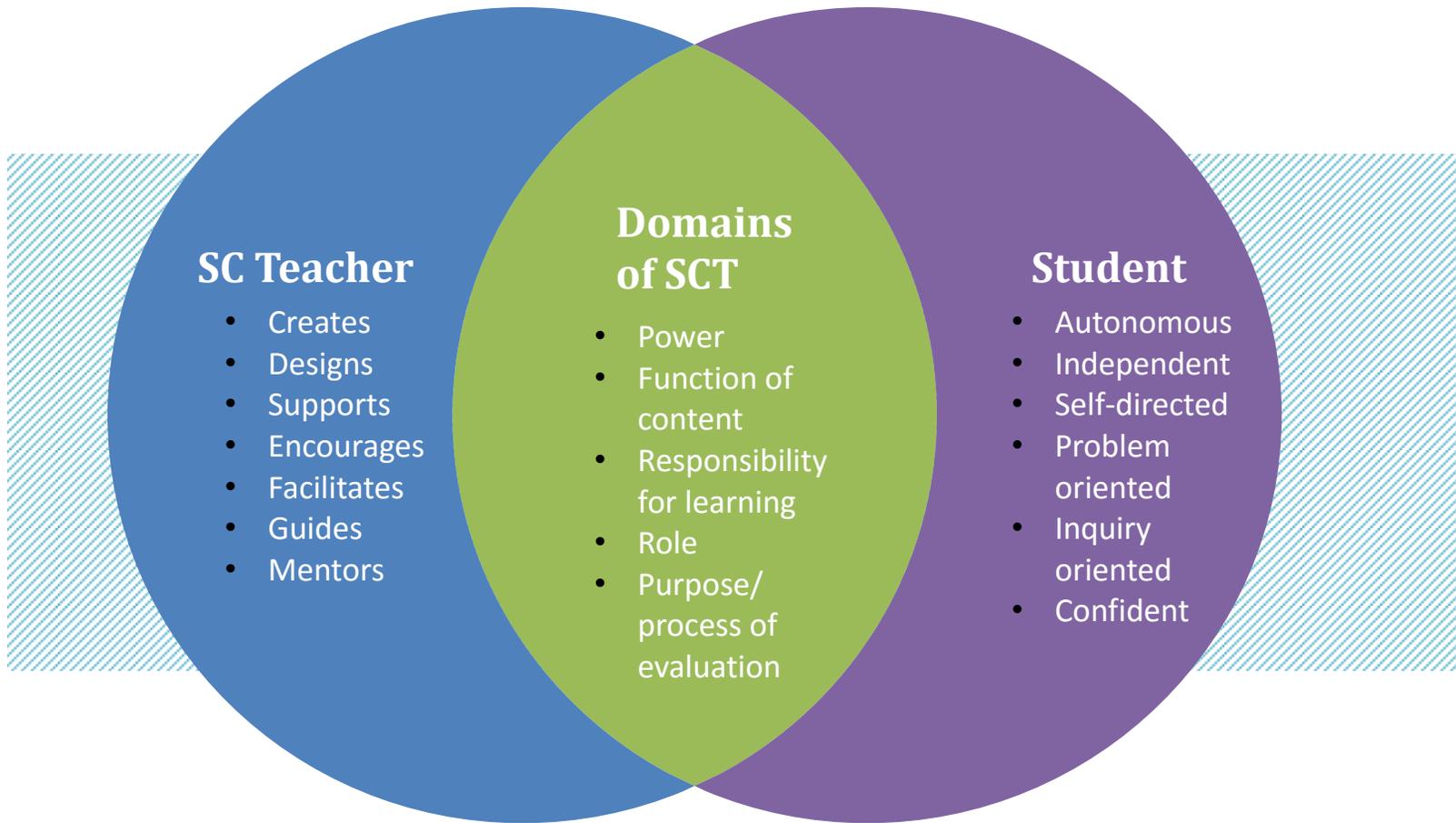
Student-centered teaching requires a shift in: (a) the role of the teacher, (b) the balance of power between teacher and students, (c) function of content, (d) responsibilities for learning from teacher to students, and (d) evaluation process for the purpose of promoting learning skills in students. According to Weimer, the effective use of SCT to achieve excellence is tied to the "practical details of instructional actions that feature students at the center of the learning process" (p. xvi). The integration and connection between these five conceptual domains and student learning are discussed in the following section.

Balance of power. The power dynamic between teacher and students influences the teaching-learning process and consequently, the learning outcome. (Weimer, 2013) acknowledges the extent to which faculty could dominate or control the learning process and how authoritarian teaching approaches could reduce students to dependent and passive learners. Weimer emphasized that students are capable learners who are more likely to be successful in egalitarian learning environments where there is less domination and when decision making about teaching-learning activities is responsibly shared. Responsible power sharing between teacher and students is referred to in the nursing literature as "empowerment", a concept which includes recognition of the self-worth of others, and provides support to develop or increase personal ability and effectiveness (Hawks, 1991; Rodwell, 1996).

Empowerment is connected with several positive effects on students' learning and on the teacher's effectiveness. Weimer (2013) maintains that when students are empowered to take charge of their learning, they are more connected with the course content. Students become more confident in their ability to work independently and are able to use course content to practice more effectively. Being empowered for learning also requires a level of responsibility on the part

of the students. On the other hand, when students accept responsibility to learn, the teacher is

motivated to prepare more difficult and challenging tasks to push students to learn (Weimer,

2013).

Research indicates that when students are empowered to learn, they develop

into intellectually reflective and caring individuals with increased problem-solving abilities,

increased communication and leadership skills, and increased autonomy and responsibility

(Hawks, 1991; Kuh, Kinzie, Schuh, Whitt & Associates, 2005). These outcomes are the essential

competencies for safe and quality nursing practice (CRNM, 2013). Active learning (AL) is

validated as an effective strategy in empowering students. Felder (2011) contends that when

AL strategies are used to get students involved in decision making and learning activities,

students are less resistant, and more willing to share ideas with peers and the teacher. This kind

of symbiotic power dynamic process should be encouraged, as it creates a learning environment

conducive for students as well as a positive work environment for the teacher.

An authoritarian teaching model may lead to problematic teacher-student relationships.

Weimer (2013) acknowledges the negative effects of an authoritarian teaching approach

including resistance from students, frustration, and lack of respect, which is extremely stressful

for both teacher and students. Nursing students may experience feelings of fear and anxiety in

practice settings as a result of a strained relationship with faculty and clinical staff (O'Mara,

2013). Authoritarian clinical learning environments add to existing students' anxiety leading to

potentiate negative effects. Weimer (2013) identifies lack of confidence, self-motivation,

initiative, and self-direction as negative student outcomes of authoritarian teaching

models. Ideally, nursing students require opportunities to develop confidence and independence.

Graduates of nursing programs need to be capable of positive interpersonal skills with the ability

to collaborate on client care with other members of the health care team (CRNM, 2013).

Teaching-learning activities should be designed to empower nurses for these responsibilities.

Moreover, nursing students require opportunities to develop leadership skills. Nurses often assume leadership roles within the health care team (CRNM, 2013; Jones, 2010). Among the attributes of a good leader are: approachability, clinical competence, being supportive, acting as mentors or role models, being visible in practice, directing and helping people, inspiring confidence, having effective communication skills, and behaving with integrity (Stanley, 2014). Ability to delegate power is also an important quality of a good leader (Stanley, 2014); the CNE may serve as a positive role model in sharing these qualities by the use of teaching strategies that foster empowerment in students.

An element of autonomy or choice is often referred to in connection with empowerment for learning (Dewey, 1966; Klunklin et al., 2010; Sweeney, 1986). Hawks (1991) describes several conditions that must exist to establish autonomy including trust, openness, honesty, genuineness, communication and interpersonal skills, acceptance of people as they are, mutual respect, value of others, courtesy and shared vision, willingness to allow choices, willingness to facilitate participation in decision-making, and goal-setting. On the other hand, students must be willing to assume responsibility, participate in goal-setting and decision-making, and accept behaviors that encourage empowerment (Hawks, 1991). As much as Weimer (2013) advocates for students' empowerment, she also warns about the risk for complete transfer instead of sharing power. In this case, the students are in complete control of decision-making about learning, and with little or no input from the teacher. According to Weimer, students require guidance and gradual nurturing to the level where they can make reasonable decisions that promote learning. The CNE uses negotiation of learning to address decision making

regarding assignments as suggested by Weimer or work closely with students to set their own

learning goals as a good strategy to promote autonomy and sense of ownership.

Function of instructional content. Effective use of instructional content is another

domain of SCT. Building on the theory of constructivism which emphasizes active involvement

of students in knowledge construction rather than passive reception of information, Weimer

(2013) considers teaching as student-centered when teaching is focused on the three functions of

instructional content: knowledge construction, skill development, and creation of self-awareness.

Rather than focusing on how much should be covered or the amount of knowledge that should be

acquired, Weimer suggests that instructional content should be used as the means to

assist students to learn how to create self-awareness for knowledge construction and skill

development.

Knowledge construction. In using instructional content to construct knowledge,

students' interaction with content is important. According to Weimer (2013), interaction with

content requires time to explore, process, and relate new information to previous

learning experiences. Nursing students need experiences that focus on integrating theory with

practice, practice settings provide the opportunity for these experiences (Waters et al., 2012).

Therefore, sufficient time should be allocated to teaching-learning activities so that students can

develop deep learning and understanding of factors associated with patient care.

Weimer (2013) suggests various means of promoting students' interactions with

content and helping gain insight into learning needs and skill development. The CNE has a vital

role to play in assisting students to recognize real life experiences that can be connected

to prior theoretical knowledge and practical skills. Ability to integrate previous knowledge in

new contexts helps deepen an understanding of nursing practice from different

perspectives (Nielsen et al., 2013). Learning opportunities that enable students to relate

various course concepts to clinical situations should be incorporated into clinical teaching. For

instance, Longo and Lindsay (2011) describe an innovative way to engage students in knowledge

construction by reflective journaling and guided discussions to connect theoretical knowledge

with experience. CNEs are to be creative in designing those activities

to facilitate students' interactions with the course content in ways that will assist students to

maximize learning, therefore they incorporate interactive activities and teaching strategies that

promote self-reflection into clinical teaching Lambert & Glacken, 2005). Reflective journaling

represents students' documentation of subjective learning (Johns, 1995) and can be used to

document how theory connects to practice (Harris, 2008). Writing reflective journal entries after

a critical incidence has been credited as an aspect of experiential learning (Dewey, 1997). The

CNE can engage students in reflective journaling to promote reflective practice and experiential

learning among students.

Skill development. Skill development is an important function of course content through

which learning is sustained across a career and for a lifetime (Weimer, 2013). Hand-on

experience plays a major role in skill development. According to Weimer, when students are

provided with opportunities for hand-on experience, they are able to connect content with such

experience. Content in clinical nursing is related to the competencies of nursing practice and

clinical competence is associated with the ability to connect knowledge, skills, and attitudes

across the continua of clinical practice areas (Oermann, Yarbrough, Saewert, Ard & Charasika,

2009). The CNE can be creative in selecting patient assignments that provide appropriate skill

development for students. Lapkin et al. (2010) advocate that students should be given the

opportunity to develop clinical reasoning skills and application of theoretical knowledge through

experiential learning in the real health care environment.

Analytical skill, reflective abilities, and communication are required for competent

nursing practice (CRNM, 2013) but these skills cannot be acquired through memorization and

regurgitation. Students require specific learning experience to acquire practice competencies to

function effectively. However, the teacher's methods of instruction and the students' learning

orientation influences the ability to retain learning for real life application (Weimer, 2013). The

literature reports a disconnect between theoretical learning experiences with clinical practice in

which students find it challenging to integrate theoretical knowledge in problem solving clinical

situations (Eggertson, 2013). This author confirms Weimer's (2013) claim that when teaching

encourages memorization of facts and elements of course content, students are not able to

analyze or construct new knowledge for effective application in the real world, that there is need

to teach students the skills for learning. Lasater et al. (2009) found that students often document

journals on the narrative recount of details of clinical experiences, which tend to report a

chronological description; and students are unable to ascertain clinical implications or effects

on their professional development. However, guidance from the CNE can help students

develop their reflective skills and thereby increase their clinical reasoning skills

(Daroszewski, Kinser, & Lloyd, 2004; Kuiper & Pesut, 2004). Craft (2005) and Weimer (2013)

also suggest the importance of the teacher being available to offer guidance on a case-by-case

basis beyond an initial orientation, so that students can fully explore their thinking.

A variety of clinical experiences targeted at specific learning allows the CNE to facilitate

a scaffolding process. Spouse (1998) defined scaffolding as the guidance offered by a coach who

talks a novice through aspects of a procedure where there is need for extra help. Scaffolding

requires the CNE to be available to provide guidance and support, particularly when a student is in an unfamiliar learning experience. Scaffolding also addresses how new knowledge is constructed. In other words, scaffolding is a gradual construction of knowledge. Clinical activities such as case presentation or self-reflection during post conferences or writing of incidence reports are adapted to fit the clinical instructional content (Hsu, 2007). Nursing practice requires more than reproducing knowledge or regurgitating information, it requires the ability to problem solve and adapt to different situations (Candela et al., 2006), therefore teaching-learning in the clinical setting should be focused on activities that require students to explore, reflect on, and process information to a meaningful level to build new knowledge.

Creation of self-awareness. A student-centered teacher designs activities and assignments that cultivate self-awareness, encourages students to confront and analyze their individual skills in specific areas (Weimer, 2013). Self-confidence is an important consideration when creating activities that promote self-awareness for students. Students generally report lack of self-confidence throughout their clinical experience, due to fear of making mistakes (O'Mara, 2013). Several strategies are used to help students create self-awareness about their abilities and learning needs. Weimer suggests that teachers use the initial interaction with students to learn about the students' characteristics, such as effective learning strategies, ability to use feedback effectively, ability to use group activities, and ability to reflect on clinical experience in such a way that promotes learning. At the conclusion of the initial interaction, teachers can provide students with feedback for clarification and confirmation in an effort to raise students' self-awareness.

Post-clinical conference discussions also help students develop self-awareness. During post clinical conferences, the CNE can facilitate self-reflection, peer feedback, questions and

answers. The CNE provides constructive feedback and reinforces students' abilities. According

to Weimer (2013), documenting learning logs also helps students recognize their own strengths

and weaknesses, as well as those of others. Moreover, it is important for CNEs using SCT to be

familiar with these strategies to be able to assist students to achieve life-long productive

learning (Weimer, 2013).

The role of the teacher. Due to the interconnectedness among the conceptual domains of

SCT, the various roles of the teacher are featured in all five domains. Weimer (2013) explains

the need for a change in the traditional roles so that the teacher is no longer the main

performer to make learning happen. Teaching should be focused on designing learning activities

that promote learning rather than performing tasks or telling students what to do. Weimer also

describes the principles that depict the roles of a student-centered teacher: The teacher does less

of the learning task, allows students to discover, designs and models, facilitates, and creates and

provides feedback. A student-centered teacher designs appropriate learning experiences that

motivate students to explore. For instance, the student-centered CNE is capable of initiating a

case study debate on a controversial or problematic clinical topic during the post-clinical

conference (Hsu, 2007). This strategy is an effective way to get all students involved, but as

Weimer (2013) cautions, the CNE is careful not to dominate the activity. Rather, the CNE

assumes the role of a facilitator to offer advice, points out pitfalls, and directs students to

available resources. Banning (2006) describes a facilitative teaching as an approach that not only

engages students in intellectual analysis, critical thinking, problem-solving, and the sharing of

vicarious experiences, but motivates students to learn from the experiences. A student-centered

CNE encourages students to reflect on clinical events, relate such events to previous

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experience, and identify any new knowledge gained from the situation for future

application.

Responsibility for learning. Taking responsibility for learning requires a sense

of intellectual maturity, learning skills, and autonomy on the part of the student. Weimer (2013)

emphasizes the importance of the faculty's role in creating and maintaining conditions that

promote growth and movement toward autonomy and independence. Weimer asserts that the

social learning environment also exerts significant influence on students' learning processes,

including motivation to learn and willingness to accept responsibility for learning. A student-

centered teacher works with students to create a non-threatening learning environment that

fosters autonomy and sense of responsibility, where students do what they need to develop

themselves as learners and act in ways that support their learning efforts. Weimer (2013)

identifies three principles that set the stage for a climate that develops students into mature and

responsible learners: i) clear delineation of responsibilities of both the teacher and the students,

ii) establishment of logical consequences of actions, and iii) consistent messages in words and

actions. The CNE is responsible for creating conditions that foster self-confidence and motivate

students to accept responsibility for learning such as: providing guidance to students

in identifying learning needs, and setting priorities to address them, facilitating help-seeking

behaviors and peer learning; and using feedback to enhance practice. The CNE has the obligation

to design and assign clinical activities relevant to the content, offer the required guidance, and

lead students to resources that they might need to accomplish learning.

Purpose and process of evaluation. Implementation of student-centered concepts

requires a change in purpose and process of evaluation to promote learning (Weimer, 2013).

Traditionally, the concept of evaluation refers to summative assessment of learning, in which a

grade is closely associated with students' ability. Oermann et al. (2009) defines evaluation as a process of systematic collection and interpretation of data gathered from multiple sources about clinical competence, as well as the product or outcome of that process. Using Oermann and colleague's definition, the purpose of evaluation is to develop students' skills to enhance learning. The argument for a shift from the traditional grade-oriented evaluation towards student-centered evaluation is age-long. Brown, Bull, and Pendleburry (1997) and Weimer (2013) argue that evaluation in higher education be designed to facilitate learning rather than a focus on grade acquisition.

Studies document how grade-oriented evaluation influences students' learning strategies, and the undesirable consequences for students' learning processes (Biggs & Tang, 2007; Gijbels, Segers, & Struyf, 2008; Postareff, Virtanen, Katajavuori & Lindblom-Ylanne, 2012). Formative modes of evaluation, such as self-assessment which is an active and creative assessment of the learning process, encourage students to focus on the construction of knowledge and deep understanding (Walser, 2009), while traditional forms of evaluation lead students to focus more on memorization and grades rather than learning (Weimer, 2013). Both formative and summative evaluations are equally important in nursing. Formative evaluation is an ongoing, informal feedback given to students throughout the clinical learning process about their strengths and weaknesses to assist students in formulating learning strategies for improvement, summative evaluation is done at the end of a clinical rotation to provide the final judgment as to whether or not the student has achieved the educational goals or has met established standards of safety and competence (Oermann et al., 2009). Some critics have argued that faculty members are usually more concerned about course content and teaching methods and often take these modes of evaluation for granted (Postareff et al., 2012).

Other critics also argue that most faculty see evaluation as something that follows learning, rather than as a way of supporting deep learning and helping students to gain deeper understanding to their abilities (Ramsden, 2003; Taras, 2002).

There is practice demand for competencies in cognitive abilities, communication skills, psychomotor and technological skills, and professional values in the contemporary health care system. Therefore, enhancement of practice competencies requires evaluation of students in these areas. Peer feedback is an approach to formative evaluation that CNE have incorporated into post-conference debriefing, for the purpose of developing students' skills in self-assessment and peer assessment (Banning, 2008).

Chapter Summary

In this chapter, a review of literature demonstrates that many authors equate SCT with pedagogical methods such as active learning, PBL, and collaborative learning, without any consensus regarding a definite conceptualization. A critical review of the research literature shows that SCT is incorporated into undergraduate nursing both in classroom and simulated laboratory settings in the United States and the United Kingdom. However, no studies were found about the use of SCT in the practice settings in Canada. Two themes emerged from a critical review of 34 studies that examined SCT in nursing education: (1) student outcomes, and (2) faculty experiences.

Researchers consistently identified that students reported satisfaction with SCT. Although, many researchers identified a relationship between SCT and development of higher order skills, there are conflicting findings regarding student outcomes. Moreover, some studies have indicated insufficient understanding and other challenging experiences among nursing faculty using SCT (Colley, 2012; Greer et al., 2010; Lekalakala-Mokgele, 2010), and conflicting

evidence in faculty's rhetoric of SCT philosophy and their actual teaching practices (Moore, 2009). The lack of clarity in the meaning of SCT may affect how it is understood and consequently the way SCT is implemented. Williams and Beattie (2008) found that lack of physical and human resources were barriers to the use of SCT effectively and can force faculty members to revert to the traditional methods. Since no studies were located specific to CNEs' understanding of the meaning of SCT or what it is like to use SCT in the practice settings in Canada, a qualitative study is necessary to fill this gap.

Given the significance of SCT in nursing education, a more complete understanding of the concept is essential to explain the conflicting evidence and in filling other identified gaps. The inconsistent outcome of SCT methods as reported in the literature and the fact that research acknowledges the barriers associated with transitioning to SCT are important reasons for a closer examination of factors that influence the CNEs use of SCT in practice settings. According to Ironside and McNelis, (2011), the difficulty faculty face in transforming clinical education is exacerbated when the focus is only on adoption of innovative strategies without serious consideration for the underlying pedagogies from which the selection of strategies is derived. Therefore, lending a voice to the CNEs using SCT is important to gain insight into relevant individual and contextual factors.

This chapter also presented a detailed description of Weimer's (2013) model, the conceptual framework that was used to guide this study. Weimer's model incorporates the practical details of the components of SCT that are used as a benchmark to interpret the CNEs' meanings of SCT. The five conceptual domains of SCT provide an appropriate guiding framework to interpret the CNEs' perspectives on SCT, and how they use SCT to promote students' learning skills.

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Chapter Three: Methodology

This chapter provides a detailed overview of the research design and

the philosophical justification for choosing interpretive phenomenology as the research

design. The sections also describe the sample and setting, sources of data and data collection

procedures, data analysis plan, methodological rigor, and dissemination plan.

Study Design

This study used an interpretive phenomenological design guided by Weimer's five

conceptual domains (2013). Phenomenology is a qualitative research approach that

focuses on direct exploration of the integrated whole to elicit the meanings of a phenomenon as

experienced by a group of informants (Streubert & Carpenter, 2011). In phenomenology, the

researcher focuses on participants' constructions of subjective realities of the world. Data are

produced through interaction between the participants and the researcher to elicit personal

meaning of a phenomenon (Smith, Flower & Larkin, 2009).

Philosophical underpinnings of the research design. Philosophical ideals and

structures are important to determine the appropriateness of the methodological process for

qualitative research. Philosophical basis of a chosen design also serves as a guide for the

researchers in data analysis and the way discussion of findings are presented. The philosophical

stance that provides methodological insight to the study is Heidegger's hermeneutic

phenomenology. Heidegger's hermeneutic phenomenology is described as "a qualitative

approach that explores an individual's life world, as experienced rather than as conceptualized or

theorized" (Lindseth, & Norberg, 2004; Munhall, 2012). According to Flood (2010), each

individual has unique and subjective experiences known as "dasein" or "being there" and the

meaning or interpretation of such experience which is influential to the choices made by the individual.

Interpretive phenomenology provides a deep understanding of a phenomenon as experienced by several individuals and is especially useful when the aim of the research is to understand and provide a description of first-hand experience of the phenomenon by the participants (Creswell, 2007; Munhall, 2012; Rubin & Rubin, 2012). Since limited evidence exists to demonstrate CNEs' first-hand experience of SCT, interpretive phenomenology is appropriate for answering the research question in this study. Interpretive phenomenology allows for a detailed exploration and understanding of how the CNEs make sense of their experience of SCT and the meaning they hold for the experience (Flood, 2010).

In addition, qualitative researchers often bring a basic set of philosophical beliefs or paradigms that inform their works. Creswell (2007) suggests that phenomenological enquiry requires that those philosophical beliefs are identified by the researcher. The broad philosophical assumption of SCT is rooted in a constructivist world view which emphasizes active involvement of students in teaching-learning process. Since Weimer's (2013) model is rooted in constructivism, this model was used as a lens in this study with the aim to examine what the CNEs consider as SCT. The model was used to guide data collection and analysis of CNEs' meanings of SCT; for example, CNEs were invited to share how they empowered students to be active learners and take responsibility for learning. Weimer's model was used to interpret what the CNEs' describe as the essence of SCT.

Sample and Setting

To obtain an understanding of SCT in the practice settings, it is important for the researcher to recruit individuals with the knowledge and the experience of the phenomenon

under study (Creswell, 2007) and purposive sampling is the technique that achieves this

aim (Streubert & Carpenter, 2011). A purposive sample of 10 CNEs was recruited from selected

Bachelor of Nursing program in Manitoba. Qualitative researchers often argue that participants

in phenomenological research are chosen for their ability to provide insight into the phenomenon

under investigation and not for their representativeness of a population distribution thus, even a

small sample size of 5 or 10 has the potential to produce hundreds of pages of data

(Onwuegbuzie & Leech, 2007). Moreover, too many scripts may encourage shallow reflection

during the analysis of data (van Manen, 2014). The purposive sample of 10 participants in this

study provided rich information through in-depth interview.

      Recruitment. Participants were recruited via an e-mail invitation (see Appendix C) on

behalf of the researcher by the administrative secretary of the participating undergraduate

nursing program's dean or director. Inclusion criteria were: i) self-identified utilization of SCT in

a practice setting, ii) willingness to participate in a 1 hour, individual, audio-recorded, face to

face interview and iii) employed by the participating educational institution for at least 6 months

as a CNE in a practice setting (hospital, personal care home or community agency). This

requirement for inclusion allowed for recruitment of participants who had sufficient experience

to speak knowledgeably regarding SCT in practice settings. Interested CNEs were asked to

contact the researcher via email or telephone. The researcher then provided the interested

participant with further information about the purpose and nature of the study. The researcher

and CNE arranged a mutually convenient date and time for the audio-recorded interview to occur

in a private location that was amenable to each participant. Prior to the scheduled interview, the

researcher sent a copy of the informed consent form to the participant via email (see Appendix

D). A hard copy of the informed consent form was provided when the researcher met each

participant in person. Recruitment was ongoing until data saturation was achieved, that is, when new codes or themes were no longer identified from data.

Data Sources and Data Collection

Data sources included a short demographic survey (see Appendix E). The researcher formulated the interview questions using an audio-recorded, semi-structured interview (see Appendix F), and a reflective journal. The semi-structured, interview guide was used as the main source of data in this study to allow for the greatest detail and the opportunity for participants to discuss SCT in their own words. Some preliminary actions were required to be taken by the researcher to enhance conducting a face to face interview. Streubert and Carpenter (2011) suggested that gaining respect and mutual trust between the researcher and participant allows for a successful interview and access to closely held information. In order to facilitate respect and trust, it was important for the researcher to first establish rapport with the participants (Rubin & Rubin, 2012).

Following acquisition of a signed informed consent, a short demographic survey was collected followed by an audio-recorded, face to face, semi-structured interview. The demographic survey was used to gather descriptive information about the participants in the study: gender, age, educational background, length of experience as a nurse, length of experience as an educator, general description about the level of students, and practice area (surgery, medicine, mental health, labor and delivery, personal care home, or community agency). The researcher relied on the semi-structured interview guide that contained open-ended questions to collect rich data.

The aim of the interview was to examine and gain understanding of the participants' own meaning of the phenomenon or experience (Flood, 2010). Participants were encouraged to

share their understanding and experience of SCT during the 1-hour interview. When appropriate, each question in the semi-structured interview guide was followed with open-ended probes to elicit more detailed descriptions of the participants' lived experience.

Upon completion of the interview, the researcher provided each participant with an opportunity to debrief. Participants were informed that they would receive an e-mail approximately a month after the interview date, to verify accuracy of the interview transcripts (see Appendix G). Each participant received a $10 Tim Horton's gift card as recognition for the time spent and contribution to this study. A self-reflection journal was kept by the researcher, and analyzed with the corresponding transcript of the recorded interview. Self-reflection was important for the researcher to critically examine and analyze for her possible influence on the interview process. Following each interview, the researcher documented observations, thoughts, and feelings about data collection and analysis in a reflective journal.

Data organization and analysis procedure. Qualitative researchers often follow a path of analyzing data to develop an increasing detailed knowledge of the topic being studied (Creswell, 2007). The audio-recorded interviews were transcribed verbatim to ensure the lived experience of participants was translated into words, with the aim of achieving the true meaning of the experience (van Manen, 2002).

Thematic analysis involves a process of seeking meaning, identifying, and reflecting on the essential themes that describe the phenomenon through writing and re-writing of participants' stories (Finlay, 2014), grasping and making sense of what the participants have said, isolating thematic statements and creating interpretations of the lived experience (van Manen, 2002).

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The researcher and advisor individually examined two of the 10 interview transcripts to determine the main categories to be used to code the data. Once a consensus was reached, the researcher commenced the task of coding the remaining transcripts.

A qualitative data software program (NVivo10, Student Version) was used to organize and manage the data. NVivo 10 is a software package designed to aid the analyses of qualitative data. The first step in organizing the data on NVivo which was installed onto personal password-protected laptop computer, was to create a new project with the title "The Clinical Nurse Educators' Lived Experience". The interview transcripts, which were in a Word format documents, were imported into NVivo.

The researcher also used the personal reflective journal that was previously documented during data collection process. The personal reflective journal was used to ensure that the interpretation remained a reflection of the participants rather than of the researcher's personal beliefs. The journal was formatted in a word document to document the researcher's thoughts and feelings before, during, and after each interview. The journal also documented identified biases, differences, attitudes and values of the researcher, as well as all observations made during the interviews. This cognitive process of documenting personal beliefs and thoughts helped to prevent judgments and interpretations based on the researcher perceptions as suggested by Streubert and Carpenter (2007). The reflective journal was also uploaded into NVivo10.

Each of the interview transcripts was read several times in order to gain preliminary understanding of the participants' responses and to highlight significant statements. Participants' responses were coded at two main categories or parent nodes "Meaning" and "Experiences of SCT". These two 'parent nodes' were each assigned a position on top of the two 'trees' that

constitute the node listing for the project. Sub-categories or child nodes were then generated under the parent nodes to further refine the participants' responses. Coding was mainly performed by either selecting segments of text in the document, or by highlighting the specific portions of the transcripts that fit with the categories.

Beginning with the first interview transcript, excerpts that matched the parent nodes were selected and coded accordingly. Line numbering was not used in the coding process because some quotations started and ended in the middle of the line, and some words were unnecessarily included in the chosen extract. The entire document was coded in this fashion, using the parent nodes, child nodes, and grand-children nodes, some more than others and not all nodes being used for coding individual transcripts. More child nodes were inserted into the node list as additional categories were identified during the process of coding individual interviews. As the ten transcripts were being coded, the categories were further explored and refined, utilizing the query and text search in NVivo.

The texts coded through the process described above were further analyzed, using the thematic analysis process described by Smith, Flower and Larkin (2009). The focus of analysis was any statement pertaining to the participants' meaning and typical day experiences of SCT in practice settings. The overarching theme was SCT in a non-student-centered world with the two parent nodes or main categories: the meaning of SCT and the experiences of SCT in practice setting now forming the subthemes.

Methodological Rigor and Trustworthiness

The methodological rigor of a study determines the quality of the findings. Although there is controversy regarding the criteria to determine the integrity of qualitative studies, there are many frameworks that set standards for determining the quality of qualitative research

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(Polit & Beck, 2012). Four common criteria used for developing the trustworthiness of a

qualitative inquiry include: credibility, dependability, confirmability and transferability (Polit &

Beck, 2012).

Credibility. Credibility refers to the researcher's effort to instill trust and confidence in

the truth and interpretation of the data generated in the study (Polit & Beck, 2012). To ensure

that the participants' voices were heard and that their experiences were accurately

represented. Verbatim quotes from participating CNEs were used to illustrate identified themes.

A reflective journal was kept to document the researcher's personal beliefs, assumptions,

experience, knowledge and expertise to facilitate immersion in the participants' world. For the

purpose of transparency, the reflective journal was written to identify personal suppositions

about SCT that could influence participants' interview and the interpretation of the research data.

Personal experiences that were similar to those of the participants were particularly

acknowledged. For instance, during an earlier interview, the researcher noted that it was

necessary to halt an urge to interject when what the participants were sharing resonated with the

researcher's own experience as a CNE. To influence what the participants were sharing, the

researcher had to defer sharing own experience till after interview s were completed. In terms of

data analysis, the reflective journal served as a tool to caution the researcher's interpretation of

the raw data in the light of her own beliefs and experiences as a CNE, instead, the researcher

used the conceptual framework as a guide in interpreting the data.

Dependability. This term refers to the stability of data over time and conditions (Polit &

Beck, 2012). Strategies to obtain rich, comprehensive, and valid data included: purposive

sampling, audio-recording the interview, and listening attentively during interviews with careful

probing to clarify and expand on responses of participants. Reflective journal notes were kept to

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describe details about data collection and analysis and uploaded into NVivo10 to facilitate

identification of codes, categories, and themes. The researcher often verified and probed for

clarification and expansion on the description of participants' experiences during the

interviews.

Confirmability. Confirmability refers to objectivity or potential for congruence between

two or more independent individuals regarding data accuracy or meaning (Polit & Beck,

2012). To ensure accurate interpretation of the participants' description of their lived experience,

data analysis of two transcripts was conducted independently by the researcher and her thesis

advisor.

The researcher used NVivo software to code significant statements from the interviews

into nodes that represented the initial themes. Following the initial process of coding of the two

transcripts, the researcher and advisor met to compare and review consistently recurring sub-

themes from coded statements. Both the advisor and the researcher discussed consistent sub-

themes and agreed on sub-themes and categories that best represented the coded statements. Both

the advisor and researcher initially deliberated on separating the meanings of SCT from SCT

strategies that were identified in participants' statements but this idea was not possible since

participants themselves were unable to compartmentalize the definition of SCT and strategies to

facilitate SCT. Therefore, we decided to co-create several figures that depicted the

interconnection between these two subthemes. Having completed the coding of the remaining

interviews, the researcher and advisor had another meeting where they identified the overarching

theme and final subthemes for the study.

Transferability. Transferability refers to whether the conclusions in the study are

capable of further import to other contexts or groups (Streubert & Carpenter, 2011); in other

words, how the study's findings resonate among other CNE populations. In order to ensure

transferability, a sample size of 10 was chosen to provide a broad yet rich perspective of the

lived experience of SCT in practice settings as this sample size falls within what is typical of

interpretive phenomenology studies.

Ethical Considerations

This section, guided by the Tri-Council Policy statement (Canadian Institutes of Health

Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences of

Humanities Research Council of Canada, 2010), describes the ethical issues that were considered

in this study. Further ethical considerations were guided by the Canadian Nurses Association

Code of Ethics (2009), which guides the practice of the researcher who is a registered nurse. In

addition, the researcher was bonded by the provincial legislation known as Personal Health

Information Act (PHIA). This confidentiality pledge is usually signed by all health care

employees as a legal agreement which indicates that health care providers cannot share

identifiable personal information about patients, families, or co-workers with anyone other than

the original source of the information unless permission has been obtained to share such

information (Manitoba Health 2010).

Since this study was conducted with human participants, careful attention was given to

matters of ethics. According to the Tri-Council Policy statement (2010, article 1.1), "Respect for

human dignity requires that research involving humans be conducted in a manner that is sensitive

to the inherent worth of all human beings and respect and consideration that they are

due". Steps were taken to ensure sensitivity to human dignity and inherent worth. Written

permission to access CNEs was obtained from the educational administrator (the executive

director of nursing education) of the participating undergraduate nursing program.

The proposal for this study was submitted for review and approval by the University of Manitoba Education/Nursing Research Ethics Board (ENREB) and the participating educational institutions. Following acquisition of an informed consent from the participating CNEs, data collection commenced. No names or identifying features were shared in study reports, and none will be shared in future publications. For example, the undergraduate nursing program was referred to as an undergraduate nursing program located in Western Canada. Additionally, the clinical setting was not referred to by specific unit nomenclature and the names of the health care facilities were not mentioned. For example, the units were described as a medical/surgical unit in an acute care hospital, and other practice settings were identified only as personal care homes. There is a plan that at the completion of the study, all participants and educational administrators will receive an executive summary of the study's findings and its recommendations. There is also a plan that the researcher will provide faculty at the participating school of nursing with a presentation of the study's findings in a seminar format.

Respect for persons incorporates the dual moral obligations to respect autonomy. As an important mechanism for respecting participants' autonomy in this research, the researcher obtained the participants' free and informed consent. Before data collection, the researcher provided the participants with detailed information about the study. The explanatory email letter and consent (see Appendix C) included the title, purpose for the study, an explanation of the research, procedures to be followed, risk, and potential benefits both to the participants and others. The letter also included a statement that the participants had an opportunity to ask questions, participation was voluntary, and the CNEs were not under any obligation to participate in the study. The participants were asked to sign the consent form only when the information provided had been affirmed to be clearly understood.

According to Polit and Beck (2012), the researcher has the obligation to avoid, prevent, or minimize harm to humans. Participants were made aware that they were free to withdraw from the study at any point in time with no untoward consequences. The researcher also gave consideration to participants' comfort and emotions during the interview process. Given the purpose and nature of the study, emotional distress was not anticipated, and there was none exhibited by the participants throughout the interview process.

Limitations of the Study

This qualitative study was conducted with ten CNEs recruited from an undergraduate nursing program in Manitoba. The rich data provided insight to the lived experience of SCT in the practice settings. However, there is a caution to the readers about the transferability of the findings to other geographical regions with dissimilar health care systems and educational structures and processes for nursing students. Given the various levels of SCT in health care professions and settings, this study identified numerous barriers in the implementation of SCT in practice settings. Also, this study incorporated a snowball approach, which provided easier access to individuals with the experience of SCT, and the opportunity to obtain data to the level of data saturation. However, the data obtained may have represented only a network of friends or acquaintances with similar experiences. Also, the snowball approach incorporated into the participants' recruitment may not guarantee the anonymity pledged in the study. All participants in this study were females, which limit the findings to only female CNEs. Active recruitment of male participants in future studies may provide findings that could represent a wider diversity of CNEs.

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Chapter Summary

In this chapter, a detailed overview of the research design was provided. The philosophical underpinnings of interpretive phenomenology were described. Additionally, the design, sample and setting, study procedures, data collection methods, and data analysis plan were discussed. The processes and procedures for ensuring ethical conduct of the study were described with specific consideration for informed consent, confidentiality, autonomy, and fair treatment. Strategies to ensure methodological rigor and trustworthiness were presented as well as the dissemination plan for the findings of the study.

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Chapter Four: Findings

This chapter provides a general description of the characteristics of the participants in the study with a focus on the major themes that emerged from the analysis of textual data. The chapter includes major themes relevant to the meanings that participants assigned to SCT and the participants' experiences of SCT in the context of their practice settings.

Description of the Purposive Sample

The ten CNEs who volunteered to participate in this study were all females between 26 to 65 years of age. Participants reported various educational backgrounds. Five out of the ten participants had bachelor of nursing degrees, and five were enrolled in graduate nursing programs. All participants previously worked as Registered Nurses (RNs) providing direct patient care before assuming a clinical teaching role. While years of clinical teaching experience ranged from two years to 25 years (mean length of clinical teaching experience was 12 years), five participants taught theoretical nursing courses in a classroom setting in addition to clinical teaching. Participants' practice settings included medical, surgical, geriatric, pediatric, labor and delivery, and community settings.

Participants were asked to reflect on the model of nursing education that they experienced as student nurses. Seven participants received a traditional model of nursing education, and two participants received a combination of traditional and student-centered education, while only one participant received student-centered form of nursing education (Table 1). Although there was no detailed exploration of the life histories of the CNEs, some occasionally referred to their personal lives that were not included in this analysis. The purpose of incorporating the backgrounds of the participants in this section is to present information that

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affords the reader the opportunity to gain some insight to the sample characteristics and gauge

the transferability of the study's findings to other CNE groups.

Table 1. Participants' Characteristics (N=10)

Participants (fictitious names)	Age range (years)	Education level	Years of work as RN	Clinical teaching experience (in years)	Level of students taught	Practice setting	Type of Education received
Alice	26-35	BN	8	5	2nd year	Medicine/Surgery	Traditional
Blue	> 65	BN	> 46	5	2nd year	Long-term care	Combination
Bobbie	46-55	MN	30	25	3rd year	Medicine	Traditional
Candace	36-45	BN	10	4	2nd year	Labor/delivery	Traditional
Diana	26-35	MN	13	2	2nd year	Medicine/Surgery	Combination
Marie	46-56	BN	34	13	3rd year	Community agency	Student-centered
Melanie	36-45	MN	15	15	3rd year	Medicine/Surgery	Traditional
Brenda	46-55	MN	25	4	2nd year	Labor/delivery	Traditional
Paula	46-55	BN	26	15	4th year	Surgery	Traditional
Winnie	56-65	MN	30	3	1st year	Long-term care	Traditional

Participants' Meanings of SCT

In listening to the voices of the participants as well as by reading and re-reading and line

by line coding of the textual data of the transcripts and the journal notations, it became apparent

that each participant assigned various meanings to SCT. The meanings assigned to SCT were

interwoven with descriptions of incorporating SCT in practice settings. For instance, most of the

participants often described strategies when they were asked to share their meanings of SCT and

they often described what they believed to be student-centered when they were asked to describe

their experience. In other words, how the participants conceptualized SCT had a significant

influence on the way they used SCT, which shaped their lived experience of SCT in their clinical

teaching and vice versa.

> *We sort of develop a plan as to what they can do independently and what they need*
>
> *some assistance with and then arrange times for that as well (Alice).*

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       Although some participants provided a theoretical conceptualization of SCT, the experiences they discussed demonstrated the realities and the barriers associated with each unique practice setting. It became evident that the lived experiences were in connection to the CNEs' struggles to balance students' needs with the health care system's demands and available resources along with the CNEs' responsibility to ensure patients' safety. Analysis of research data identified the meanings of SCT, the lived experience of SCT in the practice setting, and the overarching theme: SCT in a non-student-centered world (Figure 2).

Figure 2. SCT in a non-student-centered world

CNES' PERSPECTIVES OF SCT

CNES' MEANINGS OF SCT

Teaching to needs, thinking like students, making
things muddy, goal setting, sharing power, creating
positive learning environment , Facilitating
experiential learning, facilitating self-awareness

MAIN THEMES

CNES' LIVED EXPERIENCES

Between a rock and a hard place, dealing with
students fear, working in chaotic environment,
appeasement / rigid routines, reward /
accomplishment, filling the gap

CNES' SCT PRACTICES

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CNEs' Meaning of Student-centered Teaching

This section presents a detailed description of various dimensions of the participants' conceptualization of SCT. Rather than providing a succinct or concise definition of SCT, many participants found it easier to describe what they believed to be SCT and how they incorporated SCT strategies in their clinical teaching. To illustrate the approach for all findings, significant quotes are provided with a fictitious name assigned. Seven meanings were identified from the participants' descriptions to represent SCT: i) teaching to the needs of students, ii) metacognition – thinking like a student, iii) making things muddy, iv) creating a positive environment for learning, v) facilitating experiential learning, vi) setting mutual goals for learning/negotiating agreement, and vii) encouraging self-awareness.

Teaching to the needs of students. Many participants used the phrase "teaching to the needs of students" to describe SCT. The participants acknowledged the need to understand and be well acquainted with the characteristics of each student in order to identify the learning needs and adapt teaching to such needs.

> *I'm more deliberate in thinking about the individual needs of the student and I, I feel like you know my tact even over the course of the 9 or 10 weeks that we've been there have changed and I'm more, I try to be quite sensitive to what I think the level of the student is in regards to what they need and what they need to be, think about and what the questions are that I address with them (Winnie).*

Participants identified that being able to teach to the needs of students also requires building a relationship, being flexible, and recognizing and acknowledging the individuality of each student.

> *There's all different ways of teaching and learning and that you know we need to reach*
>
> *these students and some, you know students learn in all different ways, so we need to*
>
> *maybe adapt or model our teaching in different ways to meet the students… like some*
>
> *students are more confident, some are less confident… So you know the students who*
>
> *need a bit more confidence, I'll spend a bit more time with, go over things with them,*
>
> *help build up that confidence before they go in and do the skill (Paula).*

While participants acknowledged the need to facilitate students' independence and problem-solving skills, they identified varied approaches. Some participants would initiate student's self-assessment at the beginning of a clinical rotation in order to identify what students could perform and what nursing skills required the CNE's assistance. A participant described how she facilitated peer teaching and how she modified teaching according to the knowledge and skill level of students.

> *My individual orientation is asking the students maybe some of the concepts or some of*
>
> *the tasks that they're still struggling with or unsure of because they haven't had enough*
>
> *experience or exposure. And during orientation we go to the ward, I get them to pull the*
>
> *policy and procedure on that task or procedure, collect all the supplies and go through a*
>
> *mock scenario. And so they're the ones that are actually performing it, they're the ones*
>
> *that are teaching their fellow students, so it's their language, it's kind of and all the*
>
> *students are kind of helping them get through that task, so we work together" "For some*
>
> *of the students I think I'm a little bit harder and have higher expectations of them*
>
> *regarding medication and stuff because I do teach pharm, but in the end every time we do*
>
> *final evaluations all they have is you know there's a few negative comments but they all*
>
> *say like thanks for pushing me a little bit harder and all this stuff (Diana).*

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Metacognition – Thinking like a student. The participants believed that a student-centered teacher is able to think about how students think and understand the student as a person. To the participants, being student-centered goes beyond building interpersonal relationships or adapting teaching to the needs of students; it is the ability of a teacher to enter into the thought process of students. Participant expressed that a CNE must be able to monitor his or her own thought process to better understand the mental process leading to students' decision-making regarding client care. Participants acknowledged the need for empathy and consideration for the students' previous experiences and diverse backgrounds of the students.

And it's about thinking about how the students are thinking…how is the student thinking about going and providing care to a patient who is a two-person assist, what are the factors that are affecting their decision. So I looked at the contributing situation to their decision-making…So I think that its understanding, taking the time and the empathy to understand where they're coming from, what their experiences are (Winnie).

Immersed in reality/making things muddy. The notion of "making things muddy" was expressed in terms of incorporating problem-based approaches. The majority of participants shared that since the students were being educated to become critical thinkers, students should be given the opportunity to solve certain clinical problems with minimal assistance from the teacher. Several participants shared that rather than providing a "ready solution" to some clinical problems, they often challenged students to explore, problem-solve, anticipate, and think of what could be done in "mock" or potential critical situations.

Having the students have to find the answers on their own and making things a little bit muddy for them, so that it's not, I'm not always giving them the answer…So they need to think about what they would do if situation A happened, what they would do if situation B

happened in terms of a client that is declining. So getting them to critically think and ask

themselves those questions I think can, can be done in the clinical area (Alice).

Some participants stated that they used the assessment of students' strengths and weaknesses to

determine the type of responsibilities that could be assigned and the type of responsibilities that

required CNE guidance and supervision.

I think the key thing is to, to allow the student to, to show what they can do first. So to let

them explain to me how they're going to do whatever it is that they're going to do.

(Bobbie).

Contrary to the above approach, one participant revealed that she did not conduct an initial

assessment of students, but would rather provide students with opportunity to handle difficult

cases and allow them to learn from the experience. This participant believed that this approach

was a way of facilitating a positive learning experience and students should embrace the

opportunity.

So I'm not looking at really the strengths and the weaknesses and trying to baby, baby

them. I'm giving them difficult patients, patients that they can learn from and but this is

after the, the first few weeks. Once, you know the first few weeks they were babied and

then, then I'm throwing them into the, trying to get them as, as positive experiences and

as much learning as possible, because they are the ones that are doing the learning

themselves (Blue).

Participants not only sought opportunities to promote students' problem-solving skills, but they

recognized students' individual backgrounds, previous exposure, previous learning experiences,

and availability of resources as key factors to be considered when using SCT in this regard.

Some participants believed that it is better to identify these factors during clinical orientation.

I think you have to give your students tools to problem solve and to be self-directed and to know how to be an independent practitioner. I'm not into spoon feeding at all, but I like to be able to think that I give my students tools so that they know how they would problem solve a situation in the future, where to go to find the answers (Marie).

Although participants acknowledged the need for autonomy in problem-solving and making clinical decisions, they also recognized students' limitations in handling difficult situations and when there is need for the CNE to take charge of patient's care. For instance, a participant shared how she intervened when a patient's health status drastically declined.

And so I think that, or another example is or when a client who was not previously in respiratory distress now becomes, turns and becomes, has severe respiratory distress, that's not an opportune time to allow them to have any latitude in decision-making. I'm now directive and I don't think that, I think that's a learning, like there is learning that takes place there, but it's not for me a comfortable way to teach (Bobbie).

Creating and defining a positive environment for students. Although the participants identified that creating a positive environment is a SCT approach, they shared various perspectives about factors that constitute a positive learning environment. While some of the participants focused on the physical environment, others expanded their definition to include the social or relational environment as well, and some participants regarded a positive environment in terms of flexibility in the work assignment. A participant described a positive learning environment as a place where students could communicate freely or ask questions without the fear of being reprimanded.

So I think in order to facilitate that learning, that positive learning environment - students need to trust their facilitators and that goes for the clinical environment themselves as well as those environments need to be positive, trusting, safe environments

for student learning because they're not always, like I know there, there are wards where

students can't ask questions of staff nurses because they get negative responses (Alice).

Sometimes, creating a positive learning environment required more than the physical or social environment; it also required a deeper consideration for the student's gender, cultural beliefs and values. One participant shared how she demonstrated cultural sensitivity when planning patient assignments with students to ensure students' success. In the following quote, a participant found that experienced mothers (patients) were more open to being cared for by male nursing students. Likewise, women with hyphenated names were perceived to be more comfortable with male students possibly because they were likely from a non-male dominated culture, and therefore may not feel threatened or dominated by male nurses.

And so I considered it somewhat SCT to give them patients where they could succeed as

much as possible, so often I found moms with many children, like two or more children

were more comfortable with male students, or we always joked about this as nursing

instructors, but women with hyphenated names were often more comfortable with male

nursing students, maybe just you know (Brenda).

The majority of the participants reflected on the effect of relational approaches to student learning. There was an expressed need to facilitate a learning environment that promoted respect and dignity for students. Four participants shared that they promoted a positive learning environment by making the learning activity less stressful and by positively acknowledging students' efforts during group activities.

I think this approach is helpful in that students feel comfortable, they're relaxed, they're

not scared, they enjoy being there and I always, if they're here for 12 hours and they're

not enjoying it that's like a waste of 12 hours. So I try to make clinical enjoyable,

challenge them. But I think we, we need to start treating them as one of our own, they're

learning as much as I am. We need to start treating them like one, colleagues that are

learning 'cause eventually they are going to be nurses, most of them are, so we need to

start treating them like one, just in a different page than we are (Candace).

At the completion of the program, nursing students are expected to be confident and autonomous in clinical decision-making. Participants believed that being open and approachable facilitated a positive non-threatening environment where students could grow to be confident in clinical decision-making.

I think having students not be afraid of the clinical instructor 'cause I've heard students

say that one of the compliments that students have said to me is that I know I can come

and ask you a question and you're not going to make me feel stupid (Bobbie).

Although the concept of power did not feature prominently in the transcripts, participants also described SCT in connection with power. The issue of power was implicit in the discussions with most of the participants, however only a few used the term "power" in their description of what they believed to be an ideal positive learning environment. A participant expressed that students need to be treated as colleagues.

I think some, of the human elements of nursing that is missing were this expectation of us

to be perfect. We need to start treating them as one of our own. How do we make, I don't

know, how do we make students feel more like they are our, that we need to make them

feel like they are our colleagues. We need to start treating them like one, colleagues that

are learning 'cause eventually they are going to be nurses. We get that we are evaluating

them but we can't let them be fearful of the process of evaluating (Candace).

CLINICAL NURSE EDUCATORS' LIVED EXPERIENCE

Several participants acknowledged the existence of a power differential in teacher-student relationships and how learning was affected when students related to the CNE as someone in a position of power. To these participants, an ideal teaching-learning situation would be where there was no power differential between the teacher and students.

> *Well I think, I mean we are in a power situation with students right?...And so you need, it is difficult when you're, so because you know we can have a strong influence on whether they pass or fail their particular clinical situation. And you know they certainly feel that. So the student-centered approach hopefully has the potential to reduce the position of that, and I hope, I mean you can't ever do away with it; it is the reality of the situation (Winnie).*

While the above participant openly shared that an ideal SCT would be an equal sense of power between the teacher and the student, one participant expressed a contrary opinion. The major concern this participant expressed was in regard to the quality of student learning and the tendency to compromise nursing practice standards, particularly when empowered students in decision making about learning. There was an expressed concern that students do not possess adequate knowledge, skills, and competence to make appropriate decisions without the guidance and close supervision. This participant identified that equal power may compromise patients' safety by opening the door for incompetent or unsafe nursing practice.

> *And how, how can we do it, we have to figure out a really good way that is student-centered as well as you know meeting the competencies that they have to meet at the end of the day and, and doing it as a collaboration, that there's a collaboration between the educators and the students, like in a really collaborative way, how can we you know improve this knowledge. But students, they're all young people, they're basically selfish,*

they don't have, they have a tunnel vision of what they need to do, they can't figure it out

themselves either. They're coming to us as the experts to say, okay show us the way,

right. So it has to be a combination, it can't be student-learning only, it has to be both

and it has to be integrating theory into practice. That's all I have to say (Blue).

Facilitating experiential learning. To some of the participants, SCT meant creating opportunities for students to learn from experience, recognizing previous experience and building or scaffolding on such experience. Participants believed that when students have had previous clinical experiences they were more comfortable if they were assigned similar patient or skills another time, particularly if the previous experience was a positive one.

Now they are third year students right so that makes a big difference because they've had

previous clinical experiences, so they're building on those previous clinical experiences

and that's the expectation that we talk about in orientation is that I expect that I can

build on what you already have, that we can build together and that if, if I'm not

providing you the feedback in the way that you would like it provided (Bobbie).

Having student practice clinical skills shortly before going to the patient's bed side to provide care was regarded as a form of experiential learning that could be helpful to students. One participant who was accustomed to practicing clinical skills with students prior to delivery of actual patient care expressed satisfaction with students' performance.

So giving them the opportunity to manipulate and have that hands-on experience part,

getting to the bedside, I could see like a look of relief in their faces and I think that you

know having done clinical for a few years where I hadn't ever done that and then started,

I notice a big difference in the students' comfort level going to the bedside to administer

medications (Alice).

Experiential learning was regarded as a creative way in which SCT could be successfully incorporated into clinical teaching, particular when students were perceived to be enthusiastic about their past experience and demonstrated the willingness to incorporate the knowledge or skill set in their learning. A participant shared an occasion when a student successfully incorporated her own personal experience in planning an educational activity to share with other students.

> *One student really wanted to talk about how to control your temper because she had particular experiences with that growing up and then thus being a mother about you know her experience in her family of origin and now her experience as a mom, she says I found a lot of really interesting things and I've done a lot of reading, would it be okay if I did a topic on this. And I could see the passion in her, I could see the excitement in her and I thought yeah absolutely, you know (Marie).*

Mutual goal setting/negotiating agreement for learning. The majority of participants equated SCT with mutual goal-setting between the teacher and the students. Participants shared they found that students were more motivated and open to learning when they were encouraged to set learning goals at the beginning of their clinical rotation with the teacher providing guidance throughout the learning experience. The participants saw that mutual goal-setting was acceptable to students because the approach was student-centered and helpful in addressing students' self-identified learning needs. The participants also reflected on the various ways in which they used mutual goal setting to engage students in active learning. Participants believed that students capable learners therefore they encouraged students to identify their own learning needs, set learning goals, and design the strategies to accomplish the learning goals.

Having students set individual goals is a piece that would be student-centered, so the student is responsible to identify what it is that they need to know in terms of learning (Alice).

Teaching and learning were regarded as a joint venture or agreement between two parties in which each party was expected to fulfill obligations. One participant reflected on how she engaged in private dialogues with students to identify their own learning needs and worked in collaboration with students to accomplish the learning goals.

I have a conversation with them, a private conversation…and I identify what areas are missing that they aren't meeting the expectations. And I say to them these are some suggestions, what are your suggestions as to how are you going to now meet these expectations. And, and then I observe for it, and if they aren't met they won't be successful, if they are met they will, they'll be successful as long as there's no other not met criteria in the evaluation tool (Bobbie).

As perceived by these participants, goal setting among pairs of students was found to be acceptable to students. Participants expressed that students performed more effectively and were more independent when given the opportunity to select areas for their clinical assignments. Two participants shared how they facilitated goal setting among students by working in collaboration with students to accomplish the self-identified learning goals.

I'd ask each student to choose five areas they wanted to teach their patient, let me know what they were before lunch and that would be their goal for the day and I'd check their teaching list to see if they even signed off and sometimes talk to them about what they had taught-it was easier to, to like be collaborative with the student about their goals because they would have my pager and then they would, when they'd see an opportunity for

learning that they wanted to take they would page me…my nurse said I could support my

patient through the epidural insertion, would you be able to come down and help me with

that (Brenda).

Participants believed that goal setting requires that students themselves be ready to take initiative and identify what they need to learn and how they want to learn.

Clinical for me when its student-centered is they're really taking that initiative, saying I

want to learn this today, or taking that initiative to say you know I haven't inserted a

Foley catheter and if they hear, that yeah there is a patient who needs a Foley catheter

and then they come to me with their buddy nurse and say "you know what I want to put a

Foley catheter because I've never done this, can you help me or can my instructor help

me or can a buddy nurse help me". So they're sort of taking that initiative themselves and

focusing on what they need to learn (Melanie).

Also, a commonly expressed view among the participants was that SCT should incorporate a form of learning agreement that requires negotiation between the teacher and the students. Some participants described how they engaged in SCT when a mutual agreement transpired between the CNE and students. In portraying equality with students, one participant described the ways she negotiated teaching-learning decisions with students.

I negotiate the value of them learning and if I get agreement", "And the feedback, you

know and it wasn't like I was just telling him he had to do it" "I want an agreement

where it's negotiated between two equal people, that's what I, that's what I feel is the

feedback that I get if I'm doing student-centered care (Winnie).

Participants believed there is a connection between self-awareness and the ability to set reasonable learning goals and take responsibility for learning. Therefore, the ability to facilitate students' self-awareness was considered a student-centered teaching strategy.

> *I think being self-aware and for a student to be able to set goals and be in charge of their learning and take ownership for their learning" (Alice).*

Encouraging self-awareness. Participants believed there is a connection between self-awareness ability to set reasonable learning goals and take responsibility for learning. Therefore, the ability to facilitate students' self-awareness was considered a SCT strategy.

> *I think being self-aware and for a student to be able to set goals and be in charge of their learning and take ownership for their learning" (Alice).*

Participants acknowledged that being able to set learning goals requires self-awareness on the part of the student so there was an expressed need to facilitate self-awareness in students. Several participants shared some instances of when they facilitated self-identification of needs, strengths and skills among students.

> *The one thing that I do is on the first day in orientation I give the students a sheet and on the sheet it has identify your strengths that you will bring to this clinical rotation based on previous evaluations that you've had that have identified your strengths or based on your own identification, your self-identification of strengths. Identify areas requiring or for further development that you feel that you can gain from this pediatric rotation. And then the third question is do you have any fears and if so what they are and then there's what about what off the unit experience would you like if you could have any in the pediatric area (Bobbie).*

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CNEs' Lived Experience of SCT in the Practice Setting

As participants described their experiences in terms of what it was like for them incorporating SCT in the practice setting, it became apparent that there were individual unit-specific, organizational, and health care system-related factors that influenced the extent to which participants could incorporate SCT in the practice setting. "The realities of SCT in the practice setting" was identified as a major theme comprised of these main categories that emerged from the data: (a) barriers to SCT (student and system related factors), (b) rewarding experiences and a sense of accomplishment, and (c) filling the gaps.

Barriers to SCT. Although the challenging experiences reported by participants varied according to the type of practice setting, participants identified common barriers to SCT in terms of system and student factors. The lived experience of barriers to SCT was described as being powerless or in other words, being between "a rock and a hard place" (difficult situations), dealing with students' fear and anxiety, working in chaotic environments, and stipulated, rigid, task-oriented system routines. Participants found these barriers challenging, restrict their ability to incorporate SCT.

> *I did use SCT at times but I think there are, like there's restriction to your ability to use*
> *SCT in the clinical area because of, and it depends on the unit, but let's take post-partum*
> *for example. There's certain expectations of what a student needs to do during the day*
> *and as an instructor I was very busy just keeping everybody safe. It's much more difficult*
> *to take student goals into your planning when you're kind of just trying to keep everybody*
> *safe and in the right places and, and make sure all their checks get done and there's, the*
> *nurses have expectations on the students. I think another issue for me especially and*
> *probably for many instructors or CEF's is if they worked on the area, their colleagues,*

> *their nursing colleagues are expecting them to do all these things with the students to*
>
> *make their life easier which can take away from the students' needs (Brenda).*

The following section provides a description of all the sub-categories identified as challenging experiences by the CNEs.

   Powerlessness: Being between a rock and a hard place. Participants described some student related factors that they found particularly challenging in implementing SCT in the practice setting; the participants described themselves as being *"between a rock and a hard place"*. Feelings of powerlessness were expressed in terms of inability to make students understand the plan of action as a supportive learning contract. Participants shared that they perceived that students often failed to understand that these approaches were not meant to be punitive but rather, participants viewed the plan of action or supportive learning contract as an effort to promote student learning. The participants found it essential to incorporate SCT approaches in the evaluation of clinical practice but when students did not share the same perspective in terms of the intention or the purposes, these approaches often led to reactions from the students that were associated with significant emotional distress on the part of the participants. For instance, participants told their stories of frustrations when students failed to understand the aims of providing feedback or initiating a plan of action or supportive learning contract.

> *So I find it the most challenging presenting plan of actions to students and it almost*
>
> *seems like I'm breaking their heart when I say that you know you're having a hard time*
>
> *with this and, and it just seems that I find that that's, just personally that's a really hard*
>
> *thing for me to do is present the plan of actions to students (Diana).*

A specific example was when I was dealing with a student who did not take feedback very well from the staff that she was working with, this was a student who was working with a buddy nurse and pretty much wouldn't accept any of the feedback that she was getting from them or if she'd get any negative feedback she didn't take it very well, supposed to be constructive feedback so that she could improve. I remember this particular student was very hostile and didn't really appreciate any kind of negative feedback or constructive feedback I should say. And I found that very challenging because I didn't know how to help her" "that was the most challenging teaching that I had in clinical (Melanie).

Problematic evaluation or providing negative feedback to students was particularly challenging for the participants when they perceived a lack of support from the course leaders. They described feeling powerless and helpless particularly when they were not able to advocate for students in difficult situations or when a student had to repeat a course. In retrospect, a participant shared an account of her experience at the early part of her practice as a CNE and how she felt about the experience.

Once I felt a student, my assessment of a student was that they were a low "C" and my course leader really didn't think the student was competent and she went, made a meeting with me and went through my evaluation and like after an hour and a half of dialoguing with her and kind of discussing with her and fighting with her in way, she convinced me to fail this student. And I look back on it now and I still feel that was a weak moment, but it was one of my first clinical and I just didn't have the strength to really stand up to her. Yeah. Well this person told me that I had ruined his life, so I felt pretty bad about, I felt like is this job worth the stress, that's what I felt, is this worth it. .I

really liked being a clinical nurse, I made more money, and is this worth that stress, so

yeah that's what I felt (Brenda).

Participants identified certain instances when it was difficult for them to influence the

facility staff or advocate for competent practice; they interpreted that doing so would create a

conflict that would negatively affect students' learning environment. Participants shared their

stories about a staff member whose practice was deemed as unsafe. The fact that this participant

decided that she was unable to do anything to correct the situation had its consequences. A

feeling of guilt, shame, and betrayal was evident as a participant reflected on her experience of

being powerless and being a complicit practitioner.

I still feel very guilty about it. I feel like St. Peter, you know when he denied Jesus at the

gate and said he didn't know who Jesus was at Easter time. You know do we go running

to the, to the nurse manager or to the supervisor and say this is what I saw when it's her,

her staff or his staff, it's very difficult, and the students can see that, you know I think that

that's a, a big issue. I feel uncomfortable sometimes you know interfering and what he,

this particular nurse justified as being okay, despite the fact that the floor was filthy dirty,

and it was filthy dirty 'cause there had been lots of people coming in from off the street

and stuff like that (Blue).

Dealing with students' fear and anxiety. Some participants determined that quite often,

students bring fear and anxiety into the practice setting that might be related to a previous

negative experience. Some participants found it challenging to diffuse students' anxiety and this

affected interpersonal (teacher-student) communication and the way students received and

interpreted feedback. Sometimes, the anxiety made it almost impossible to engage students in

questioning (to assess their knowledge level) and identifying learning needs (to establish a SCT

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plan). A situation that provoked an emotional response from a student sometimes led to the CNE

wondering if the participant's action was responsible for the problem. A feeling of self-blame

was embedded in the following account of the experience as one participant shared her story.

> *It can be hard especially if an individual starts crying you know because you know that*
>
> *they're having a hard time coping with the situation and like sometimes you know why*
>
> *because they've maybe shared with you a past experience or something that triggers that*
>
> *response, but other times you might not know right and so then it's like okay, well was I*
>
> *being mean to, was I being too assertive or aggressive or am I expecting too much you*
>
> *know? (Alice).*

As much as the participants acknowledged students' anxiety in the practice settings, some

participants admitted that the CNEs had a role to play. According to the participants, for some

students, fear was perceived as a result of an awareness of power or teacher's dominance. One

participant openly acknowledged the effects of power on students' learning.

> *As students they, they often feel overwhelmed and at the same time they are in a position*
>
> *where as an instructor I'm evaluating them, so there's a little bit of a power dynamic in*
>
> *there that affects their ability to communicate with instructors. They, they are fearful of*
>
> *us and I find sometimes that I spend a lot of, I put a lot of effort in making sure my*
>
> *students understand that my role and my responsibility as, as an instructor is, yes it is to*
>
> *evaluate them, but at the same time a majority of what I do is to facilitate their learning*
>
> *from, from coming into a busy medical unit where they are overwhelmed with things to*
>
> *do and analyzing those things that they do throughout the day, so that way they learn*
>
> *from those mistakes that they made or potential mistakes"(Candace).*

Working in chaotic environments. Although the majority of nurses manage the barriers of working in a fast-paced complex practice environment, implementing SCT in the practice setting presented unique barriers. The theme of "chaos" was evident in the account of a typical day experience in the practice setting. Participants working in medical or surgical units or labor and delivery units were responsible for acute and sometimes unstable patients. These participants strove to deal with patient cases requiring fast paced activities, supervised a variety of nursing tasks, communicated with many health care professionals, and maintained safe practice. Participants described having to teach students in fast-paced and chaotic environments in which they had to adapt to facility routines and task-oriented daily activities. One participant reflected on what a typical shift is like and shared her activities to prevent medical errors and ensure patient safety in a fast-paced unit.

> *We're on a busy ward, so lots of these patients are, are pretty acute and now the students are at the point where they could have more acute patients. So we basically, each student has about three minutes to go over what their patient's going to be looking like or what they can anticipate their priorities are for that day…but it's very important for me to make sure that they understand what they're giving their patients and knowing what system and what the mechanisms of action are those drugs, so then they can know what they're going to be assessing prior to giving the medication and even after. So they go over every medication with me together and then every narcotic I have to pull with them, every narcotic I have to be there present with them (Diana).*

Mornings were described as being the most chaotic time because of all the activities and multiple health care professionals in each setting. Most activities referred to by participants were task-based routines, and sometimes a unit would be so busy that both the teacher and students

could easily miss the scheduled break times. A participant shared her story of what a typical

twelve-hour shift is like.

> *Well, being on a very busy unit, like the typical morning was completely full with like*
>
> *dressing change and IV medications and treatments and helping with assessments,*
>
> *discharges, you know I'd help them discontinue epidurals, take out urinary catheters, you*
>
> *know they had a lot of urology on that unit for abdominal surgeries. Try and get away for*
>
> *lunch if I could and then after lunch some of them would have time hopefully to sit down*
>
> *and caught up on their charting, I would help them with that and then like by 2:00*
>
> *there'd be afternoon dressings and more medications and more treatments and we would*
>
> *stay on the ward until 5:00. Then at 5:00 I would get them all to check-off with their*
>
> *nurses and they would go down and have their supper. When they were down having*
>
> *their supper, I would go around to all the units and go through all the charts to make*
>
> *sure all the meds were signed off, make sure all the charts were done properly, talk to the*
>
> *nurses and make sure everything was okay, nothing was left undone and then I would go*
>
> *and meet them afterwards for a post-conference, we'd spend about an hour or hour and a*
>
> *half in post-conference talking about the day (Paula).*

Even a long-term care gerontology setting was no exception to the chaotic nature of practice

setting particularly in the morning.

> *And so you know it's pretty intense in the morning as you know" (Winnie).*

The chaos in the practice settings was also attributed to limited space, heavy traffic and

having to teach a large number of students.

> *And it also depends on whether or not the staff on the unit are supportive of mentoring*
>
> *students as well because if one instructor is to observe and support all seven or eight*

students and with no support from the staff on the unit, sometimes that can tie things up

depending on the needs of each individual student (Alice).

Appeasement of staff/system rigid routines. The challenge of meeting the demands of

the health care organization or particular unit and its stipulated routines and task-oriented

activities were apparent in the participants' descriptions of a typical day. The stress of

conforming to rigid routines and ritualistic tasks of facilities and the impact on SCT were the

common experiences shared by most participants. Five of the participants reflected on how they

ensured that students complied with the routines.

It's very; it's clearly outlined expectations for the day. I usually have that plan in place

during the preconference session. I would be asking questions regarding what their plans

are for the day, if they have to do dressings, if I feel the need to be watching and

observing them do dressings or other nursing technical techniques I would inform them

of that ahead of time (Candace).

A typical day was depicted as being loaded with task-oriented routines, which most of the

participants found challenging as they were pressured and were ultimately responsible to ensure that

students completed tasks correctly. Some participants described their struggles with the need to

maintain a balance between instructional activities, task-oriented routines, time management and

patient safety.

Meds are usually given anywhere between I guess starting between 7:30 and 9:30

depending on the time that they're provided and depending on the unit that we're placed

on sometimes meds run a little bit late because there might only be one Pyxis machine for

all of the nurses and the students and the students tend to take quite a bit of time

withdrawing their medications and that sort of thing yet, so we often end up running a

little bit behind and then we try to take a break, students take a break around 10, 10:30

or 11 and it's not often that every student gets to go for the break at the same time, it's

just they're not able to organize their day well enough at this point to all get off the ward

at the same time (Alice).

I mean and there still is an element of militarism, I can see that even in this program. But

you know for sure there's militarism and you know fitting into the regime and kind of

thing (Winnie).

The pressure to complete scheduled procedures according to rigid time frame was often overwhelming for the participants and students.

Another challenge is when, when you scheduled a time with a student so like I said I

usually schedule when we have to do specific skills, so I schedule that time and the

student doesn't come. And so that and, and because we have so many meds that are due

at 9:00, it becomes a bit disarrayed then and the students get a little bit annoyed if

someone else jumps in before them and they know that they're, they're supposed to be

there at 9:00. Other students get a little bit, they get a bit annoyed (Bobbie).

Participants considered creating a positive learning environment to be an approach to SCT. In an effort to create a positive environment for students, the participants often engaged in task-oriented routines that were not clearly articulated as part of teaching roles. For instance, participants described what they would do and what they would not do so that they could maintain peace and co-operation of the unit staff:

If you don't have a good relationship with the staff on the ward it makes it very difficult

to provide a positive learning environment for the students, because you can't be

somewhere, you can't be in eight places at one time (Alice).

One participant shared that she sometimes takes additional responsibilities in order to ensure patients' safety. There was an expressed need to appease the unit staff on certain issues in order to maintain an environment that was conducive for student learning.

> *So I think part of the challenge for me was that I worked on that unit for many years, so the nurses really entrusted me with all the care with the students, so they didn't oversee any of the care with the patients. When Brenda was there with her students Brenda took care of the students and all the patients. So when, this is what you want right, just keep on. So usually within a couple of days they'd have two moms and two babies, so they'd have four patients, so I had six students, so that meant I was really responsible for twenty-four people, so really busy. And then another big part of the afternoon for me was checking charts. I think 'cause I worked on the unit I was very aware of how irritating it was when students left pieces of the chart unfilled out. So I would actually set up a little office, get all my students to bring me their charts, mom and babies, so by the end of their time it was twenty-four charts I was checking and I'd spend an hour and a half checking every single part of every single chart and give every student a little yellow sticky if there were things they had missed" (Brenda).*

Participants sometimes provided opportunities for the nursing students to participate in inter-professional activities where they could make their voice heard within the health care team; it appears students had no input in these activities, but rather they just absorbed information and carried on.

> *Yeah, there are activities that they are engaged in. They are expected to listen to clinical rounds, doctors and nurses and pharmacy and medical students for example would be participating in clinical rounds, discussing their patients. Students are expected to gather*

information during that time that pertains to their patient only. When they've gathered all

of that information then they carry on with their clinical day (Candace).

Rewarding experiences and accomplishments. In spite of the barriers encountered

while incorporating SCT in the practice settings, these participants regarded their teaching as

successful in terms of SCT when they could observe that their students demonstrated an

understanding of how a nurse should think and act. To the participants, the students' thought

processes were evident in the way the students delivered client care. Many participants expressed

satisfaction at being rewarded in certain instances when students were able to demonstrate the

evidence of growth in the delivery of quality care to patients and families. One participant

reflected on her feelings of accomplishment when she was able to spot the outcome of a "rich

learning experience" in students.

> *When I see students advocating on behalf of the family related to family need. Another*
>
> *example is when I've had students say to me you're making me think like a nurse. So it's*
>
> *their perception of what a nurse should be thinking like. And I often hear that related to*
>
> *assessments and verbalization of assessments. I feel pride more than probably anything*
>
> *in, in them. And when they talk about the happiness that they felt and, and that they felt*
>
> *the learning was rich, that then gives me sort of the pat on the back with no physical*
>
> *contact right. But it, it makes you feel like okay I did my job, I did what I needed to do.*
>
> *Hopefully they gain a sense of what they want to do too, and what they're telling me in*
>
> *post-conference is that yes that is what they want to do. Yeah. (Bobbie).*

Not only did participants feel rewarded when students were able to demonstrate

professional values in the care of patients and family, they also described what it feels like when

they could see that students delivered meaningful nursing care with confidence.

It made me feel good, I mean I felt that I was actually doing something that was

meaningful to them and to her, the first one and then to the rest of them, the rest of the

week, I mean the rest of the weeks. And yeah I felt, I felt that I was actually doing what I

envision (Alice).

As students were sometimes intimidated by the overwhelming complexity of the practice setting, participants described feeling a sense of victory and they found teaching very rewarding when they were able to provide support to students during moments of vulnerability. A participant, reminiscing on such an experience, stated:

The student came out just like beaming and just like, I totally want to be a nurse, I'm so

excited about today like. And I actually met her a couple of years later and she just was

like loving being a nursing student, it was awesome to see. So yeah I felt like it was a

moment of real vulnerability for the student and I felt like I helped her find her feet and

she actually ended up with an "A" in the clinical placement, totally picked up steam and

yeah did really well (Brenda).

Filling the gap. Most participants acknowledged that they lacked specific education to prepare for the effective incorporation of SCT in the practice settings. To these participants, years of experience on the job, creativity, clear objectives and guidelines, reflective and relational practice were the key factors that have been helpful in implementing SCT. The participants pointed out the need to fill the gaps in these areas. For some of the participants, they identified that it could take some years to get to the competence level of incorporating SCT effectively, and some participants even admitted that formal educational programs would be necessary to develop competence in incorporating SCT in the practice setting.

Well I think I didn't have a lot of training in terms of how I would facilitate students in

the clinical area. So then when I started my, my job as a clinical instructor it was, that

was my entire, that was my role right, I didn't have any other requirements at the time, I

was only there for the students. And I think it took a lot of learning. After you have

worked for you know a few years I'd say 2 years at least then you kind of get a sense of

what is normal in terms, especially if you're teaching the same course, you kind of know

what your expectations are, what the course expectations are. So then you don't so much

question yourself but I think anytime that there is a negative experience you certainly

wonder like what could I have done differently, like should I maybe not have questioned

the student in the room but outside of the room or did that individual have a bad day like

what's going on in their personal lives, sometimes that's a factor as well right (Alice).

So I think it's really hard to have a standard I don't even know like guideline for

instructors because you almost need to get into your clinical situation and find your niche

and find where those opportunities are where you can adopt more of that student

centered approach in the teaching and learning (Diana).

Chapter Summary

In this chapter, I presented a description of the purposive sample and the findings of the

data analysis process with a major theme identified. "SCT in a non-student-centered world

emerged as the overarching theme with two subthemes reflecting participants' meaning and lived

experience of SCT. As the participants shared their perspectives and stories of SCT in the

practice settings where they facilitate learning with undergraduate nursing students, it became

apparent that participants assigned numerous meanings to SCT. Some participants shared a

humanistic perspective about SCT in regard to mutual sharing of power between the CNE and

the students, and negotiating agreement for learning goals. Other participants considered SCT a holistic approach in which teaching is designed to meet the needs of students. Participants shared a general perspective that SCT involves creating a positive environment for learning. Findings of the study revealed that participants viewed SCT as both rewarding and challenging based on their values of the shared experiences within the individual practice settings where they educate the nursing students.

As the participants shared their stories of implementing SCT and the realities of the practice settings, it became apparent that there were student and system related factors restricting the capacity to which the participants could incorporate SCT in the practice setting. However, findings demonstrated that in spite of the barriers reported by the participants, they still found SCT worthwhile and rewarding when they see the transformational learning outcome of SCT in their students.

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Chapter Five: Discussion of Findings

With the aim to provide the best education that will prepare nurses for the health care demands in the modern world, some participants attempted to adopt a SCT model in their clinical teaching. This study explored SCT from the perspective of the CNEs using SCT in the practice settings. This chapter presents a discussion of the findings in comparison to the current evidence about SCT in higher education and clinical nursing education. The discussion incorporates the conceptual framework in relation to the meanings of SCT from the participants' perspectives and how the meanings influenced their practice. Furthermore, the discussion includes the implications of the findings of this study for leaders and administrators of nursing education, nursing faculty, practice settings and recommendation for future research.

Meanings of SCT

The study explored the meanings that the participants attached to their day to day experiences of SCT in the practice settings. Findings revealed that the participants equated SCT with teaching strategies, and that a teacher is being student-centered when using those strategies. Findings provided insight into the way the participants conceptualize SCT and consequently how they operationalized the concept in their practice. This finding supported the view of Qhobela and Moru (2014) that the relationship of the teacher's conceptualization of SCT and instructional practice cannot be over-emphasized. This finding is also congruent with those of Williams and Beattie (2008), in which clinical faculty's understanding of SCT has a significant influence on how it is incorporated into clinical teaching. Participants' accounts also suggested that they understand SCT as a relational or humanistic approach, (see p. 61-62) which gives consideration not only for learning needs but also for students' dignity and self-esteem needs.

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In interpreting the participants' meaning of SCT in relation to Weimer's model (2013), the identified themes were found to be relevant to the five tenets of learner-centered teaching that: power should be shared with students as they are capable learners, learning responsibilities should be given to students to determine what and how they want to learn, the role of the teacher should be of a facilitator rather than an instructor, the content should be used as means to develop learning skills, and feedback and evaluation should be used to promote learning.

Empowerment for learning. In terms of students' empowerment for learning decisions, few participants made overt references to sharing of power. As suggested by Weimer (2013), an ideal teaching-learning situation should be whereby there is responsible power sharing between the teacher and the students. Weimer (2013) proposed that students should be empowered to be key players in the decision-making about learning and in the teaching-learning process. However, the participants shared various instructional practices that reflected their belief about students' empowerment for learning.

The expressions of empowerment were salient in the teaching-learning activities described by the participants. Most participants engaged in strategies that included facilitating a nurturing and a caring learning environment, respect for the self-worth of students, acceptance, respect, and value for students' individuality, courtesy, willingness to allow choices, willingness to facilitate participation in decision-making, and mutual goal-setting. These participants recognized the importance of a positive learning environment where students could feel confident to ask questions without the fear of consequences.

Many participants also discussed how they facilitated independence and decision-making power among the students. The participants worked collaboratively with students, empowering students to identify learning needs and set personal learning goals. The SCT strategies described

by these participants are in agreement with the findings in Greer et al. (2010) that learner-centered nurse educators engage in practices that reflect students' empowerment for learning.

However, this study's findings revealed contrary opinion to this notion. A participant expressed the belief that students do not possess intellectual maturity to direct their own learning. This point of view indicated that the participant assumed responsibility to direct students' learning. Any activity that would interfere with this role could mean that they were not performing their duty as they should. The fact that this participant was not in support of autonomous learning is suggestive of a teacher-centered mindset and a lack of self- awareness that the participant still engaged in traditional teaching practice that is teacher-centered despite the claim of being student-centered. This teacher-centered belief and the lack of support for student empowerment may not be surprising, given the demographic characteristics of the participants; the majority of the participants received their nursing education in a system dominated by authoritative teacher-centered culture of the older generation of nurses. These findings brought to light the need for faculty development in the area of SCT pedagogy and a change of orientation about academic dominance.

Responsibility for learning. The participants described SCT in relation to mutual setting of goals with students and identifying learning needs. Many participants discussed the process they used to gradually get students to accept responsibility for learning. Weimer (2013) argued that the goal of education is the creation of independent learners who are able to take responsibility for learning. She believes that a learner-centered teacher often begins with students who are dependent, passive, and not self-confident, then moving them in the direction of intellectual maturity and autonomy. While an experienced and older participant had a different opinion, several participants described strategies that give responsibility for learning as mutual

goal setting, facilitating autonomous decisions and choices about what to learn, facilitating peer collaboration, and providing accessibility to leaning resources. Most of these strategies were initiated by the participants at the beginning of the clinical rotation.

      Using content to promote learning. Weimer (2013) suggested that the teacher should desist from "covering course content" but rather teach students to develop learning skills. According to Weimer (2013), learning skills involve an understanding of the unique configuration of content, the ability to apply theoretical information to complex practical problems, an integration of information from different areas creatively into practice, and more than just a basic skill set. Contrary to this idea, the participants' teaching-learning activities were focused more on psychomotor skills such as dressing change, medication administration, and urinary catheterization. These were task-oriented activities dictated by the practice settings, and around which the participants had to adapt their teaching. Although the participants may not intend to replace deep learning with these psychomotor skills, the lack of flexibility about the activities inherent in the clinical learning environment may produce a negative effect on students' learning. Benner et al. (2010) advise that, in addition to teaching psychomotor skills, nursing students should be educated to develop life-long learning skills, engage in clinical enquiry, and learn multiple ways of thinking. Routine psychomotor activities may force students to revert rote learning which does not support critical thinking or SCT.

      Participants struggled to get tasks completed by students according to the stipulated time, which made it appear like they were compelled to "cover the stipulated content" within a limited time frame. The pressure to get the tasks completed, and the demand to teach according to facility policy constituted a huge barrier for the participants. Moreover, it seemed like the participants had to teach according to the syllabus designed by the course leaders, which perhaps,

gave the participants limited opportunity for their input and less autonomy in regard to the course content. These barriers raised the questions of who was in control of power in regard to teaching-learning content, and whether the participants had enough opportunity to engage students in higher order skills as intended.

Although some participants attempted to use strategies they described as "making things muddy" for students, they identified that many students were not familiar with this approach. This approach could be interpreted as problem-based learning or not giving students ready-made answers to clinical problems. By using this approach, participants believed that any learning that might occur while students actively searched for solutions to problems would be more permanent than when the teacher readily provided the answer. Unfortunately, due to lack of understanding, this approach might not be well appreciated by some students as they tended to interpret it as lack of support from the educator as revealed in Alice's shared experience. Weimer (2013) also suggests that course content should be used to create self-awareness in the learner, which could be interpreted that the student should be guided to identify his or her own strengths and weaknesses, understand own learning styles, propensity for learning, and become self-directed as a learner. This study revealed that the participants tried to use this approach with their students; however the participants often experienced difficulties while providing feedback to students. The possible explanation for this finding could be that either the participants have limited skills in presenting feedback or the participants' approach was unfamiliar to the students.

Role of the educator. Participants equated being student-centered with metacognition, which is the attempt to understand the thought process of their students. Weimer (2013) contends that in order to facilitate learning that changes how students think and understand, teachers must begin by discovering students' existing conceptions and then design instruction that changes

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those conceptions. For the participants, entering into a student's thought process might not be possible unless there is a relational interaction between the educator and students to the point that the educator could understand how students think and what prompts students to make certain decisions about learning. Also, participants shared that they engaged in providing guidance, facilitating, and nurturing students' learning. Weimer (2013) used different metaphorical examples to describe a learner-centered teacher, *"A gardener-planting, tendering, and nurturing the plants"(p.)*, *"A midwife- activates, empowers, pushes, pulls, but knows when to step back and keep silent"* (p. 75), *"A mountaineer- climbs with climbers, guides with rope, connects with and among climbers, communicates"* (p. 75), *"A maestro before orchestra-directs and harmonizes a group of individuals who play at different levels of ability"* (p. 76), *"A coach-designs, instructs, and participates in the game"* (p.75). According to Benner et al. (2010), a good coach knows his or her students, modifies teaching to students' learning needs for a particular situation, asks a series of questions before a student goes to provide care, and helps students overcome anxiety so as to provide the best of care to clients.

Participants fit into one or more of these examples, but the most salient among the themes was the role of a coach. Most participants described their role as that of a coach who guides and instructs but ready to jump in when things are not going well particularly when there is sudden change in a patient's status. One participant's decision to take charge of patient's care during a life-threatening situation was a good example of a coach who takes charge when things are not going well during a game.

Using evaluation to promote learning. Weimer (2013) advocates the use of evaluation to promote learning. A student-centered teacher is not only concerned with using evaluation to promote learning but the teacher is also concerned with the kind of learning involved. Also, Weimer discouraged too much emphasis on the use of a grade to measure learning. Students' evaluations were among the barriers experienced by the participants in this study. Although, some participants shared strategies that adequately represented the best use of summative evaluation to promote students' learning, it is not clear why some participant experienced some difficulties with the evaluative aspect of SCT, and in particular, with students' defensive behaviors when feedback was not favorable. Perhaps these participants still engaged in some activities that focus on grade acquisition or their students still held the beliefs about grades being a yardstick to measure success. It appeared the participants had limited skills in addressing students' defensive responses to unfavorable evaluation. A lack of adequate skill may have been an additional barrier when a student was evaluated as unsatisfactory and when the CNE and student experienced a conflict. This conundrum also indicates a need for faculty professional development in the area of SCT pedagogy.

Lived Experience of SCT

Participants' experiences are discussed in relation to student factors, staff factors and health care system factors. Figure 1 (p. 53) depicts the factors that contribute to the participants' experience of SCT in the practice settings.

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Positive experiences. Positive experiences were expressed as the ability to facilitate mutual engagement for transformational learning among their students. Participants expressed their commitment to guiding students through the process of self- assessment to identify learning needs, planning and setting of learning goals, developing clinical skills, and self-evaluation of clinical practice. To the participants, the ability to engage students in this process was considered an achievement of SCT. The participants expressed satisfaction and passion for achievement of excellence for their students. The expressed satisfaction and the sense of accomplishment were largely related to being able to educate students to develop practice competency but not SCT. This finding is consistent with the existing evidence about teaching-learning outcome and teachers' motivation. For example, Colley (2012) found that educators experience intrinsic satisfaction and a sense of accomplishment when they see the powerful impact they have in shaping the future of their students. Also, passion for students' success was found to be a powerful driving force for educators, and a key contributor to their career success (Pheps & Benson, 2012). Particularly, clinical nurse educators found student outcomes as a yardstick to measure their own success while striving to achieve practice excellence (Spurr, Bally, & Ferguson, 2010).

Although participants expressed that they felt rewarded when able to develop clinical competency in their students, many instructional activities were focused on tasks-oriented routines raised a question on what constitutes clinical competency. The aim of SCT is "to develop life-long learning skills and the confidence to use them" (Weimer, 2013, P. 5), but due to the task-focused instructional activities and the chaotic nature of the learning environment, the question is to what extent were the participants were able to accomplish this aim. Moreover, clinical competence is not limited to a technical skill set. According to Dreysfus et al. (in Benner

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et al., 2010), "To become a good nurse, one must develop not only technical expertise but also the ability to form helping relationships and engage in practical ethical and clinical reasoning" (p. 86).

Barriers to SCT. Participants also expressed the frustrations that they experienced while dealing with students and staff issues, and the complexities of practice settings. These findings are similar to those found in existing research on the lived experience of clinical educators. For example, Higgs and McAllister (2005) found that clinical educators experienced considerable barriers as they struggled to cope with the competing demands of their multiple responsibilities toward students, patients and families, colleagues, and employers. Barriers will be discussed in detail according to these categories: student-related, staff-related, personal and professional, and system or contextual barriers.

Student-related barriers. Student-related barriers reported by participants were associated with students' resistance to SCT approaches. A previous study documented that most students are not receptive to active learning strategies, a remarkably challenging barrier for CNEs. For example, Greer et al. (2010) found that faculty experienced difficulties in dealing with negative attitudes and resistance towards learner-centered teaching methods. Moreover, the feelings of frustrations and hopelessness often experienced were particularly exacerbated when students were not motivated to take responsibility for learning.

Although participants in this study did not analyze any connection between student resistance and the associated psychological stress expressed, some student-related barriers and frustrations shared by the participants were in connection to feedback, evaluation or the use of supportive learning contracts. These instructional methods are aimed at supporting students' learning. However, using these methods was challenging for the participants, particularly when

students did not understand the aim of the methods. Moreover, evaluation and feedback are expected to assist students to take responsibility for learning, but taking responsibility for learning is intimidating, and students tend to become defensive when they do not understand the rationale. CNEs that incorporate a SCT approach in students' evaluations need to be aware of students' resistance and knowledgeable about the best way to address students' conflicts.

Weimer (2013) documented that students often resist a change from the traditional teaching-learning approach for a number of reasons. For instance, Kearney and Plax (1992) found lack of understanding, unfamiliarity with a teaching approach, confusion, and loss of certainty as the possible reasons for resistance. These researchers also found that students resist an unfamiliar teaching approach by demonstrating overt or covert behaviors such as hostile defensiveness, confrontation, revenge through (faculty) evaluation, or dishonesty. Participants in this study discussed the feelings of frustrations in relation to resistant behaviors from students and the negative feedback from students. However, the participants may not interpret the behaviors as the manifestation of resistance probably because they were unfamiliar with students' resistance. Studies documented that students' resistance to unpopular SCT approaches has emotional implications which are daunting and intimidating for faculty members, particularly when there is lack of sufficient skills and knowledge to address the problem (Felder, 2011; Kearney & Plax, 1992; Weimer, 2013).

Dealing with the emotional aspect of clinical teaching role is documented as burdensome for CNEs. Higgs and McAllister (2005) found that dealing with students' emotions was particularly distressful for CNEs. Participants' frustration in this study was related to dealing with students' fear and anxiety, and also may be related to loss of certainty or fear of failure. Weimer (2013) argues that too much emphasis on grades can lead to anxiety in the learner.

Participants expressed that students' anxiety and emotions were among the major barriers with which they had to deal, and most often these emotions were as a result of past negative clinical experiences (failure, or not obtaining a passing grade). This study found no evidence of adequate support for the participants in addressing the challenges of a failing student. This was difficult for the participants as they had to devise a personal means to address this barrier.

Staff-related barriers. Some participants expressed displeasure with the attitude of some facility staff. Contrary to Greer et al. (2010), who found that faculty members who implemented SCT were met with opposition from colleagues, in this study, the participants' experiences of difficulty with staff were in relation to an inability to influence or confront some compromised practice standard. Clinical faculty members were required to examine the context of the practice environment and the influence the staff may have on students' learning. In the absence of congruence between what has been taught and what some facility staff practice, a major challenge for the participants in this study was having students maintain the practice standard.

This study revealed the CNEs' experience of helplessness and lack of empowerment to confront or address practice violations by the facility staff. It is important to educate students in an environment where staff members serve as role models in maintaining exemplary practice standard. Participants expressed the need to "fill-in for students", in which one CNE is technically responsible for the students as well as the number of patients assigned to students. In a situation whereby a CNE has a group of eight students, with two patients assigned to each student, the CNE is caring for 16 patients and teaching eight students. Technically a CNE is responsible for a total of 24 individuals. Therefore, the obligation to safeguard patients' safety and facilitate positive interpersonal relationship between the staff and students meant additional responsibility for the participants. Some of the participants resorted to appeasement of facility

staff to gain support. Considering the type of situation described above, there is a question about the thoroughness and adequacy of clinical teaching.

   Personal or professional development barriers. Participants indicated a gap in knowledge of SCT pedagogy and the need for professional development to use SCT. This finding is consistent with the results of previous studies that lack of adequate knowledge of SCT philosophy is a barrier to its implementation (Colley, 2012; Greer et al., 2010; Qhobela & Moru, 2014). Qhobela and Moru (2014) indicate that most teachers who self-identified as using SCT were found drifting back to the traditional approach due to lack of deep understanding and strong pedagogical knowledge in SCT.

   This study revealed that the majority of the participants received teacher-centered education when they were students and found no indication that the participants received further education about SCT. The participants gave no account of workshops or faculty development programs through which they could gain expertise in SCT. The knowledge and the skills participants used in the delivery of their teaching were largely based on their past education experiences and what they acquired as nursing students. These findings suggest that despite the claim to using SCT, participants may still be teacher-centered just the way they have been taught. Lekalakala-Mokgele (2010) found that faculty members who received traditional education tend to be less student-centered and often find it difficult to use SCT as they tend to continue to use the traditional approach.

   Weimer (2013) posited that SCT requires more than using instructional methods, but extends to pedagogical skills to implement the methods appropriately and handle the associated barriers effectively. Greer et al. (2010) also concluded that that SCT is not limited to instructional strategies but embraces all aspects of the learner-centered domains. The same

argument is true for this study, it is important for the participants who are using SCT to receive education to prepare them to handle barriers adequately. Clinical faculty who are using SCT to promote self-direction and responsibility in their students require unique instructional skills, the absence of which could lead to conflict and frustration between teacher and students. Apart from the skills to handle resistance, CNEs need to acquire pedagogical skills and knowledge to deliver SCT appropriately. Weimer (2013) documented that students do not object to SCT philosophy in itself, but students respond to the implementation details such as assignments, policy, practices, and the activities involved in. Understanding and embracing these details requires a level of intellectual maturity on the part of students, which may be lacking at the beginning of clinical practice. CNEs that use SCT need to learn how to identify students' readiness and maturity before introducing any new change in an instructional approach. There are many promising and evidence-based SCT methods but if not presented appropriately, can provoke resistance from students.

  System-related barriers. Most participants described a typical day as chaotic. The stressful experiences expressed by the participants were similar to what Benner et al. (2010) described as the barriers to teaching in a complex health care environment. Due to the complexities and contextual factors in the practice environment, there is a limit to the extent a CNE can design or control the students' experiential learning (Benner et al., 2010). For example, the participants needed to adapt teaching to the stipulated institutional routines and tasks of the practice settings, regardless of whether these routines had direct relevance to students' learning or not.

  More often, the participants discussed having to adapt their teaching to the highly paced environment so that the students would not be perceived or labeled as burdensome. The issue of

time constraints identified in this study was in consonance with what was reported in a number

of research studies regarding SCT. For example, Qhobela and Moru (2014) found that time was a

major challenge for teachers implementing SCT. Likewise, in the studies by Colley (2012) and

Greer et al. (2010), insufficient time was among other identified barriers for implementation of

SCT. Dalley, Candela, and Benzel-Lindley (2008) found that nurse educators using SCT

struggled with time pressure to cover a massive content within limited time. Although previous

studies may have revealed that SCT requires more time than the traditional teacher-centered

approach, the experience of time pressure reported in this study were in connection to the need to

complete stipulated task-related routines, for example medications, and other tasks completed

within a scheduled time. There seemed to be no room for flexible teaching-learning activities as

advocated by Weimer (2013), and this may have caused additional stress for the participants.

In this study, the challenges experienced by the participants were not expressed as

discouragement to the passion and enthusiasm they have in incorporating SCT. Most participants

expressed that they felt accomplished and rewarded by students' success. This finding can imply

that the participants are willing to use SCT strategies that promote students' learning. However,

if the CNEs feel that they are not receiving adequate support or being acknowledged for their

efforts; the motivation to use SCT may decrease in the course of time.

The majority of the instructional activities described by the participants were task-

focused. Too much focus on task-oriented activities may undermine the efforts of the CNEs to

use SCT or the effectiveness of SCT. The teaching-learning activities that are task-focused may

cause students to revert to memorization or rote learning. Memorization may not promote critical

thinking or make any significant difference in students' learning. Weimer (2013) argued that the

students' choice of what and how to learn depends, to a major extent, on students' conception of

what will be assessed. Students tend to engage in rote learning when teaching-learning activities are predictable routine tasks. While the aim of the paradigm shift from traditional teacher-centered model to SCT is to engage students in learning activities that promote higher order skills (Benner, 2012), clinical nursing education may not accomplish this aim if students spend a larger portion of their time on tasks and routines. In this study the participants intended to use SCT to promote students' learning, but there were many factors in the practice setting that inhibited their efforts, and this in turn, were stressful for the participants.

Recommendations

The exploration of the CNEs' meaning of SCT demonstrated participants in this study had some important understandings of the SCT model; however, their day to day lived experiences indicated associated barriers. With some similarities to the existing literature, this study demonstrated that the participants presented no definitive definition of SCT. However, the participants illustrated what SCT meant to them through the description of their teaching approaches. Participants described SCT from a humanistic point of view and in terms of addressing students' needs.

This study unraveled the barriers and contextual factors that are unique to the implementation of SCT in the practice settings. It is worthy of consideration, particularly the participants' perceived limited knowledge regarding SCT, and the aspect of their experience that revealed limited skills and resources to implement SCT. Lack of adequate pedagogical knowledge and skills could impede the successful implementation of SCT or prevent the intended outcome for student learning. This will consequently affect the delivery of quality patient care thereby raising a question on how the health needs of the society are being met in the 21st century. A lot can be achieved in clinical nursing education if the knowledge needs of the

CNEs regarding SCT are appropriately met. Clinical nursing education may improve and the quality of health delivery to society will be improved in due course. In the near future, some of the challenging experiences of SCT may be subject to change and be influenced positively through the nursing education reform. This kind of reform in the profession can be accomplished by improving the preparation of clinical faculty members, through a kind of educational program that will prepare the CNEs to meet the learning needs of the nursing students.

An important way to improve clinical nursing education is through faculty development programs that will adequately prepare clinical nurse educators for their teaching role. An educational program on SCT pedagogy will not only expand the CNEs' skills and expertise but prepare them to respond to the associated barriers more appropriately. Steps to educate CNEs begin with organizing workshops and seminars to familiarize CNEs with various SCT strategies applicable in clinical education. Not only that, CNEs could be educated on risks and benefits of these strategies, and how to recognize and respond to students' resistance appropriately.

There are many factors in the practice environment that make clinical teaching stressful; implementing SCT could produce both physical and psychological stress for clinical nurse educators as well as for students. This study revealed that the practice (learning) environment is "chaotic". It is not likely that effective learning would be accomplished in a chaotic environment. An important way to minimize feelings of stress would be a professional support system for the CNEs. The coordinators of nursing education have responsibilities to advocate for their clinical faculty members and students. Educational opportunities and programs could be offered to empower the CNEs and build their self-esteem, by which they will know their right and have more confidence in taking decisions that will favor their students.

A forum could be provided for CNEs, in which they could be involved in decisions affecting their practice, including an institutionally supported system for the improvement of their professional status. The most effective way to do this is to establish regular faculty clinical colloquium as a forum for open discussions of professional and political issues that affect their practice.

A mentoring program could be established to assist new clinical faculty in developing the experience required to be successful in their teaching roles. Dickson, Walker and Bourgeois (2006) opined that registered nurses be supported to "up-skill" in clinical teaching as students spend the majority of their time with CNEs in the practice setting. The CNEs with more experiences in clinical teaching should be available to provide support in terms of mentorship for the younger and the newer members. Professional development programs on SCT approaches should be available to the CNEs on regular basis in order to keep abreast of current educational changes.

All stake-holders should be kept apprised regarding SCT, the expectations and the roles of individuals to make the SCT model work to accomplish the ultimate goal, which is the best health care delivery for society. A successful implementation of SCT in the practice settings is a joint endeavor among stake-holders in health care. Therefore, faculty members, administrators, students and patients should be involved in the strategic planning and curriculum design aimed at the resolution of policy issues. Policies of practice settings can be reviewed for more flexibility to support SCT in clinical education. Facility administration could lobby funding agencies for more nursing staff to minimize the shortage of personnel, by this, CNEs and students will be more focused on teaching-learning instead of being the extra hands in patient care. All these efforts will reduce some of the barriers to SCT in practice settings. Coordinators of nursing

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education programs could establish a mechanism to elicit valid information from CNEs and

engage them in open dialogue with them on issues that adversely affect their practice.

Findings revealed that participants remained enthusiastic about SCT in spite of the

barriers they experienced in the practice settings, an indication that the CNEs possess innate

motivation that need to be supported. The faculty administration should provide support for

CNEs not only to accomplish the means but also a successful end to SCT.

This study answered the following research questions: What characterizes the day to day

experience of the CNEs while incorporating SCT in the practice settings?

 What meaning do the CNEs attribute to SCT?

However, further research will be necessary to explore the following areas of clinical

nursing education:

What are the effective strategies to promote incorporation of SCT among CNEs?

What are undergraduate nursing students' lived experiences of SCT in the practice settings?

What are CNEs experiences of students' resistance to SCT?

What strategies do CNEs use in addressing students' resistance to SCT in the practice setting?

What impact does SCT have on student retention and students' clinical experience?

How does SCT shape student and patient outcomes?

How do CNEs and students perceive negative feedback and a learning contract?

What is male CNEs' lived experience of SCT in the practice settings?

What are the long-term impacts of SCT among graduate/practicing nurses?

Chapter Summary

Findings were discussed in relation to current evidence about SCT and Weimer's model

of SCT (2013). Findings revealed that the participants' meaning of SCT was an integral

representation of how they implemented the SCT model in their practice. While SCT may have

numerous benefits for students' learning, the identified barriers may prevent successful

incorporation of SCT in practice settings. Participants' accounts revealed that they understand

SCT as a model of teaching that focuses on relational approaches and the learning needs of

students. From the participants' perspective, activities and behaviors that address students'

learning needs and goals were highly crucial to SCT. Findings also indicated that there are many

issues to be addressed in regard to faculty preparation and professional development, the need to

educate students and facility staff about SCT, the need to provide more support to the CNEs

using SCT in practice settings, and the need for both faculty and practice setting administrative

to work collaboratively to streamline academic curriculum and practice guidelines. Additional

exploration of the impacts of SCT among students, patients, graduates or practicing nurses, and

male CNEs are recommended.

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Appendix A: Evidence of Student-Centered Learning in Undergraduate Nursing Education

Year	Author	Research Design	Sampling	Summary of Findings
2012	Avdal (Turkey)	Non-experimental Descriptive survey – Self-directed learning (SDL) scale including 40 questions Purpose: To determine if SDL was related to student success	Convenience n=220	A moderate positive correlation was found between the points of SDL and success of the students.
2005	Baumberger-Henry (USA)	Quasi-experimental with pre-test/post-test Purpose: To examine effectiveness of cooperative learning techniques combined with case study on nursing students' self-perceptions of problem-solving and decision making skills in comparison with other teaching-learning methods.	Convenience n=123	Experimental group (n = 31) provided with cooperative learning and case study. Comparison group, received instruction through lecture and large group case study (n = 46) and another comparison group received instruction through lecture only (n = 24). A third comparison group taught through lecture and occasional use of non-cooperative learning groups using continuing case study (n = 22) was used as a post-test only control group. No two groups were significantly different. Results indicated that the experimental group obtained scores indicating somewhat better self-perception of both problem-solving and decision making skills. Study's limitation: self-scored Study's strengths: strong framework of constructivist approaches to teaching-learning
2010	Brydges et al. (Canada)	Experimental Purpose: To compare self-guided learning with educator-guided learning in clinical simulation.	Randomly assigned into 1 of 4 groups n=60	Self-guided learning along with the opportunity to collaborate with the educator is an appropriate approach in simulation
2013	Cheng et al. (Taiwan)	Quasi-experimental – pretest/post test Purpose: To evaluate effects of team-based learning on learning outcomes in maternal/child nursing course. Class Engagement Survey (CES), Value of Teams (VTs), Self-Directed Learning Instrument (SDLI), and exam scores were used to measure students' learning outcomes.	Convenience n=207	Students who identified that TBL increased their learning interests had a higher score on VT; students who had high achievement from the current TBL course had higher scores on the CES, VT, and SDLI. The means of the group test scores and the final examination score were significantly higher than the individual scores from the in-class tests in both 2011, 2012, and the combination of 2011 and 2012.

				The TBL design requires out-of-class preparation before all classes, which requires active and self-directed learning. TBL provides opportunities to foster social learning that creates engagement and teamwork among learners. It also promotes academic performance. The TBL is suggested to have a greater effect on academically weaker students.
2013	Choi et al. (South Korea)	Quasi-experimental - non-equivalent group, pre-test/post-test design Purpose: To examine outcomes including critical thinking, problem-solving, and self-directed learning of nursing students receiving problem-based learning (PBL) vs. traditional lecture, and to examine correlations among these outcome abilities.	Convenience n=90	Learning outcomes were significantly positively correlated; however outcomes were not statistically different between groups. Students in the PBL group improved across all abilities measured, while student scores in the traditional lecture group decreased in problem-solving and self-directed learning. Critical thinking was positively associated with problem-solving and self-directed learning; problem-solving was positively associated with self-directed learning .Learning outcomes of PBL were not significantly different from traditional lecture in this small underpowered study, despite positive trends. Studies with larger sample sizes are recommended to study effects.
2011	Christiansen (UK)	Qualitative – phenomenology Purpose: To describe the different ways in which students approach and make sense of patient digital stories.	Convenience n=20	Digital stories were identified as a learning resource, emotional experience, reflective experience and transformative experience by the students.
2008	Clark et al. (USA)	Quasi-experimental Group comparison, pre-test/post-test design Purpose: To evaluate the effects of team-based learning, classroom engagement was compared between team-based and traditionally taught classes	Convenience n=118	Students in the team-based learning pedagogy were more engaged in the learning process and used more communication skills to articulate arguments. No change was noted in students' attitudes about valuing group work.
2012	Colley (USA)	Qualitative Purpose: To explore faculty's perceptions of adopting a learner-centered philosophy.	Purposive n=9	The implementation process was found to include these main areas: understanding the philosophy, teaching approaches, mixed responses from students, factors influencing implementation, and perceptions of the current state. Strengths: in depth examination of

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				faculty's experiences including + and – effects of implementing student-centered pedagogy
2012	Cooper & Carver (UK)	Qualitative – focus groups Purpose: To explore experiences of pre-registration post-graduate mental health student nurses undertaking a 2-year educational course in which all teaching and assessment followed a PBL philosophy.	Purposive 6 focus groups with up to 8 participants/ group	Themes: 'moves to autonomy, 'surviving the groups' and 'the impact of PBL'. The findings indicated that students had mainly positive experiences and gained a range of study and interpersonal skills central to mental health nursing. Students described initial anxieties resulting from engagement in PBL. However, they increasingly gained confidence in this approach, exercising increasing control over the PBL process. Despite this increased autonomy, participants continued to value the input of skilled facilitators. A recurring issue centered on the potential for interpersonal conflict within the group and its impact on their learning.
2007	Dearnley & Meddings (UK)	Mixed methods Purpose: To conduct a preliminary exploration and evaluation of student self-assessment and its impact on learning.	Convenience n=11 (6 students; 5 faculty)	Self-assessment must be taught and practiced to become refined. The benefits of SSA cannot be realised without significant preparation of all concerned – students and staff.
2011	Diefenbeck et al. (USA)	Mixed methods – program evaluation Purpose: To provide a comprehensive student-centered outcome evaluation of the Clinical Immersion Model. Methods of evaluation, included NCLEX pass rates, exit surveys, alumni surveys, and a focus group.	Convenience – low response rates on surveys Target population = 583 graduates n=?	The Clinical Immersion Program provided a comprehensive curriculum prior to immersion in the clinical arena. Philosophical principles upon which the program was developed include enhanced socialization, improved transition to practice, and increased student accountability. Positive aspects of this model included resource efficiency (both faculty and clinical sites) and increased emphasis on patient safety. NCLEX-RN pass rates improved. Data were aggregated over 5 years on either side of the implementation of the immersion curriculum indicating that the improvement was a legitimate trend.
2012	El-Gelany & Abusaad (Saudi Arabia)	Non-experimental – descriptive survey Purpose: To assess nursing students' readiness for self-directed learning and identify their learning styles to discern a relation between	Convenience n=275	77% scored high level of SDLR. No association between the level of SDLR and the learning styles. Implications to prepare all students for self-directed learning.

		these two concepts. Fisher's self-directed learning readiness (SDLR) scale, and the Kolb's learning styles inventory.		
2010	Greer et al. (USA)	Qualitative – online survey Purpose: To describe the learner-centered teaching characteristics of faculty who reported using contemporary pedagogy. A secondary analysis of data collected by a survey of educators regarding pedagogical teaching approaches and strategies.	Convenience n=956	Themes that emerged were placed under the concepts of power, role of teacher, responsibility of learner, and philosophy of evaluation guided by Weimer's (2002) conceptual framework of a learner-centered philosophy of teaching. Power emerged from the responses even though none of the original questions related to power. Power was recognized as shared in the formation of a learning partnership. Findings supported the notion that the philosophy of learner-centeredness was deeply engrained among the respondents.
2005	Hoke & Robbins (USA)	Non-experimental – descriptive Purpose: Using holistic, active cooperative learning strategies (faculty role modeling, student interactive and group learning and group testing) within a didactic class, the authors determined differences in the average clinical grade (87.03) when compared to the average clinical grade for students who had been taught using a lecture approach (84.19).	Convenience n=23	Statistically significant?
2002	Jeffries, Rew, & Cramer (USA)	Mixed methods Experimental design, supplemented with qualitative data and survey data Purpose: To compare the effectiveness of two instructional methodologies in teaching basic nursing skills. One approach used an interactive, student-centered focus; the other used traditional lectures and demonstrations. Methods covering the same content were compared for teaching basic nursing skills.	Convenience n=120	No significant differences between the groups' pretest to post -test cognitive gains, although there were cognitive gains for both groups. The groups also were similar in their ability to demonstrate the basic skills correctly in the learning laboratory. Results showed significant differences ($p = 0.01$) in student satisfaction, with the interactive, student-centered group more satisfied with their learning.
2009	Johnson-Farmer	Qualitative	Purposive	Consenting respondents were asked, "What do you do to

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	& Frenn (USA)	Purpose: To better understand teaching excellence.	n=17	bring nursing to life with your students?" Five major themes emerged: (a) engagement, (b) relevance, (c) student centeredness, (d) facilitation of learning, and (e) dynamic process of becoming an excellent nursing educator. The process of becoming an excellent teacher involved "change from 'instiller' to 'facilitator' and laid the foundation for continued development of my teaching self."
2013	Kalam-Salminen et al. (Finland)	Quasi-experimental – comparative study Purpose: To describe the differences between Finnish and Estonian students evaluations about their client-centeredness and educational support they received to develop it.	Convenience N=390 (195 from Finland and 195 from Estonia)	The Estonian students generally evaluated their client-centeredness higher compared to the Finnish students. The same applied to support provided by nursing education. The greatest differences were related to education and particularly theoretical teaching. In Estonia, students' client-centeredness manifested itself more in politeness and willingness to serve clients, whereas respecting the clients' values were emphasized in Finland. Students' requisites, referred here as knowledge, skills and abilities to implement client-centered nursing, for client-centeredness had deficiencies, and the support from education was also the weakest regarding these aspects. Findings point to the discrepancies in definitions of concepts and the merits of self-reports.
2010	Klunklin et al. (Thailand)	Non-experimental – descriptive survey Purpose: To describe undergraduate nursing students' readiness for self-directed learning.	Convenience n=272	The study found that the overall self-directed learning readiness was at a high level in the categories of openness to learning opportunities, self-concept as an effective learner, initiative and independence in learning, informed acceptance of responsibility for one's own learning, creativity, and the ability to use basic study and problem-solving skills.
2011	Klunklin et al. (Thailand)	Qualitative Purpose: To describe undergraduate nursing students' experiences with problem-based learning...	Purposive n=25	Four categories emerged: adapting, seeking assistance, self-development, and thinking process development. Initially participants had mixed emotions of confusion, negativity or boredom in the adaption process, but expressed satisfaction with creativity in learning, group

Year	Author (Country)	Design/Purpose	Sample	Findings
				work, and leadership development. They described increased abilities to problem solve and think critically, but struggled to develop questioning behaviours in learning. Socio-culturally in Thai education, students have great respect for teachers, but rarely question or challenge them or their learning. Problem-based learning has great potential in Thai nursing education, but educators and systems need to systematically prepare appropriate learning environments, their staff and students, to incorporate this teaching strategy.
2009	Kocaman, Dicle, & Ugur (Turkey)	Longitudinal, non-experimental – descriptive survey Purpose: To explore the perceived changes in self-directed learning for 4 years. Measured readiness for self-directed learning at 5 points	Convenience n=50	Scores were significantly lower during the first academic year compared with other years, and fourth-year scores were significantly higher than in previous years. Scores on the three subscales (i.e., self-management, desire for learning, and self-control) increased significantly during the 4 years of the program. These findings support self-directed learning as a maturational process.
2013	Lau & Wang (China)	Mixed methods – course evaluation (pretest/post-test survey design) Purpose: To develop and evaluate a learner-centered communication skills training course.	Convenience n=62	Paired t-tests and Wilcoxon signed-rank tests showed significant improvement in all post-training scores for communication ability, content of communication, and handling of communication barriers. Students were generally satisfied with the instruction.
2010	Lekalaka-Mokgele (South Africa)	Qualitative Purpose: To describe the experiences of facilitators as well as those of their students in PBL.	Purposive 12 focus groups – 4 with faculty and 8 with students	Control of teaching and learning was an issue for facilitators. These traditionally trained facilitators experienced difficulties in terms of allowing students to take charge of their own learning and function in a self-directed manner.
2011	Lerret & Frenn (USA)	Qualitative Purpose: To integrate current perspectives and the research foundation for teaching nursing by discerning what makes an excellent	Purposive n=27 (doctoral nursing	Four major themes emerged to exemplify excellent teachers: (1) know and honor students, (2) enthused, (3) knowledgeable, and (4) student centered.

		teacher.	students) + literature review from 1960	
2010	Lin et al. (China)	Experimental Purpose: To compare the learning effectiveness of peer tutored problem-based learning and conventional teaching of nursing ethics. The study adopted an experimental design. The peer tutored problem-based learning method was applied to an experimental group and the conventional teaching method to control group.	n=142 randomly assigned to experimental or control group	Students were tested for their nursing ethical discrimination ability both before and after the intervention. A learning satisfaction survey was administered at the end of each course. After the intervention, both groups showed a significant increase in ethical discrimination ability. There was a statistically significant difference between the ethical discrimination scores of the two groups (P < 0.05), with the experimental group on average scoring higher. There were significant differences in satisfaction with self-motivated learning and critical thinking between the groups. Peer tutored problem-based learning and lecture-type conventional teaching were both effective for nursing ethics education, but problem-based learning was shown to be more effective.
2012	Özbıçakçı, Bilik, & İntepeler (Turkey)	Non-experimental – survey Purpose: To compare learning goals established by faculty with learning goals set by students in different years of nursing program.	Convenience n=15 faculty n=217 students with good response rate to survey	No significant difference between faculty and students' evaluations of student level of understanding within the different years of the program. Students and faculty in all three years indicated that they achieved adequate or good understanding of learning goals. Based on these results, students were provided with a list of faculty generated learning goals at the end of every curriculum module. The students then compare these with their own self-directed goals in feedback sessions with faculty members. These feedback sessions have been popular with students.
2010	Phillips & Vinten (USA)	Non-experimental – descriptive survey Purpose: To describe clinical educators' intentions to adopt innovative teaching strategies	Purposive n=71 Recruited from an online	"Innovative teaching strategies were defined as those that embrace the tenets of sociocultural theory, a student-centered approach whereby the role of the nurse educator is to motivate and support the student and, in mutual process, to push students to reach toward their

			course for clinical educators with a 95% response rate	learning potential by using guiding techniques that can be erected or gradually reduced based on the individual student's learning needs." Three factors proposed in the Rogers theory of diffusion of innovation (compatibility and relative advantage) were identified as most influential in the adoption of innovative teaching strategies. Encouraging students to explore and apply new knowledge was described as the most likely to be adopted. Intent to adopt innovative teaching strategies may provide insight into the development of organizational climates in schools of nursing.
2003	Regan (UK)	Mixed methods Purpose: To determine factors that motivate nursing students in self-directed learning and compare perceptions of students/faculty	Focus groups 12 students, 8 teachers Surveys 97 students 18 teachers	The results indicated a wide range of motivational factors, with level of agreement between the two groups for most factors. The results also highlighted the importance of lectures in motivating students towards SDL. This link between teacher-led activities and the development of independent learners is not readily acknowledged in literature on adult learning. Data also indicated that students need specific guidance and feedback to motivate them towards SDL, which is not consistent with the philosophical basis of SDL and may lead to inconsistency amongst nurse educators.
2002	Rideout et al. (Canada)	Quasi-experimental – descriptive survey Purpose: To compare graduating baccalaureate students in a problem-based curriculum with those in a conventional nursing program in respect to perceived preparation for clinical practice, clinical functioning, knowledge and satisfaction with their education. Prior to graduation, students completed a self-report questionnaire. Following graduation, pass rates on the National Nursing Registration Examination (RN Exam) were also compared.	Convenience n=76 45 in PBL (McMaster) + 31 in conventional (University of Ottawa)	No significant differences in graduates' perceived preparation for nursing practice, although the conventional students scored higher in all areas. No significant differences between groups in perceived clinical functioning, although there was a trend toward higher function in the areas of communication and self-directed learning in the PBL group. No statistically significant differences in RN scores. The PBL students scored significantly higher on perceptions of their nursing knowledge, particularly in the areas of individual, family and community health assessment,

				communication, teaching-learning, and the health care system. Students in PBL program were more satisfied with their educational experience than the group in the conventional program, reporting higher satisfaction with educators, level of independence, assessment and program outcomes.
2003	Schaefer & Zygmont (USA)	Non-experimental – descriptive correlation design Purpose: To describe teaching styles of nursing faculty as teacher or learner centered and compare teaching style with instructional methods.	Convenience n=187	Inconsistency between self-identified teaching philosophy and learner centered activities.
2007	Smedley (Australia)	Non-experimental – descriptive survey Purpose: To describe the self-reported learner readiness for self-directed learning in first year baccalaureate nursing students	Convenience n=67	Younger students less ready for SDL
2006	Tiwari et al. (Hong Kong)	Mixed methods – descriptive survey and interviews Purpose: To determine if there was a significant difference in critical thinking skills when comparing students provided with problem-based learning versus conventional lecture. Outcome measure was students' critical thinking disposition as measured by the California Critical Thinking Disposition Inventory (CCTDI). Individual interviews were also conducted to elicit the students' perceptions of their learning experience. Data were collected at 4 times during the program.	Convenience n=79 (40 in PBL and 39 in conventional lecture)	CCTDI and subscale scores for the PBL group were not significantly different from those of the lecture group in the beginning. There were significant differences in the development of students' critical thinking between those who undertook the PBL and lecture courses, respectively.
2011	Tseng et al. (Taiwan)	Quasi-experimental Purpose: To determine if there was a significant difference in critical thinking skills when PBL and concept mapping were utilized in comparison with conventional lectures	Convenience n=120 (51 in experimental group and 69 in control group)	Finding showed that the experimental group had higher scores than the control group for the Critical-Thinking Scale, Self-Directed Learning Scale, and Students' Performance in PBL Tutorial Sessions Questionnaire at the post-test and follow-up test stages. The PBL-CM increased students' critical-thinking skills and personal accountability for self-directed learning, and it would

Year	Author	Design/Purpose	Sample	Findings
				enhance the skills of independent study, reasoning, group interaction and active participation. This study offers guidelines for new nurse-training programs and continuing nursing education in clinical practice.
2012	Yang, Voomer, & Matthews (USA)	Evaluation of teaching strategy Purpose: To describe and evaluate a pilot project whereby undergraduate nursing students were taught community health nursing using team-based approaches	Convenience n=83	Students worked in teams to explore epidemiologic data, synthesize the literature, and develop an EBP for nursing intervention and evaluation pertaining to a public health issue. Project evaluation consisted of pre- and post-project surveys by students, peer evaluation, and formative and summative evaluation by faculty. This experience suggests that instituting a collaborative learning experience as part of an undergraduate course in community health nursing can be an effective way to expose students to constructive approaches to teamwork and prepare them for EBP.
2008	Yuan, Williams & Fan (China/Canada)	Systematic review Purpose: To decipher current evidence about the effects of PBL on critical thinking	n=10 studies	The available evidence did not provide supportive evidence on developing nursing students' critical thinking through PBL.
2010	Zavertnik, Huff, & Munro (USA)	Quasi-experimental Purpose: To assess the effectiveness of a learner-centered simulation to improve communication skills by using trained actors and role-playing.	Convenience n=41 (20 in control group; 21 in intervention)	The intervention group performed better than the control group in all four tested domains related to communication skills, and the difference was statistically significant in the domain of gathering information.
2012	Zhang et al. (China)	Quasi-experimental – pre-test/post-test Purpose: To assess the effectiveness of an educational innovation on students' abilities to incorporate EBP into their clinical practicum along with SDL.	Convenience n=75	Findings showed a significant improvement in perceptions of EBP knowledge, attitudes and beliefs, and behavior levels. Beginning competencies in EBP were achieved. Participants reported great satisfaction and found this program helpful in promoting their analytical and problem-solving abilities, independent learning ability, and cooperative and communication abilities.

Appendix B: A letter of invitation (via blind carbon copy email)

Hi,

My name is Olabisi Oyelana and I am a graduate student in the Master of Nursing program at the University of Manitoba. This e-mail is being sent to you on my behalf by [name of the administrative secretary]. I do not know your name or have any information about you. For my master's thesis, I am conducting a qualitative study about **Clinical Nurse Educators' Lived Experience of Student-Centered Teaching in Practice Settings.** I would like you to share your day-to-day experiences incorporating student-centered teaching while teaching nursing students in practice settings. Dr. Donna Martin of the College of Nursing, *Faculty of Health Sciences, University of Manitoba* is my advisor for this study. This study has been approved by the Education/Nursing Research Ethics Board at the University of Manitoba [and the research board at -------------------].

I would like to conduct a face to face, 1:1, audio-recorded interview with you about your use of student-centered teaching in the practice setting. Student-centered teaching refers to a combination of various teaching approaches focused on the needs and active involvement of the student in the teaching-learning process. If you have been a clinical nurse educator for at least 6 months and are willing to participate in this study, you are eligible to participate. At the conclusion of the interview, you will be provided with a $10 Tim Horton's gift card as compensation for your time and effort. You will receive e-mail from me about a month after the interview to verify the information provided during the interview. I will compile and analyze all gathered information from your interview and the interviews of other participants and compose my thesis, highlighting the findings and recommendations for future clinical nursing education. Upon completion of the study, I will provide you with an executive summary of the study's findings. Findings of the study will also be shared with educational administrators and your colleagues and will be published in academic nursing journals.

If you are interested in hearing more about this study, please contact me and I will explain the study in further detail and answer your questions. If you decide to participate, I will arrange an interview time and place that is convenient for you. If you decide not to participate, you can say no without any consequences. Participation throughout this study is completely voluntarily and you may stop at any time.

Thank you for your time and consideration of this study.

Sincerely,

Olabisi Oyelana, RN, Graduate Student

College of Nursing, University of Manitoba

Email: oyelanao@cc.umanitoba.ca

Telephone: (204) 804-1156

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Appendix C: Research Participant information and consent form for Clinical Nurse Educators

Research Project Title: Clinical Nurse Educators' Lived Experience of Student-Centered

Teaching in Practice Settings: An Interpretive Phenomenology

Principal Investigator:

Olabisi Oyelana, RN, Graduate Student, College of Nursing, Faculty of
Health Sciences, University of Manitoba
Email: ~~oyelanao@myumanitoba.ca~~

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Thesis Committee members:

Dr. Donna Martin, Assistant Professor, College of Nursing, Faculty of Health
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Manitoba
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This consent form, a copy of which will be left with you for your record and reference is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask questions. Please take the time to read this carefully and to understand any accompanying information.

Purpose of study This is a thesis project by a graduate student to explore and understand Clinical Nurse Educators' Lived Experience of Student-Centered Teaching in Practice Settings

Study procedures In this study, you, as a Clinical Nurse Educator, are being asked to participate in an in-depth interview. The duration of the interview is estimated to be about one hour. Your socio-demographic information will be obtained including: age, level of education, work experience, level of students that you teach, practice setting, and educational background i.e. if

you received traditional teacher-centered education or student-centered education. A set of questions will be used as a guide to direct the discussion. During the interview, our discussion will be audio-recorded using a small, digital recording device. You will be asked questions about your typical work day and what it is like using student-centered teaching in the practice setting. I will write reflective notes after the interview to document the interview process. The audio-recording will be transcribed word for word and the transcriptionist will remove all names and identifying features. Your name will not be used. I will assign a fictitious "code" name to your transcript and my corresponding reflective journal about our interview. For example, you may be referred to as Alice, Bob, Candace, or Melanie. Red River College will not be identified in any study documents. I will refer to your place of employment as a Bachelor of Nursing Program located in Manitoba.

I will read and re-read all transcripts to identify common and unique themes about student-centered teaching in practice settings. If you indicate that you would be interested in reviewing your transcript, you will receive an Email with the transcript to verify or refute its representation of your statements during the interview. All information, both audio-recorded and study documents will be treated with confidentiality. For example, all names and identifying features will be removed from the transcripts and research reports. All word documents – transcripts, journal notes (no names or identifying features) will then be uploaded into a qualitative research software program that is located on a password protected computer accessible only to the principal investigator and Dr. Donna Martin.

Risks and Discomforts There are no known risks or any anticipated discomforts to participating in this study. However, direct quotes or in other words, your statements (made during the interview) could be used in a final report; no identifiable information will be linked with the statements.

Benefits There are no personal benefits to participating in this study. Participating in this study will provide you with an opportunity to make contributions towards evidence based understanding of the factors that impact the implementation of student-centered teaching in practice settings.

Compensation Upon completion of the interview, you will receive a $10 Tim Horton's gift card to compensate for your time.

Voluntary Participation/Withdrawal from the Study Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time or refuse to answer any individual question with no negative consequences. To withdraw from the study, inform the PI (Email, telephone call) and your interview transcript and the corresponding reflective journal will be deleted. If you decide to withdraw from the study, you will still keep the gift card provided.

Confidentiality All study data (digital recordings, transcripts, journal notes) will be stored in a pass word protected computer file only accessible to the researcher and Dr. Donna Martin, the thesis supervisor, on a University of Manitoba S: drive. Consent forms and transcripts will be locked in a filing cabinet in my office at the University of Manitoba and they will be shredded when the study is completed (06/2015), according to the University of Manitoba's policy for

destruction of confidential material. Electronic files on the University of Manitoba's S: drive will be deleted permanently by June, 2017. Information gathered in this research project may be published or presented in public forums. However, your name and other identifying information such as the specific name of the educational institution or practice setting will not be used or revealed.

Results of the study When the study is completed you will receive a copy of an executive summary of the study's findings. If you would like to receive a mailed or emailed copy please provide your address (mail or email) in the space below.

Address:　　　　_____

　　　　　　　_____

　　　　　　　_____

　　　　　　　_____

Email Address: _____

Please indicate if I may contact you by email to review your transcript for accuracy.

YES　　　　NO

Your signature on this form includes that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your record to see that the research is being done in a safe and proper way. This research has been approved by the Education/Nursing Research Ethics Board at the University of Manitoba and the Research Ethics Board at Red River College. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Coordinator (HEC) at 474-7122 or ▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓. A copy of this consent form has been given to you to keep for your records and references.

Participant name (please print): _____

Participant signature_____Date_____

　　　　　　　　　　　　　　　　　　　　　　　　(Day/month/year)

Researcher's signature _____

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Appendix D: Short Demographic Survey

Thank you for volunteering to participate in this study. I would like to learn more about what it is

like to use SCT in the practice setting. Please share your experiences of a typical work day.

Before we begin the interview, I would like to collect some demographic information about you

to describe the general features of the sample that I recruit for this study.

Do not put your name of this form.

Background information:

Circle the appropriate descriptors about you (below):

Age range: < 25 years

26 – 35 years

36 – 45 years

46 – 55 years

56 – 65 years

- 65 years

Highest level of education: RN   BN   MN   PhD   Other

_____

Length of work experience as a RN (in years): _____

Length of work experience as a clinical nurse educator (in years): _____

What level of students do you teach? 1st year   2nd year   3rd year   4th year

What is the practice setting where you teach nursing students?

Medicine/Surgery

Mental health/palliative

Labor/delivery

Long-term care

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Community agency

Other   (Specify)

In a brief statement, please describe your educational background as a nurse i.e. would you say that you were educated to become a nurse in a traditional teacher-centered program or SCT program?

_____

_____

_____

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Appendix E: Semi-Structured Interview Guide

Introduction to the Interview: I would like to learn more about clinical teachers' experiences in the practice setting.

Note: Probes will only be used as necessary to elicit further discussion.

1. What is a typical day like for you with your students in the practice setting?
2. Tell me about a "teaching-learning" situation that was successful.

   What factors influenced this success?

   How did you experience this success?
3. Tell me about a specific "teaching-learning" situation that was challenging.

   What factors contributed to this challenge?

   How did you experience this challenge?

   In a perfect world, what supports/resources might have helped turn this "teaching-learning" situation into a success?
4. What does student centered teaching mean to you?

   Have you incorporated student centered teaching with your students? [If no – what prevents you from doing so?]

   [If yes – please tell me more about your incorporation of student centered teaching

   How did you experience incorporating student centered teaching?]
5. Based on your experiences as a previous student and as a clinical teacher, what supports/resources/strategies would enhance clinical education of student nurses?
6. Is there anything else that you would like to tell me?

Guide for Reflective Journal Documentation

Describe the interview location and the interview process.

Document key statements that depicted how the participant experienced their work life.

Identify what worked well in the interview process and what could be enhanced in future interviews.

What aspects of the participant's experiences were similar or different to mine?

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Appendix F: **Email to Participants with Transcript**

Hi,

My name is Olabisi Oyelana and I am a graduate student in the Master of Nursing program at the University of Manitoba. For my master's thesis, I am conducting a qualitative study about **Clinical Nurse Educators' Lived Experience of Student-Centered Teaching in Practice Settings.** Thank you for sharing your day-to-day experiences about teaching nursing students in practice settings.

Attached to this email is a copy of the transcript of your interview with me. I have removed all names and identifying features. Please review the transcript and feel free to modify, add or delete any pieces as you wish in order to ensure accuracy of your statements.

Upon completion of the study, I will provide you with an executive summary of the study's findings. Findings of the study will also be shared with educational administrators and your colleagues and will be published in academic nursing journals and presented at conferences.

If you decide not to participate, you can say no without any consequences. Participation throughout this study is completely voluntarily and you may stop at any time.

Thank you for your time and consideration of this study.

Sincerely,

Olabisi Oyelana, RN, Graduate Student
College of Nursing, University of Manitoba
Email: ████████@█████████████
Phone: ████████████████

CLINICAL NURSE EDUCATORS' LIVED EXPERIENCE

Appendix G: Confidentiality Pledge for Transcriptionist

Project Name: clinical Nurse Educators' Lived Experience of student-centered reaching in practice Settings: An Interpretive Phenomenology

Principal Investigator: Olabisi Oyelana

Co-Investigators: Dr. Donna Martin

Dr. Judith Scanlan

Dr. Bev Temple

Dr. Thomas Falkenberg,

I, _____, agree to keep the contents of the audio-recorded interviews being transcribed and any identifying information about the participants strictly confidential. I will not discuss this research project with anyone except the principal investigator or the co-investigators. Transcription of the audio-recorded interviews will not be typed on the computer at my place of work. The audio-recorded interviews and transcription data will be secured in a safe place in my home to prevent electronic or physical access by any unauthorized persons, until such time as they are transferred into the possession of the principal investigator. Once the audio-recorded interviews are transcribed and data are transferred to the principal investigator, all computer files will be permanently erased and any paper copies of the transcripts will be shredded. Any notes I have made will be turned over to the principal investigator at the conclusion of the process.

My signature indicates my willingness to comply with this confidentiality agreement.

_____   _____

Signature of Transcriptionist   Date

_____   _____

Signature of the principal investigator   Date

CLINICAL NURSE EDUCATORS' LIVED EXPERIENCE

Appendix H: Certificates of Ethics Approval

RED RIVER COLLEGE

RESEARCH ETHICS BOARD

CERTIFICATE OF APPROVAL

PRINCIPAL RESEARCHER(s)	DEPARTMENT	NUMBER
Olabisi Oyelana,	Graduate Student College of Nursing, University of Manitoba	2011/15-06

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Red River College

CO- RESEARCHERS
Dr. Donna Martin, Dr. Judith Scanlan, Dr. Bev Templo, Dr. Thomas Falkenberg

SPONSORING AGENCIES

MCNHR

TITLE:
Program Evaluation: A healthy sexuality social marketing campaign

APPROVAL DATE	TERM (YEARS)	AMENDMENT	AMENDMENT APPROVED	ANNUAL REPORT/ RENEWAL DUE DATE
November 6, 2014	One			November 6, 2015

CERTIFICATION

The protocol describing the above-named project has been reviewed by the Red River College Research Ethics Board and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Research Ethics Board by:
Ashley Blackman, Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.

UNIVERSITY OF MANITOBA | **Research Ethics and Compliance**
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone (204) 474-7122
fax - 204- 269-7173

APPROVAL CERTIFICATE

September 22, 2014

Advisor – D. Martin
MCNHR

TO: Olabisi Oyelana
           Principal Investigator

FROM: Lorna Guse, Chair
           Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2014:115
           "Clinical Nurse Educators' Lived Experience of Student-Centered Teaching
           in Practice Settings: An Interpretive Phenomenology"

Please be advised that your above-referenced protocol has received human ethics approval by
the **Education/Nursing Research Ethics Board**, which is organized and operates according to
the Tri-Council Policy Statement (2). This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the
Human Ethics Secretariat in advance of implementation of such changes.

Please note:

-    if you have funds pending human ethics approval, please mail/e-mail/fax
(261-0325) a copy of this Approval (identifying the related UM Project Number) to the
Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM
Project Number: http://umanitoba.ca/research/ors/ort-faq.html#ct0)

-    if you have received multi-year funding for this research, responsibility lies with
you to apply for and obtain Renewal Approval at the expiry of the initial one-year
approval: otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from
this project to demonstrate compliance with this approved protocol and the University of
Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at
http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order
to be in compliance with Tri-Council Guidelines.

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umanitoba.ca/research