A CROSS-SECTIONAL, DESCRIPTIVE, CORRELATIONAL STUDY OF ORIENTATION DELIVERY METHOD AND ORIENTATION LENGTH AND PERCEIVED CONFIDENCE IN SKILL ACQUISITION WITH CLINICAL ADJUNCT FACULTY IN NURSING EDUCATION

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DOCTOR OF PHILOSOPHY

by
Kelly Lynn Hantack

BSN, Jewish Hospital College of Nursing and Allied Health, 2002
MSN, Goldfarb School of Nursing at Barnes Jewish College, 2013

Kansas City, Missouri
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Kelly Lynn Hantack, Candidate for the Doctor of Philosophy Degree

University of Missouri-Kansas City, 2025

ABSTRACT

Background: The ongoing nursing shortage, coupled with increasing reliance on adjunct faculty, has created a critical need to examine how clinical adjunct nursing faculty are prepared for their teaching roles. Adjunct faculty play an essential role in educating future nurses, yet their orientation and professional development remain inconsistent across programs. Orientation design, length, and delivery methods are variable, with limited empirical evidence linking these factors to confidence in skill acquisition. Grounded in Meleis' Transitions Theory, this study examined whether orientation format (delivery method and length), years of teaching experience, and participation in mentoring programs predict confidence in skill acquisition among clinical adjunct faculty in prelicensure baccalaureate nursing programs in the United States.

Methods: A cross-sectional, descriptive, correlational design was employed using an emailed electronic survey. The convenience sample included 257 clinical adjunct faculty teaching in accredited baccalaureate programs across 37 states. The instrument incorporated demographics, orientation format, and the Clinical Nurse Educator Skill Acquisition Assessment (CNESAA), which measured perceived confidence. Predictor variables included orientation

delivery method, orientation length, years of teaching experience, and participation in a formal mentoring program; the dependent variable was the CNESAA composite score representing confidence in skill acquisition.

Results: Participants were predominantly female (93%, *n* = 240), white (85%, *n* = 219) held a master's degree as their highest level of education (57%, *n* = 147), and had an average age of 43 years (*n*=257) with an average of 16.6 years of clinical experience (*n*=257). More than half of participants (53.3%) reported receiving orientation, most commonly delivered face-to-face (65.4%) and lasting an average of six hours. The mean CNESAA composite score was 157.27 (SD = 33.84), indicating moderate to high confidence in skill acquisition. Regression analysis revealed orientation delivery method, length of orientation, years of teaching experience, or mentoring participation significantly predicted confidence in skill acquisition ($p > .05$).

Conclusions: This is the examination of orientation format and confidence in a national sample of clinical adjunct faculty. Findings indicate factors beyond orientation and mentoring may influence confidence development during the transition to the educator role. Further research is needed to identify strategies that foster confidence among clinical adjunct faculty.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Nursing and Health Studies, have examined a dissertation titled "A Cross-sectional, Descriptive, Correlational Study of Orientation Delivery Method and Orientation Length and Perceived Confidence in Skill Acquisition with Clinical Adjunct Faculty in Nursing Education," presented by Kelly Lynn Hantack, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

Supervisory Committee

Cynthia L. Russell Lippincott, Ph.D., RN, FAAN, Committee Chair
UMKC School of Nursing and Health Studies

Steven Chesnut, Ph.D.
UMKC School of Nursing and Health Studies

Matthew Chrisman, Ph.D.
UMKC School of Nursing and Health Studies

Theresa M. Valiga, Ed.D., RN, ANEF, FAAN
Duke University School of Nursing

Anita Skarbek, Ph.D., RN
UMKC School of Nursing and Health Studies

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CHAPTER 1

INTRODUCTION

This chapter reviews the expanding use of clinical adjunct faculty in nursing education, which has evolved due to the nursing and nursing faculty shortages. It identifies how clinical adjunct faculty are prepared for that role and gaps in the literature related to that preparation. The purpose of the study, along with the research questions, hypotheses, and innovative study design, are introduced.

The Health Resources and Services Administration (HRSA) projected a shortfall of 63,720 registered nurses by 2030 (HRSA, 2022). One of the contributing factors to the nursing shortage is the aging population, which contributes to the increasing number of nurses retiring and the increased need for healthcare services (Haddad et al., 2023). The consequences of the nursing shortage are numerous, including staffing shortages in hospitals, which increase the incidence of medical errors and lead to higher morbidity and mortality rates among hospitalized patients (Haddad et al., 2023).

One cause of the nursing shortage is the lack of educators, including those prepared for the challenges of teaching in complex clinical environments. In 2022, the overall vacancy rate for full-time faculty positions in all types of nursing schools in the United States was 8.8%, an increase of 0.8% from 2021 (Byrne, n.d.). Sixty-one percent of the 909 schools surveyed reported having full-time vacancies. One hundred twenty-eight schools reported no full-time vacancies but still needed faculty (Byrne, n.d.). The American Association of Colleges of Nursing (AACN) reported that 47.7% of these schools that need additional full-time faculty but have no vacancies have administrations that are unwilling to commit to additional full-time positions (Byrne, n.d.). Similar to the reasons for the nursing shortage, recruitment is also a

factor in the nurse educator shortage. Schools reported that noncompetitive salaries and difficulty finding faculty with the right specialty mix were the most common issues with faculty recruitment (Byrne, n.d.). In 2017, AACN identified that one-third of today's nursing faculty workforce in baccalaureate and graduate programs is expected to retire by 2025 (Fang & Kesten, 2017). According to the 2022 National Nursing Workforce Survey, there has been a decline in the percentage of nurses reporting that they practiced in a school of nursing over the last seven years (Smiley et al., 2023). In 2015, 3.6% of the nursing population were nursing faculty; in 2022, this dropped to only 2.1% (Smiley et al., 2023). This nurse educator shortage impacts enrollment in nursing schools, as illustrated by the fact that in 2022, 66,291 qualified applications for entry-level baccalaureate programs were not accepted at schools of nursing nationwide. Insufficient faculty was cited as one of the primary barriers to accepting all qualified students (AACN, 2024). Qualified nursing faculty are needed to increase nursing schools' capacity and the number of nurses prepared to enter practice (National League for Nursing [NLN], 2024a). One of the solutions to the nurse educator shortage is to utilize adjunct or part-time faculty to teach in the clinical setting (Luckenbach et al., 2021; Meyer, 2017). An adjunct nursing faculty member is a part-time educator hired on a contractual basis to teach specific courses or supervise clinical practice within a nursing program. These positions are usually temporary and do not include the same responsibilities or benefits as full-time, tenure-track professors. Adjunct faculty focus primarily on teaching and direct student interaction, bringing specialized clinical expertise to enhance the educational experience for students.

In their study of part-time clinical instructors, Davidson and Rourke (2012) defined part-time clinical instructors as registered nurses who provide clinical instruction in on-campus laboratory settings and/or off-campus (community, hospital) clinical placements on a short-term

contract (less than 12 months duration) and in the literature, part-time faculty can sometimes be referred to as adjunct faculty (Meyer, 2017). Benefits to employing part-time faculty include flexibility as enrollment fluctuates, and reduction of employment-related costs since benefit packages are not offered to part-time faculty (Westphal et al., 2016). Qualifications for adjunct nursing faculty include a graduate degree in nursing and relevant clinical experience as a nurse. For instance, the National Council of State Boards of Nursing (NCSBN) recommends that faculty in registered nursing (RN) programs hold a graduate degree in nursing. In contrast, those in practical nursing (PN) programs should have at least a Bachelor of Science in Nursing (BSN) degree (NCSBN, 2025). The American Association of Colleges of Nursing emphasizes that faculty, including adjunct faculty, should be academically and experientially prepared for the areas in which they teach. This preparation ensures they can effectively contribute to the program's mission, goals, and expected outcomes (AACN, n.d.b). In summary, adjunct nursing faculty are part-time educators with appropriate academic and clinical qualifications crucial in delivering nursing education, particularly in clinical and specialized areas.

Clinical faculty in nursing need knowledge and skills to be competent and confident in their role as educators. In 2005, the NLN developed eight competencies for academic nurse educators based on their scope of practice (NLN, 2024b). The primary content areas of the competencies are facilitating learning, facilitating learner development and socialization, using assessment and evaluation strategies, participating in curriculum design and evaluation of program outcomes, functioning as a change agent and leader, pursuing continuous quality improvement in the role of the nurse educator, engaging in scholarship, and functioning within the educational environment (NLN, 2022).

To attain these competencies and effectively teach and evaluate students, nursing faculty must be oriented to their educator role. Nursing faculty orientation typically spans several hours to weeks, aiming to familiarize new educators with institutional policies, curriculum frameworks, teaching methodologies, and resources. These orientations can include in-person sessions or online modules (Johnson, 2016; Roman, 2018). The goal is to equip faculty members with the necessary tools and knowledge to effectively engage with students and deliver high-quality instruction (Rogers et al., 2020). Orientation sessions are commonly facilitated by experienced faculty members and administrative staff. They are typically conducted before a new academic term starts or whenever a new faculty member joins the institution (Rogers et al., 2020). A well-structured orientation significantly impacts the quality of instruction by ensuring educators are confident, competent, and aligned with the institutional standards, enhancing student learning outcomes and overall academic excellence (McMillian-Bohler & Tornwall, 2023). However, adjunct and part-time faculty role orientation is inconsistent, and therefore the quality of the instruction provided by these faculty is inconsistent across nursing programs (McMillian-Bohler & Tornwall, 2023). There is little evidence regarding best practices for designing and implementing orientation for clinical adjunct faculty in nursing (Johnson, 2016).

Measured outcomes of adjunct faculty orientation have varied and include knowledge gained, confidence, and satisfaction with the orientation. Confidence is needed for teaching efficacy and is essential for effective teaching. According to transitions theory, knowledge and socialization are facilitators of transitions, and developing confidence is a progress indicator during transition (Meleis, 2010). In two cross-sectional studies of clinical nurse educators, Kim and Shin (2017) and Nguyen et al. (2018) reported a positive association between years of teaching experience and confidence in nurse educators.

Gap and Innovation

Although adjunct and part-time faculty make up a substantial portion of the nursing education workforce, limited research has focused specifically on their preparation and confidence in the teaching role. A major gap exists in understanding confidence in skill acquisition among clinical adjunct faculty, as currently no U.S. studies have directly examined this construct within this population. Previous research has primarily described general orientation practices for nursing faculty, but these studies are now outdated. It has been 10 years since Carlson's (2015) foundational study described the characteristics of part-time clinical faculty orientation programs, and the field has since experienced significant shifts. Moreover, many previous studies were conducted within single institutions, limiting generalizability to broader regions and/or the national level. Another gap is the lack of use of validated instruments to assess confidence among clinical adjunct faculty; most studies have relied on self-developed tools with limited psychometric testing. Consequently, little is known about how orientation format and content relate to faculty confidence, and no updated national data exists to inform evidence-based orientation design for this essential faculty group.

This study contributes several innovations to the body of nursing education research. It is the first national study to examine the relationship between orientation format and perceived confidence in skill acquisition among clinical adjunct faculty in prelicensure baccalaureate programs. The study extends the use of the Clinical Nurse Educator Skill Acquisition Assessment (CNESAA), a validated instrument developed by Nguyen et al. (2017), to a new population and geographical context, making this the first application of this tool with U.S. nursing faculty. Lastly, it provides needed data on an underrepresented population of nursing faculty, and findings can inform the development of novel intervention approaches in this group.

Purpose and Research Questions

This study aimed to generate evidence about the orientation of clinical adjunct faculty and determine if the delivery method and length of the orientation predict confidence in skill acquisition in clinical adjunct faculty. The study's results can inform faculty and administrators in nursing schools by adding knowledge to enhance the design of orientation programs. The following research questions are addressed in this study:

Research Question 1: What is the format (delivery method and length) of clinical adjunct faculty role orientation?

Research Question 2: What is the confidence level in skill acquisition of clinical adjunct faculty in prelicensure baccalaureate programs in the United States?

Research Question 3: To what extent do length of orientation, delivery method of orientation, years of teaching experience, and participation in a mentoring program predict confidence in skill acquisition in clinical adjunct faculty in nursing?

Hypothesis 1: The delivery method of face-to-face orientation will have a more significant impact on the confidence of clinical adjunct faculty than online or blended/hybrid orientation.

Hypothesis 2: More time in orientation will have a greater impact on the confidence of clinical adjunct faculty compared to less time in orientation.

Summary

This chapter presented recent statistics related to the nursing shortage, the nursing faculty shortage, and nurse educator orientation. It also provided information about the gaps in the literature, the innovation of the study, and details about the purpose and research questions of the

study. The next chapter critically appraises the literature on clinical adjunct faculty, orientation, mentoring, years of teaching experience, and confidence.

CHAPTER 2

REVIEW OF LITERATURE

This chapter provides a review of existing literature on the five key concepts of the study to provide context for the rationale for examining the relationship between orientation delivery method, orientation length, participation in a mentoring program, years of teaching experience, and these variables' ability to predict confidence in skill acquisition in clinical adjunct faculty in nursing. First, literature describing orientation of adjunct faculty is synthesized. Next, literature related to the delivery method and the length of clinical adjunct faculty professional development activities like orientation are described. Next, literature describing years of teaching experience and mentoring programs for clinical adjunct faculty are reviewed. Next, literature describing these activities and their ability to predict confidence in clinical adjunct faculty are described. Finally, transitions theory is described as the theoretical framework guiding the study's design.

Orientation

The predictor variables for this study include how clinical adjunct faculty are prepared and supported during their transition from registered nurse to nurse educator. In nursing education, faculty members are prepared for their role through orientation. Part-time and adjunct faculty have reported that orientation and preparation for the role are important (Elder, 2016). New part-time clinical faculty reported a lack of knowledge about the role (McPherson & Wendler, 2023). Results identified that teaching in a clinical setting requires much preparation and that part-time faculty did not feel prepared for the role (Mann & DeGagne, 2017). Part-time clinical faculty reported a lack of information on how to teach (Wenner & Hakim, 2019) and a lack of structure and guidance (Cangelosi, 2014). New part-time clinical faculty reported variable onboarding (McPherson & Wendler, 2023) and the need for more preparation for the

role (Wenner & Hakim, 2019). Onboarding was defined as a process of supporting faculty from prehire through the recognition and achievement of mutually identified goals (Schaar, 2015). New adjunct clinical faculty identified that strong orientation is important and that graduate courses on teaching and learning, residencies, orientation, and continuing education conferences facilitate the transition to teaching (Mann & DeGagne, 2017). Another need related to preparation was to develop an orientation to minimize the disorientation phase of transition (Wenner et al., 2020) and a general need for help learning the role (Cangelosi, 2014). New adjunct clinical faculty reported developing teaching skills through on-the-job training, reading, continuing education, and academic courses (Mann & DeGagne, 2017). Nursing faculty reported that preparation and support is variable (McPherson & Candela, 2019), with new faculty reporting receiving formal and informal orientation (Roberts et al., 2013) and a need for more training for understanding of roles and clear and consistent expectations (McPherson & Candela, 2019). New part-time and adjunct faculty identified that they need orientation (Roberts et al., 2013) and that workshops, seminars related to teaching, orientation sessions, and faculty manuals are important (Elder et al., 2016) but not available. Administrators identified several challenges in employing part-time faculty. Many part-time faculty have had no formal courses and have a limited understanding of the role (Meyer, 2017).

Orientation Topics

Best practices in orientation design include completing a needs assessment to identify topics that need attention. For specific learning needs, adjunct and part-time clinical faculty have reported a need for more structured orientation, knowing expectations for faculty, strengthening skills in assessment and teaching (Morrison, 2020; Owens, 2017), writing curriculum (Morrison, 2020), and knowing how to grade (e.g., by providing an example) (Roberts et al., 2013). Specific

orientation topics identified as essential were faculty tools and resources, accessing the website/instructional software, student clinical policies, referrals to remediation, description of nursing courses, correlation of theory and clinical, and role in clinical simulation (Davidson & Rourke, 2012). Additional needs identified by novice part-time faculty were handling student issues, using technology, and improving lab skills (Owens, 2017). Part-time faculty identified course leads as important support people and preferred face-to-face orientation and online support for training (Morrison, 2020). New adjunct faculty identified the following topics as very important but omitted or insufficiently discussed during orientation: resources, referrals, grading, evaluation, equipment, job description, and choosing assignments (Sousa & Resha, 2019). Specific learning needs identified by adjunct faculty were examples of strategies for teaching and handling student problems (Paul, 2015). Administrators identified the needs of part-time faculty as knowledge of curriculum, student development, and student outcomes (Meyer, 2017).

In 2005, the NLN developed eight competencies for academic nurse educators based on their scope of practice (NLN, 2024b). The primary content areas of the competencies are facilitating learning, facilitating learner development and socialization, using assessment and evaluation strategies, participating in curriculum design and evaluation of program outcomes, functioning as a change agent and leader, pursuing continuous quality improvement in the role of the nurse educator, engaging in scholarship, and functioning within the educational environment (NLN, 2022). Researchers have also used the Quality and Safety Education for Nurses (QSEN) Framework for orientation topics (Schaar et al., 2015). Schaar et al. (2015) proposed to design orientation using the Quality and Safety Education for Nurses (QSEN) competencies to deliver an onboarding orientation model for new adjunct clinical faculty. For each QSEN competency, orientation topics, learning objectives for new faculty, and orientation activities were offered.

This model is a template for onboarding new adjunct clinical faculty, thus lessening role-transition stressors (Schaar et al., 2015).

Orientation Delivery Methods

Orientation delivery methods for nursing faculty encompass face-to-face, hybrid, and online components. Other terms used are classroom or traditional for face-to-face, blended for hybrid, and web-based for online. The types of delivery methods used have been described in nursing faculty orientation literature; however, empirical research on their effectiveness on different measurable outcomes is limited.

First, the literature describing the state of the evidence on delivery method is presented. Carlson's (2015) cross-sectional study of 553 part-time clinical nursing faculty described orientation practices in undergraduate nursing programs according to orientation format. With an author-created instrument, 54% of part-time nursing faculty reported that their orientation was provided in a classroom setting (Carlson, 2015). Additional program evaluations of orientation with pretest, posttest designs, and program development studies have provided further information about part-time and adjunct faculty orientation. Methods of delivery of orientation training for adjunct and part-time nursing faculty included face-to-face (Dunker & Manning, 2018; Reid, 2013; Rice, 2016), web-based discussions and activities (Reid, 2013), simulations (Reid, 2013), and blended programs offering both face-to-face and online modules (Hinderer et al., 2016).

Limited research has been conducted on the delivery method as a predictor of any outcome of nursing faculty orientation. The delivery method of orientation can influence employee learning and performance. To report the effectiveness of the delivery method on learning outcomes, literature outside of nursing education was reviewed. In general employee

training, eLearning offers flexibility and cost-effectiveness for technical skills. At the same time, traditional classroom or blended approaches may be better suited for soft skills development, enabling organizations to enhance engagement, and job satisfaction through tailored training programs (Nayak, 2024). In undergraduate students, Alzahrani (2019) compared synchronous (real-time) and asynchronous (self-paced) synchronous distance learning methods among 49 freshman female students at the University of Ha'i in Saudi Arabia. The findings indicated significant differences in performance and perception between the two groups ($p < 0.001$), with the blended model group achieving better performance and outcomes, suggesting that the mode of content delivery influences learning effectiveness.

Insights about effective approaches to preparing clinical adjunct faculty can also be gained from studies related to strategies used to facilitate student learning. With nursing students, Perez et al. (2022) compared course performance outcomes when teaching foundational nursing courses using blended learning (a combination of online and face-to-face instruction) versus traditional face-to-face instruction with 90 and 89 sophomore students, respectively. No significant differences were found between the two modalities in exam grades ($p = 0.20$) or final course grades ($p = 0.08$), indicating that blended learning is a valuable strategy for teaching foundational nursing courses. Also, with nursing students, in a systematic review evaluating the impact of online or blended learning versus face-to-face learning of clinical skills in undergraduate nurse education, McCutcheon et al. (2015) found that online learning for teaching clinical skills is no less effective than traditional means. The types of e-learning interventions varied throughout the 19 studies and with 17 using online approaches and two reporting on a blended approach. Although not specific to employee training, Khatony et al. (2009) completed a quasi-experimental pretest-posttest study comparing web-based and traditional face-to-face

methods in educating 140 nurses working in hospitals in Iran. The web-based education included learning materials about Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). They found no significant differences in knowledge improvement between the two groups ($p = 0.163$), suggesting that online education can be as effective as in-person instruction for specific topics.

In a scoping review of 17 articles, Smith et al. (2023) identified that faculty development programs in nursing and midwifery often focus on learning and teaching approaches, leadership, research, and assessment practices. These programs are typically delivered through blended methods combining online and face-to-face interactions. However, evaluations have relied on self-reported measures of satisfaction and confidence, lacking longitudinal assessments of their relationship with educational practice and student outcomes. With a pretest-posttest design, Roman (2018) utilized an online platform to deliver education to 37 new and experienced clinical faculty. Learning modules were asynchronous, and discussion boards were set up for learners to communicate after the educational activities. Self-reported knowledge gained about their role as clinical faculty improved significantly ($p < .05$), indicating success with this delivery method of education. This study did not compare delivery methods.

With nurses and nurse educators, studies of delivery method of instruction related to orientation and professional development have varied in their methodology, with most using pretest-posttest design to measure knowledge gained. In summary, while various orientation delivery methods are employed to educate nursing faculty, there is a pressing need for more comprehensive research to determine the optimal delivery methods and appropriate duration of these programs to maximize their effectiveness.

Orientation Length

Multiple studies have reported on orientation length in clinical faculty in nursing education. Ross and Dunker (2019) completed a literature review of clinical faculty orientation methods to obtain relevant information and research findings about new clinical nurse faculty orientation. Results included that face-to-face orientation lasted one hour to one week.

Most orientation and professional development studies of part-time nurse educators identified the orientation length in hours (Johnson, 2016; Roman, 2018). In Carlson's (2015) cross-sectional survey of 553 part-time faculty, respondents reported an average of four hours of orientation, with close to half (47%) receiving up to two hours. Research on the length of orientation programs for part-time clinical nursing faculty is limited, and there is no consensus on optimal duration. In an integrative review of 48 articles, Rogers et al. (2020) emphasized that nursing faculty orientations vary in length, content, and comprehensiveness, which may influence faculty effectiveness and retention. Across the literature, orientation length has ranged from four hours (Dunker & Manning, 2018) to 30 hours (Hinderer et al., 2016). Johnson (2016) implemented a 4-hour faculty development workshop for clinical adjunct faculty in nursing and collected pre- and post-test self-reported knowledge gained on clinical evaluation of students. Although this study was not specific to orientation to the role of clinical adjunct faculty and the competencies associated with the role, it provides some insight into the length of professional development activities with clinical adjunct faculty employed two years or longer. A limitation of this study was that only knowledge gained was measured. Additionally, with a pretest-posttest design, Roman (2018) utilized six online modules based on a needs assessment and 37 faculty were expected to spend approximately one hour per module for six hours (Roman, 2018). Roman (2018) reported a significant change ($p<0.05$) in participants' knowledge of clinical teaching

after completion of the modules. No studies were identified comparing different lengths of orientation with the same delivery method and their effectiveness with nursing faculty or other populations.

Confidence

The outcome variable for this study is confidence in the skill acquisition of clinical adjunct faculty. Confidence is the foundation for action, and is an affective outcome that will influence the behavior of nurse educators. Bandura (1986) defined self-efficacy as confidence in one's ability toward specific task accomplishments. Although confidence and self-efficacy are separate concepts, the literature reports on both in nursing education. Antecedents of self-efficacy include social experiences and mastery experiences (Zulkosky, 2009). In a concept analysis of self-efficacy, Zulkosky (2009) defined self-efficacy as a person's judgment of capabilities to perform a particular activity to attain a specific outcome. Self-efficacy is a conscious awareness of one's ability to be effective and to control actions (Zulkosky, 2009). Likewise, Bourne et al. (2021) defined clinical teacher self-efficacy as the clinical teachers' beliefs in their capabilities to make a positive difference in student engagement and learning in the clinical setting, even with difficult or unmotivated students. The confidence of faculty is important because it can lead to better performance as a faculty member in teaching and evaluating students, leading to better student learning outcomes. Literature that explains any predictive relationship between orientation and confidence is described in the next section.

Orientation and Confidence

Concerning clinical nursing faculty, confidence in clinical teaching starts with learning about the role, which can be described as role orientation. While no data have been reported to date related to the delivery method and length of orientation and their relationship to confidence,

researchers have measured confidence before and after faculty development activities for nurse educators. Roman (2018) developed an online learning community to provide initial and ongoing education for novice and experienced clinical instructors through professional development using asynchronous learning modules and discussion boards. She measured perceived confidence and knowledge gained with a sample of 37 clinical faculty and found a significant difference between novice and experienced clinical faculty members' self-reported confidence before the educational program ($p < 0.05$). These results confirm that an initial education program can increase confidence in novice clinical faculty. The limitations of this study included the fact that the tool for confidence was not well developed.

Similarly, Hunt et al. (2015) implemented a professional development simulation experience for 26 new and experienced clinical faculty related to assessing students during simulation to prepare them for the clinical instructor role and increase their confidence. In an author-created survey, all 26 clinical instructors agreed or strongly agreed that the clinical simulation had increased their confidence in guiding students' critical thinking and handling potentially unsafe situations at the bedside without alarming the patient (Hunt et al., 2015). A limitation of this study was using an author-created survey to measure confidence that had not been adequately validated, and the confidence was only measured post-intervention.

In a study focused on nurse educators but not specific on clinical faculty, Garner et al. (2018) implemented a faculty development workshop and assessed the self-efficacy of teaching for nurse educators using a pretest-posttest design. The purpose of the study was instrument development and validation. The Self Efficacy Towards Teaching Inventory for Nurse Educators (SETTI-NE) was validated with 87 faculty from 20 nursing schools in India. The intervention was an 8-hour faculty development workshop on simulation and included didactic,

demonstration, and hands-on training for nurse educators. The results showed a significant ($p < 0.001$) improvement in self-efficacy in using simulation to help students learn after the workshop. The total score percent change was a mean of 17 percent. The sample consisted of nurse educators and did include clinical faculty, but it was not focused solely on them. The results provided additional evidence that education about the role of the teacher can improve levels of confidence as teachers.

In an additional study of clinical nurse educators, Nguyen (2018) used a cross-sectional design to study preparation strategies in 334 clinical nurse educators and how they predict confidence in skill acquisition in Vietnam. The researchers measured perceived confidence in skill acquisition as a clinical educator to identify which preparation strategies assisted in developing confidence in clinical teaching. A new tool was used for this study. In 2012, Ramsburg and Childress used the NLN Nurse educator competency statements and the Dreyfus Skill Acquisition Model to validate a survey tool called Nurse Educator Skill Acquisition Assessment (NESAA). In 2017, Nguyen et al. adapted the NESAA to focus on clinical nurse educator competencies. Nguyen et al. (2017) reduced the number of items from 40 to 24 and the number of domains from 8 to 5 and validated the instrument with 138 clinical nurse educators in Vietnam. The new tool was named Clinical Nurse Educator Skill Acquisition Assessment (CNESAA). Formal preparation of the clinical nurse educator, defined as structured and planned instruction, predicted self-reported perceived confidence using regression analysis ($p= 0.04$) (Nguyen et al., 2018). Although this study did show a correlation between formal preparation and the confidence of clinical nursing faculty, it did not compare preparation methods or length and the confidence of those faculty.

Years of Teaching Experience and Confidence

The years of teaching experience of clinical adjunct faculty are expected to influence their confidence based on theory and literature in nursing and other disciplines. Many factors influence self-efficacy, but mastery experiences are its principal source (Bandura, 1986). By mastery experiences, Bandura meant a person's performance accomplishments in an activity domain. High levels of accomplishment raise personal efficacy and provide the confidence and resilience to face challenging tasks (Bandura, 1986). The more time one spends experiencing the role of a position, the more awareness one has of the role's requirements.

Since limited research has been completed with clinical adjunct nursing faculty, insights can be gained from studies of teachers in other disciplines. In the historical literature on K-12 teachers, Tschannen-Moran et al. (2007) thoroughly reviewed over 80 teacher efficacy and experience studies. They concluded that there is a moderate positive relationship (r = 0.30 to 0.45) between years of teaching experience and self-efficacy. A more recent systematic review and meta-analysis by Duan et al. (2024) focused on confidence in a specific K-12 teaching skill of classroom management as the dependent variable. In 29 studies, years of working experience as a teacher had a statistically significant relationship with confidence in classroom management ($p < 0.05$) using a random effect model (Duan et al., 2024).

In nursing education literature, several researchers have explored the relationship between years of teaching experience and confidence. In their 1999 study on teacher self-efficacy in new nurse educators, Nugent et al. surveyed 50 novice nurse educators from accredited associate degree and baccalaureate programs in the Great Lakes region. The authors reported a statistically significant moderate and positive correlation between the length of time in the teaching role and teacher self-efficacy, with Pearson's $r = .46$ and $p < .001$. The study further

highlighted that “practice or experience” in the educator role was the primary factor influencing the development of self-efficacy. These findings underscore the importance of providing novice educators with supportive, hands-on teaching experiences and mentorship early in their academic careers to foster growth in self-efficacy (Nugent, 1999).

More recently, in Korea, Kim and Shin (2017) completed a cross-sectional study of 263 registered nurses in clinical practice education to identify factors that influence nurses’ teaching efficacy. Kim and Shin (2017) used Hwang’s questionnaire to measure teaching efficacy and the Clinical Nurse Teacher Survey to measure perception of clinical practice education. The demographic of clinical teaching experience was asked as a yes or no question. Participants with teaching experience had a mean teaching efficacy score of (M=72.5) compared to participants with no clinical teaching experience (M=70.8) had significantly higher ($p < 0.001$) teaching efficacy scores. In Vietnam, Nguyen et al. (2018) surveyed 334 clinical nurse educators to measure the effect of professional background on perceived confidence levels. Years of clinical teaching experience positively influenced ($p<0.001$) perceived confidence level as measured by the CNESSA. Goodrich (2014) surveyed 535 registered nurses across the United States using the Career Transitions Inventory to measure confidence among other variables. The number of years in the academic nurse educator role was not significantly related ($p=0.484$) to confidence in this sample using between subjects testing. Garner et al. (2018) surveyed 87 nurse educators to investigate relationships between faculty sociodemographic and the degree of self-efficacy in teaching using the Self-Efficacy Towards Teaching Inventory. Years of nursing education experience did not have a significant relationship ($p=0.14$) using the Kruskal-Wallis test for continuous variable with faculty perceived self-efficacy increase from before to after an 8-hour simulation workshop intervention.

Mentoring and Confidence

Another variable predicted to influence confidence is participation in a formal mentoring program. In addition to orientation, some employers offer formal mentoring programs to enhance faculty support and socialization in the nurse educator role. Mentoring and orientation are distinct but complementary processes in professional development (Gies, 2013). Orientation is a structured, time-bound process designed to familiarize new individuals with organizational policies, procedures, and roles, focusing on immediate onboarding and operational readiness (Reio, 2002). In contrast, mentoring is a long-term, relationship-driven process where a more experienced individual provides personalized guidance, support, and career development to a less experienced individual, addressing broader professional growth and integration (Kram, 1985). While orientation equips individuals with the foundational knowledge to begin their roles (teaches knowledge, skills, and behaviors to prepare for a role and improve performance for a role), the focus is skill acquisition and role-specific competencies. Mentoring fosters deeper engagement and development over time, often addressing challenges and goals beyond the scope of initial onboarding. Mentoring complements orientation and can enhance skill acquisition and confidence (Busby et al., 2023). It is important to note that both processes are essential in nursing education. Orientation ensures that new nurses are prepared to meet the immediate demands of their roles, while mentoring supports their continuous professional development and long-term success in the field. Understanding the distinction between these two processes allows educational institutions and healthcare organizations to implement effective programs that address both the immediate and ongoing needs of nursing professionals (National League for Nursing [NLN], 2006).

Mentoring has been identified as foundational in the transition to the role of clinical nursing faculty (Nick et al., 2012). Mentoring clinical adjunct nursing faculty involves providing guidance, support, and expertise. Mentorship can include helping adjunct faculty develop teaching strategies, navigate challenges in clinical settings, and provide constructive feedback (Geis, 2013). Two studies that addressed mentoring as a training method for new clinical adjunct faculty are described (Carlson, 2015; Knowles, 2020). Mentoring can be formal or informal, and multiple models can be used to set up mentoring programs. In Carlson's (2015) cross-sectional study of 553 part-time clinical faculty, mentoring as training referred to a specific set of assessed events, such as being helped in meeting career goals, being listened to, and receiving feedback, advice, encouragement, and stimulation. The majority of respondents in Carlson's study reported receiving some form of mentoring, with the two most frequently reported mentoring events being the receipt of feedback and the receipt of encouragement (Carlson, 2015). Similarly, Knowles (2020) described the components and support needed to initiate a mentoring program during the transition to the faculty role in a review of mentoring best practices in nursing education. Five formal mentoring models were described: dyad, peer, group, constellation, and distance mentoring (Knowles, 2020). The traditional dyad mentorship model is when the mentee is paired with a more experienced mentor (Nowell et al., 2017). The peer mentorship model is two or more faculty as equal partners to achieve mutually determined goals. Group mentorship models involve one mentor supporting a group of mentees. A constellation mentoring model is when one mentee has more than one mentor. With distance mentoring, communication is via email, telephone, or online video conferencing (Nowell et al., 2017).

Theoretical Framework

Transitions theory is a framework used to describe the transitional experience and was selected to guide this study due to the inclusion of several key concepts (preparation, knowledge, and confidence). Transitions can be different stages, milestones, or turning points (Meleis, 2010). Transitions theory is a middle-range theory in nursing. The theoretical model describes specific phenomena of the transition process and guides practice and research questions (Meleis et al., 2000). Transitions theory explains the transition process and can be used to describe the transition of a clinical expert to a novice nurse educator. This theory emphasizes the adaptation process and the factors that influence successful role transitions, including knowledge and confidence. See Appendix A for a visual model of transitions theory.

History of Transitions Theory

In exploring the origination of transitions theory, although Meleis (2000) did not identify a parent theory, transitions theory is described as having foundational concepts from other disciplines such as sociology and psychology. McEwen and Wills (2019) identified role theory as a foundational theory for Meleis' transitions theory. Although role theory was reviewed when exploring adult transitions such as retirement during the literature review, Meleis (2010) did not identify it as a parent theory. It has been used to describe nursing transitions outside of the nurse-patient relationship, such as educational transitions and community changes (Meleis, 2010).

Propositions and Conditions of Transitions Theory

Properties of transition experiences include awareness, engagement, change and difference, time span, and critical points and events (Meleis et al., 2000). When exploring transitional experiences, an assumption was that they were stressful. Transitions theory clearly states the main components to be considered, including the types and patterns of transitions, the

properties of transition experiences, transition conditions, process indicators, outcome indicators, and nursing therapeutics (Meleis et al., 2000). The theory proceeds logically from antecedents to outcomes.

Transition conditions include facilitators and inhibitors to transition (Meleis, 2010). Personal, community, and societal conditions affect transition. Personal conditions include meanings, cultural beliefs and attitudes, preparation and knowledge, and socioeconomic status. Community conditions are described as resources available. Societal conditions could be stereotypes and marginalization. In this study, orientation aligns with the theory concepts of preparation and knowledge. Personal conditions of prior knowledge, learning capacity, and motivation influence how knowledge translates into confidence. For example, someone with prior experience in a similar role might feel more confident than someone entirely new to the context. Environmental conditions in the transition theory of support systems, mentorship, and access to resources during the transition play a crucial role and translate to participation in a formal mentoring program in the study. When knowledgeable mentors or peers guide individuals, they can acquire relevant skills more effectively, boosting their confidence in performing the role. Patterns of response that are progress indicators for healthy transitions include feeling connected, interacting, being situated, and developing confidence. Specific outcome indicators are mastery and fluid integrative identities (Meleis et al., 2000). In Meleis' transitions theory, mastery reflects the attainment of competence and confidence in performing a new role, whereas fluid integrative identities represent the seamless incorporation of that role into one's self concept and professional identity. The key outcome variable in transitions theory that was tested in this study described here was confidence.

Transitions theory is a development process between a state of vulnerability and a state of mastery. It can describe a change in status, such as professional development and new role attainment (Meleis, 2010). This study helped describe the relationship between attaining knowledge and skill as a new clinical nurse educator. Meleis described five types of transitions: Individual developmental transitions, family developmental transitions, situational transitions, health/illness transitions, and organizational transitions.

Situational transitions, including changing professional roles, were the focus of the study described here. Since this study explored the confidence of clinical adjunct faculty and the factors that influenced their confidence, the transition from nurse to nurse educator is the situational transition that was the context of much of this confidence building.

The focus of this research was the preparation of the clinical adjunct faculty for their role, identified as a personal condition by Meleis (2000). Expected patterns of response for healthy transitions include feeling connected, interacting, being situated, and developing confidence. Specific outcome indicators are mastery and fluid integrative identities. For this work, confidence in skill acquisition was measured as the outcome indicator based on its association with teaching effectiveness. Meleis highlighted that transitions involve a process of "becoming." As individuals apply their knowledge through practice, they internalize the skills and behaviors associated with the new role. Success in these efforts reinforces confidence.

Summary

This chapter reviewed the three key areas of clinical adjunct faculty preparation and socialization in their role. Literature on the delivery method and the length of clinical adjunct faculty educational experiences were described. Literature describing mentoring programs for clinical adjunct faculty was reviewed. Literature reviewing years of teaching experience in

clinical faculty was explained. Literature describing these activities and their ability to predict confidence in clinical adjunct faculty was reviewed. Finally, the theoretical framework that guided the study's design was described.

While there is insufficient evidence to conclude that the orientation delivery method, the orientation length, participation in a formal mentoring program, and years of teaching experience predict confidence in clinical teaching, evidence supports that professional development for teachers, including that received during faculty orientation, improves confidence. Most studies in this field have been cross-sectional surveys and pretest-posttest designs measuring different aspects of how confidence is predicted by teaching experience and participation in orientation or a mentoring program. While previous studies have focused on describing the orientation delivery method and length in full-time and part-time faculty, limited research exists on the ability of these two orientation components to predict confidence of clinical adjunct faculty. This dissertation sought to fill this gap by exploring the relationship between them.

CHAPTER 3

METHODOLOGY

This chapter presents the study's methods, including the design, setting, sample, instruments, procedure, and data analysis.

Research Design

A cross-sectional, descriptive, correlational research design was used to study the relationship between orientation format (delivery method and length), years of teaching experience, participation in a formal mentoring program (independent variables), and perceived role confidence.(dependent variable). The study included participants currently employed as clinical adjunct faculty teaching prelicensure baccalaureate students in nursing in the United States of America (U.S.). An electronic survey was administered via email.

Setting

Participants for this study were recruited from schools that offer prelicensure baccalaureate nursing programs in the U.S. that receive accreditation from the Commission on Collegiate Nursing Education (CCNE), Accreditation Commission for Education in Nursing (ACEN), or the NLN Commission for Nursing Education Accreditation (CNEA). Approximately 844 colleges and universities offer accredited prelicensure baccalaureate nursing programs in the U.S. (AACN, n.d.b).

Sample

The convenience sample for this study was clinical adjunct faculty employed at prelicensure baccalaureate nursing programs in the U.S. There were no data reported to date on demographics of clinical adjunct faculty at the state or national level, so full-time and part-time nursing faculty data were used to describe the population. The National Advisory Council on

Nurse Education and Practice (NACNEP) reported that 18.5% of all full-time nursing faculty in the U.S. are racial and ethnic minorities, and 7.1% are male (2021). The NLN Annual Survey of Schools of Nursing (NLN, 2024a) identified 14,546 part-time nurse educators, with 87.57% being female, 10.0% male, 0.01% as transgender, and 2.42% as unknown. The distribution of part-time nurse educators by age from the NLN (2024a) survey reported: 2.9% under age 30, 34.9% age 30-45, 41.1% age 46-60, and 21.1% age 61 and over. Data on race were only reported on full time nurse educators, with 74.7% white non-Hispanic, 11 % African American, 4.8%, 4.6% Hispanic, Asian, 3.3% unknown, 1.3% multiracial, and 0.4% American Indian. These data were reported by deans and directors from each NLN member school and were not specific to clinical faculty or prelicensure baccalaureate programs. In a cross-sectional study of a similar population, 57% of part-time clinical nursing faculty were between 36 and 55, with 94.2% female (Carlson, 2015). In a study of clinical nurse educators who were also nurse practitioners, gender percentages were 86% female and 14% male (Sebach, 2022). There were no data to describe the number of clinical adjunct faculty employed at each institution, and no specific information was available reporting the number of clinical adjunct faculty currently employed in the U.S.

Access to the sample was obtained by emailing the nursing program administrator for each baccalaureate program at the school of nursing and requesting them to forward the invitation to participate to clinical adjunct faculty employed at the institution (see Appendix B for the email to chief nurse administrators). The program administrator for each nursing school was listed on the public website for each accrediting organization (ACEN, CCNE, CNEA). The study's primary investigator (PI) obtained the emails of each nursing program administrator for each school by accessing the public websites. Eight hundred and fifty-five accredited

baccalaureate programs were identified from the CCNE site, 208 programs from the ACEN site, and 15 from the CNEA site for a total of 1,078 programs (ACEN, 2024; CCNE, 2024; CNEA, 2024). See Appendix C for an example of spreadsheet of program administrator information.

The sample for this study was clinical adjunct faculty employed at prelicensure baccalaureate nursing programs in the U.S. Inclusion criteria included an employment status of adjunct, per self-report. Inclusion criteria also included having a current teaching assignment in the clinical setting, including the simulation laboratory. Screening questions were included at the beginning of the survey to ensure that participants met the criteria (see Appendix D). Exclusion criteria included faculty with full-time employment at the nursing school and faculty that have taught in the classroom setting. An additional exclusion criterion was if the faculty member received employment benefits such as insurance, retirement, or travel reimbursement, which would indicate they were not adjunct. Faculty were included if they selected part-time and not eligible for benefits. Only nursing program administrators at schools with baccalaureate programs were contacted by email. The reason for not including associate degree programs in nursing was to reduce heterogeneity in education background of participants.

To analyze the data using multiple linear regression with four predictor variables, a sample of 200 clinical adjunct faculty was needed using 80% power (Polit & Beck, 2021), a significance level of 0.05, and a small to moderate effect size (Faul et al., 2009). This power analysis was conducted with G*Power in collaboration with a biostatistician. Although the a priori power analysis indicated that a minimum sample size of 200 participants was required for adequate statistical power, additional responses were retained because many participants reported not having received any formal orientation, and including these cases strengthened the descriptive aims of the study.

Instruments

Demographic data were collected on all participants using an author-created survey. This survey was reviewed by a panel of five experts in nursing research for content validity. Variables included age, race, ethnicity, gender, highest degree completed in nursing, and years of clinical experience as a nurse. Additional variables collected included state in which they are currently teaching, if the nursing school they teach in is public or private, and how many years of experience they have teaching undergraduate students in the clinical setting. Participants were then asked if they received orientation to the role of clinical faculty and how long ago the orientation occurred. The survey instrument had branched logic so if the participant answered that they did not receive orientation, all of the questions about orientation were bypassed. Next, orientation delivery method was asked with the options of face-to-face, online, hybrid/blended, and do not recall. If the participant answered online or hybrid/blended, they received a question asking if the learning was synchronous, asynchronous, or both. Next, they were asked to provide the duration of orientation to the role in number of hours. Participants were also asked who provided the orientation and what topics were included in the role orientation. Lastly, in this section another independent variable was collected: whether the faculty member participated in a formal mentoring program for the role of clinical faculty (see Appendix D for details).

The final section of the instrument was the CNESAA, and perceived confidence in skill acquisition for the clinical nurse educator role was the outcome measure (Nguyen et al., 2017). The CNESAA is a 24-item instrument that uses a 10-point Likert scale from 0 to 9, with zero meaning not confident at all and nine meaning extremely confident in each described competency. It is a self-report measure of individual confidence level in the competency and not a direct measure of skill performance. Higher scores indicate an increased level of confidence in

the clinical nurse educator competency identified on the instrument. The minimum composite score is 0 and the maximum score is 216. The CNESAA is based on the NLN competencies for clinical nurse educators (NLN, 2024b) including topics of enhancing student learning, relating theory and practice, engaging in scholarship, functioning as a leader, and participating in professional development (see Appendix E for the survey questions and scoring). Permission to use the tool was granted (see Appendix F).

Nguyen et al. (2017) conducted reliability and validity testing on the CNESAA with clinical nurse educators in Vietnam. Internal consistency of the tool was confirmed with a Cronbach's alpha of 0.95. Six-stage exploratory factor analysis was conducted to establish construct reliability of 0.80-0.90 for all domains Inter-item correlations were > 0.30, indicating high reliability and consistency. Face validity was established using four experts in nursing education and practice. The experts used four criteria to review the instrument: relevance, clarity, sufficiency, and appropriateness of each item. Content validity was established by an expert panel (Nguyen et al., 2017).

Procedures

The PI received Institutional Review Board approval from the University of Missouri-Kansas City (UMKC), and it was approved as an exempt study. Schools of nursing were identified by the PI by accessing the CCNE, ACEN and CNEA sites that listed each prelicensure baccalaureate program of nursing accredited by their organization. These sites list accredited nursing schools and the chief nurse administrator for the program, which is usually the dean of the school or college of nursing. Screenshots of examples from each public website are provided in Appendix C.

The PI made initial contact with each nursing program administrator via UMKC email using Microsoft Excel and Outlook. The email message included the identification of the PI and the associated university and the purpose of the study, the inclusion criteria for the study, directions on who to forward the survey to, and the link to the survey. The email also included the requirements for completing the study, that the results were anonymous, and how the participants could stop the survey at any time. Contact information was provided for any questions. Directions to complete the survey on their personal time was requested. It was hoped that the nursing program administrator would then forward the email to clinical adjunct faculty at the school of nursing. It is unknown how many clinical adjunct faculty received the forwarded invitation to participate.

The survey was administered via REDCap (Harris et al., 2009). It presented participants with screening questions, and if they were eligible, they then completed the demographic questions, followed by the CNESAA (Nguyen, 2017) (see Appendix D and E for survey questions). Reminder emails were sent by the PI to the chief nurse administrator asking them to forward it to clinical adjunct faculty at their institution at one week, one month, and two months after the initial email to provide the link for the survey. The survey remained open for 2.5 months,. See Appendix B for the recruitment email that was sent each time. At the end of the survey there was a link to an anonymous survey of one question using Microsoft Forms for the participant to enter their name and email address for a chance to win a gift card with a value of $100 (see Appendix G for the survey question). A total of five gift cards were granted to show appreciation for participation. After the study closed, five names were selected randomly by the PI, and the gift cards were delivered electronically. There was no way to link the name and email

address of the participants to the results of the study survey. The names and email addresses were kept in a password-protected Microsoft 365 account.

The survey did not ask place of employment or any job identifying information to ensure that the participants did not feel their employers would be identified and that employers did not feel that identifying information was being shared. The survey for entering personal information for the gift card raffle was not attached to the survey responses. The raffle entry question also asked for personal email to reduce the chance of employer identification (see Appendix G for survey question screenshot).

Data Management and Analysis

A biostatistician from UMKC was available as a consultant for the PI to confirm interpretation of the results of statistical analyses. The survey was distributed using Microsoft Outlook email, and data were stored within REDCap (Harris et al., 2009), which is a password-protected database. The data were evaluated for normality using visual inspection of histograms and Q–Q plots, along with review of skewness and kurtosis values. Several continuous variables demonstrated non-normal distributions; therefore, non-parametric tests were used where appropriate. Mann-Whitney U tests were conducted for group comparisons, and Spearman's rho correlation coefficients were calculated to assess relationships among continuous variables. The nominal-level demographic data were analyzed using frequencies and percentages. For research questions 1 and 2; [1] ("What is the format [delivery method and length] of clinical adjunct faculty role orientation?" and [2] "What is the level of confidence of clinical adjunct faculty?"), the ratio level demographic data were analyzed with means, standard deviations, and ranges. To analyze the third research question, that of the extent to which delivery method of orientation, length of orientation, years of teaching experience and participation in a mentoring program,

predict confidence in skill acquisition in clinical adjunct faculty, simultaneous multiple linear regression was used. For the regression analysis, all independent variables were entered simultaneously into the model to determine the collective contribution of orientation delivery method, orientation length, years of teaching experience, and mentoring participation in predicting confidence in skill acquisition. This simultaneous-entry approach aligned with the exploratory aims of the study. A simultaneous multiple regression was selected because the study's purpose was exploratory, and the intent was to examine the collective contribution of all predictors without imposing assumptions about their relative importance or order of entry. Statistical Packages for the Social Sciences Version 29 (SPSS) (IBM Corp., 2022) was used to analyze data. An alpha level of 0.05 was used for significance. Two variables needed dummy coding to analyze with regression. For the delivery method, face-to-face communication was coded as the default delivery method, and online and hybrid/blended was coded as 0. For mentoring program, the default option was yes. For years of teaching experience and length of orientation, the data were continuous and captured as a scale variable. No imputation was used for missing data in survey responses, as it was not appropriate (Polit & Beck, 2021). Instead, complete case analysis (Mertler, 2022) was used for missing data for the independent and dependent variables for the regression. The CNESAA composite score was also a continuous variable (see Appendix E).

Human Subjects Protection

To protect the participants from risk, the survey was anonymous. The PI did not notify the employer that the participants had completed the survey. The email to the nursing program administrator included directions to the participants to complete the survey on their own time, and not during work hours to protect their privacy. The HIPAA-compliant REDCap system was

used to collect data, and no identifying information such as place of employment was collected or stored with the data. Digital information collected was stored within REDCap, which is password-protected. Additional measures to protect participants included the data were reported in aggregate,, the study was approved by the Institutional Review Board (IRB) through UMKC , informed consent delivered electronically before data collection, and the PI had human subjects' protections training through Collaborative Institution Training Initiative (CITI).

Summary

This chapter reviewed the study methods including the correlational design, the setting and sample, the instruments and their psychometrics, study procedures, and data analyses. It also discussed protection of human subjects.

CHAPTER 4

RESULTS

Chapter 4 presents results of the study related to recruitment, participant characteristics, clinical adjunct faculty role orientation characteristics, and each of the three research questions.

Recruitment

Recruitment occurred from April 2025 to July 2025. A total of 1,026 baccalaureate nursing program administrators from across the U.S. received four separate emails from the PI over a 10-week period The program administrators were asked to forward the email, which contained links to the study consent and the survey, to the clinical adjunct faculty employed at their baccalaureate nursing program. All or part of the screening questions were completed by 428 faculty, with 257 participants meeting the inclusion criteria and completing the survey. No data have been reported of the number of clinical adjunct faculty employed at nursing schools in the U.S.; therefore no rate of participation of adjunct faculty can be reported.

Participant Characteristics

Demographics

The study participants included 257 adjunct nursing faculty members who were teaching in the clinical setting in the United States. The frequency and descriptive statistics are displayed in Tables 4.1 and 4.2 for categorical and continuous variables, respectively. The mean age was 42.96 years, with a range of 23 to 76 years. The distribution was positively skewed, indicating a smaller number of older participants (see Figure 4.1). Participants were predominantly female 93.4% (n = 240), white 85.2% (n = 219), and not Hispanic or Latino or Spanish Origin 94.9% (n = 244). The most common highest degree obtained was a Master's degree 57.2% (n = 147), and participants' years of clinical experience as a nurse ranged from 2 to 50 years (M = 16.61). The

distribution of years of clinical experience was positively skewed (see Figure 4.2), indicating that participants were clustered near the lower end with less clinical experience. Participants were employed in 37 of the 55 U.S. states and territories, with the largest response from Missouri 11.7% (n = 30), Ohio 8.9% (n = 23), and Oklahoma 7% (n = 18). Most participants reported working in a private institution 56.8% (n = 146) and the range of years of teaching experience in the clinical setting was 0 to 30 years (M = 4.19). The distribution of years of teaching experience in the clinical setting was positively skewed, with more participants having fewer years of teaching experience in the clinical setting. Most of the participants, 94.2% (n = 242) reported not having a formal mentoring program.

Table 4.1

Frequency Statistics of Categorical Variables of Total Sample (n = 257)

Variable		*n* (%)
Race		
	White	219 (85.2%)
	Asian	12 (4.7%)
	Black or African American	11 (4.3%
	More Than One Race	7 (2.7%)
	Unknown/Not Reported	4 (1.6%)
	American Indian/Alaska Native or Native Hawaiian or Other Pacific Islander	4 (1.6%)
Ethnicity		
	Not Hispanic or Latino or Spanish Origin	244 (94.9%)
	Hispanic or Latino or Spanish Origin	13 (5.1%)
Gender		
	Female	240 (93.4%)
	Male	17 (6.6%)
Highest Degree		
	Masters	147 (57.2%)
	Bachelors	92 (35.8%)
	Doctorate	18 (7%)
	State of Employment	
	Missouri	30 (11.7%)
	Ohio	23 (8.9%)

Variable		*n* (%)
	Oklahoma	18 (7%)
	California	17 (6.6%)
	Louisiana	13 (5%)
	Illinois	12 (4.7%)
	Connecticut	11 (4.3%)
	Texas	11 (4.3%)
	Pennsylvania	10 (3.9%)
	Michigan	9 (3.5%)
	Arkansas	8 (3.1%)
	Minnesota	8 (3.1%)
	New York	8 (3.1%)
	Indiana	7 (2.7%)
	Iowa	7 (2.7%)
	Maryland	7 (2.7%)
	Tennessee	7 (2.7%)
	Colorado	6 (2.3%)
	Massachusetts	6 (2.3%)
	New Jersey	5 (1.9%)
	South Dakota	5 (1.9%)
	Idaho	4 (1.6%)
	North Carolina	4 (1.6%)
	Maine	3 (1.2%)
	Georgia	2 (0.8%)
	Nebraska	2 (0.8%)
	Oregon	2 (0.8%)
	Rhode Island	2 (0.8%)
	Florida	1 (0.4%)
	Kansas	1 (0.4%)
	Kentucky	1 (0.4%)
	North Dakota	1 (0.4%)
	South Carolina	1 (0.4%)
	Utah	1 (0.4%)
	West Virginia	1 (0.4%)
	Wisconsin	1 (0.4%)
	Wyoming	1 (0.4%)
	Puerto Rico	1 (0.4%)
Type of institution		
	Private	146 (56.8%)
	Public	111 (43.2%)
Participation in Mentoring Program		
	No	242 (94.2%)
	Yes	15 (5.8%)

Table 4.2

Descriptive Statistics for Continuous Demographics of Total Sample (n = 257)

Variable	*n*	Min	Max	Mean	SD	Median	Skewness	Kurtosis	*Normality
Years of Clinical Exp. as a Nurse	257	2	50	16.61	11.04	14	0.95	0.27	< .001
Years of Teaching Exp. in Clinical Setting	257	0	30	4.19	4.59	3	2.41	7.39	< .001

Note: Normality is the p value of Shapiro Wilks test. Exp. = experience

Figure 4.1

Histogram for Age (n = 257)

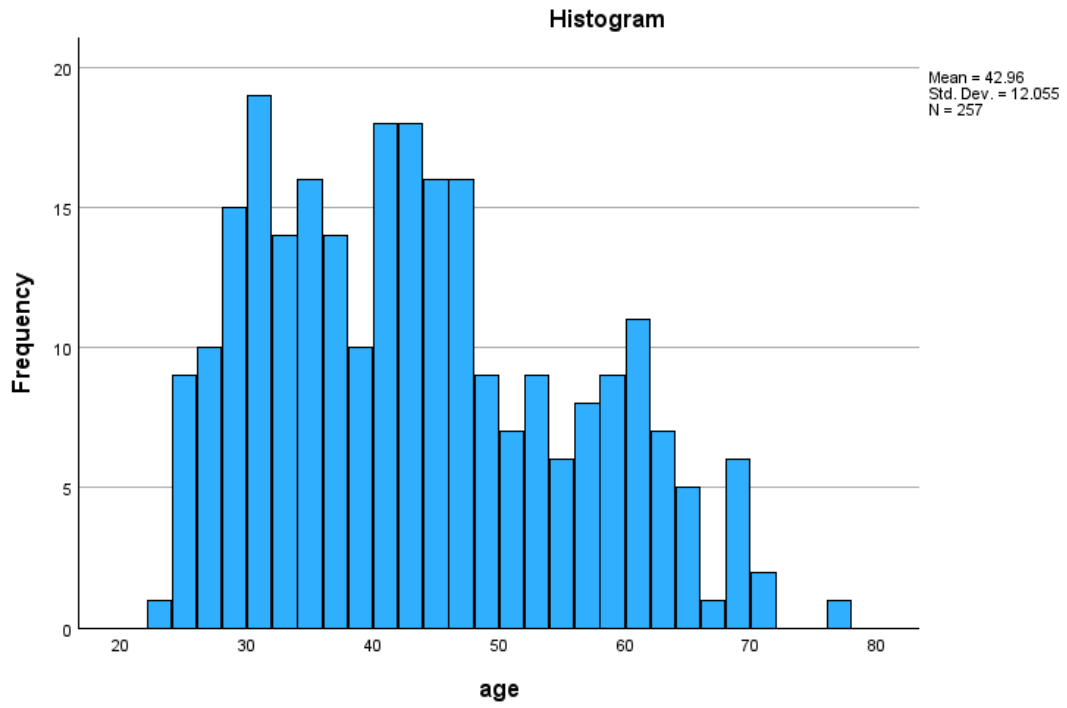


Figure 4.2

Histogram for Years of Clinical Experience as a Nurse (n = 257)

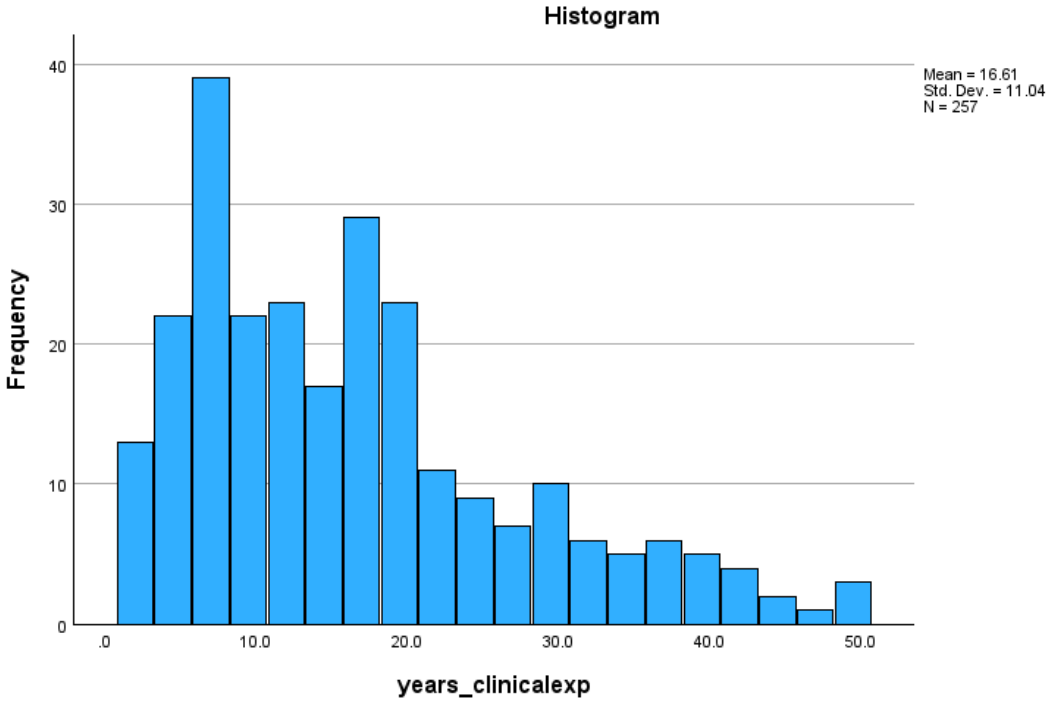
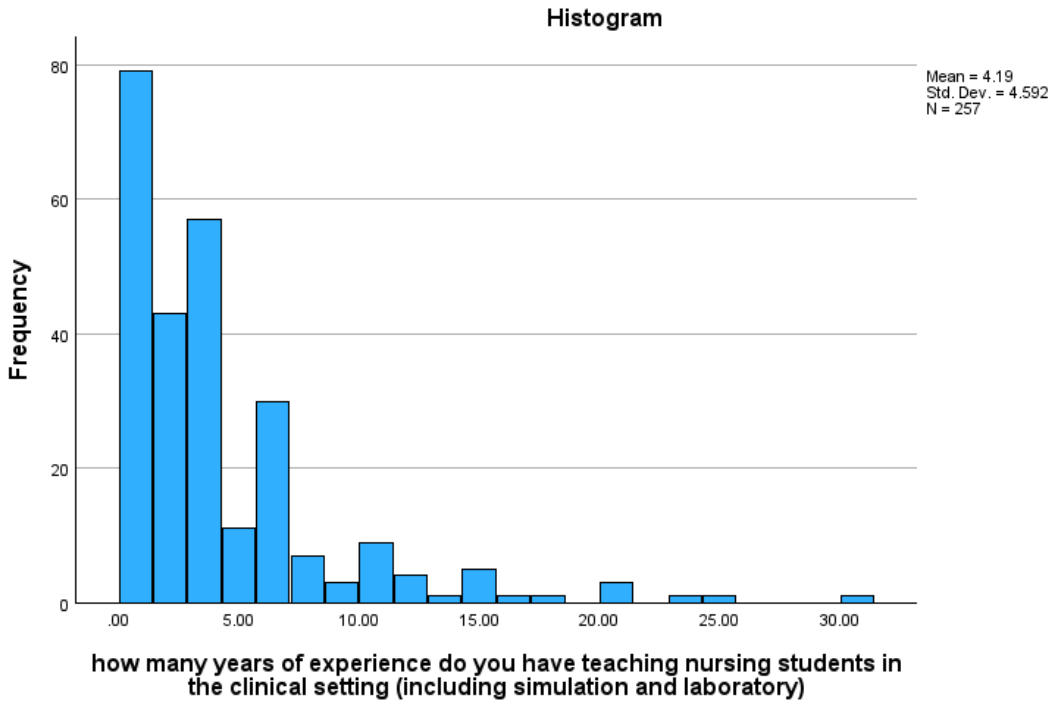


Figure 4.3

Histogram for Years of Experience Teaching in the Clinical Setting (n = 257)



Orientation to the Role of Clinical Adjunct Faculty

More than half of the participants, 53.3% (*n* = 137), reported having an orientation to the role of clinical faculty, with 136 of those participants reporting the orientation occurred between 0 and 143 months ago (*M* = 13.88) and the most common orientation delivery method being face-to-face 65.4% (*n* = 89). The distribution of time since orientation was positively skewed, indicating that the participants were clustered with less time since orientation (see Figure 4.4). Of the participants who reported an online or hybrid/blended orientation delivery method 32.3% (*n* = 44), the most common reported type of online orientation delivery was synchronous at 45.5% (*n* = 20). The reported length of orientation ranged from 0.5 to 48 hours (*M* = 6.07). The most common type of instructor from the orientation was faculty at 82.5% (*n* = 113). The distribution

of the length of orientation was positively skewed (see Figure 4.5), indicating that more participants received fewer hours of orientation. The most common orientation topic reported was teaching and learning strategies for clinical settings at 78.1% (*n* = 107). Additional orientation topics reported in the open-ended option section included: college expectations, learning platforms, grading, problem solving, policies, and simulation.

Table 4.3

Frequency Statistics of Categorical Variables of Orientation Characteristics

Variable	***n* (%)**
Orientation to role, *n* = 257	
Yes	137 (53.3%)
No	120 (46.7%)
Delivery Method of Orientation, n = 136	
Face-to-face	89 (65.4%)
Hybrid/blended	29 (21.3%)
Online	15 (11%)
Do not recall	3 (2.2%)
Type of online orientation, n = 44	
Synchronous	20 (45.5%)
Asynchronous	15 (34.1%)
Both	9 (20.5%)
Instructor for orientation n = 137	
Faculty	113 (82.5%)
Administrator (Dean, Assistant Dean, Director)	53 (38.7%)
Hospital Staff	17 (12.4%)
Do not recall	6 (4.4%)
Other	2 (1.5%)
Orientation Topics, n = 137	
Teaching and learning strategies for clinical settings	107 (78.1%)
Linking clinical placement and curriculum outcomes	64 (46.7%)
Opportunities for engagement in professional development	30 (21.9%)
Functioning as a leader in nursing education	55 (40.1%)
Other	19 (13.9%)
Engaging in scholarship as a clinical faculty	15 (10.9%)

Table 4.4

Descriptive Statistics for Continuous Characteristics of Orientation

Variable	*n*	Min	Max	Mean	SD	Median	Skewness	Kurtosis	*Normality
Time since last orientation (months)	136	0	143	13.88	21.41	6	3.05	11.55	< .001
Length of orientation (hours)	132	0.5	48	6.07	7.67	4	3.53	13.924	< .001

*Normality is the p value of Shapiro Wilks test

Figure 4.4

Histogram for Time since Orientation in Months (n =136)

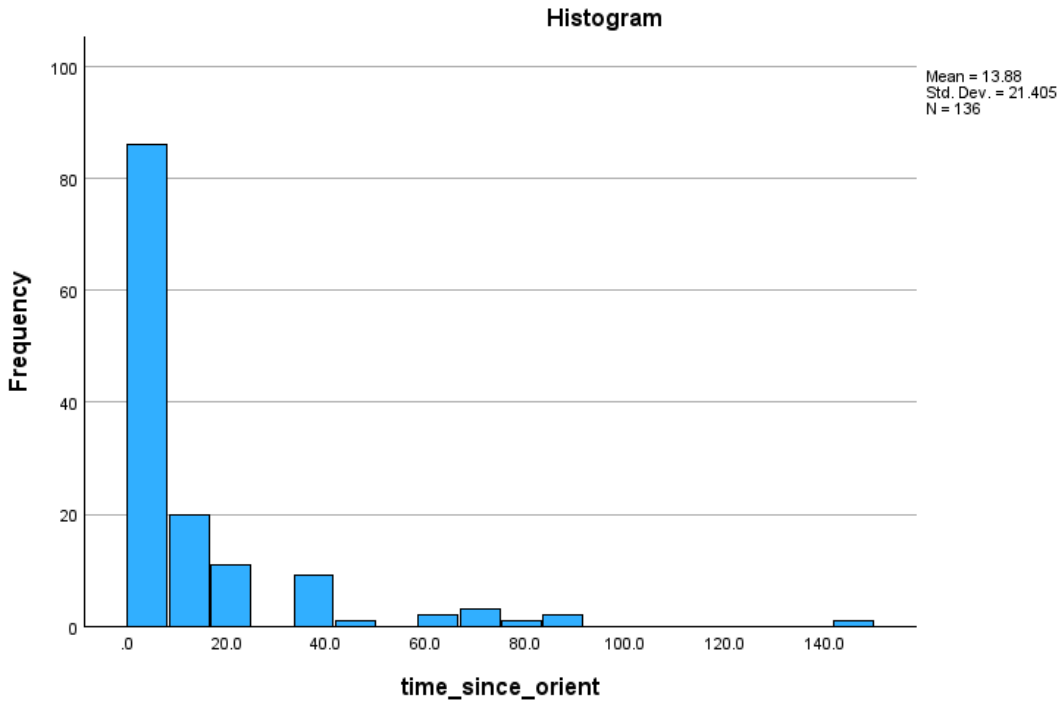
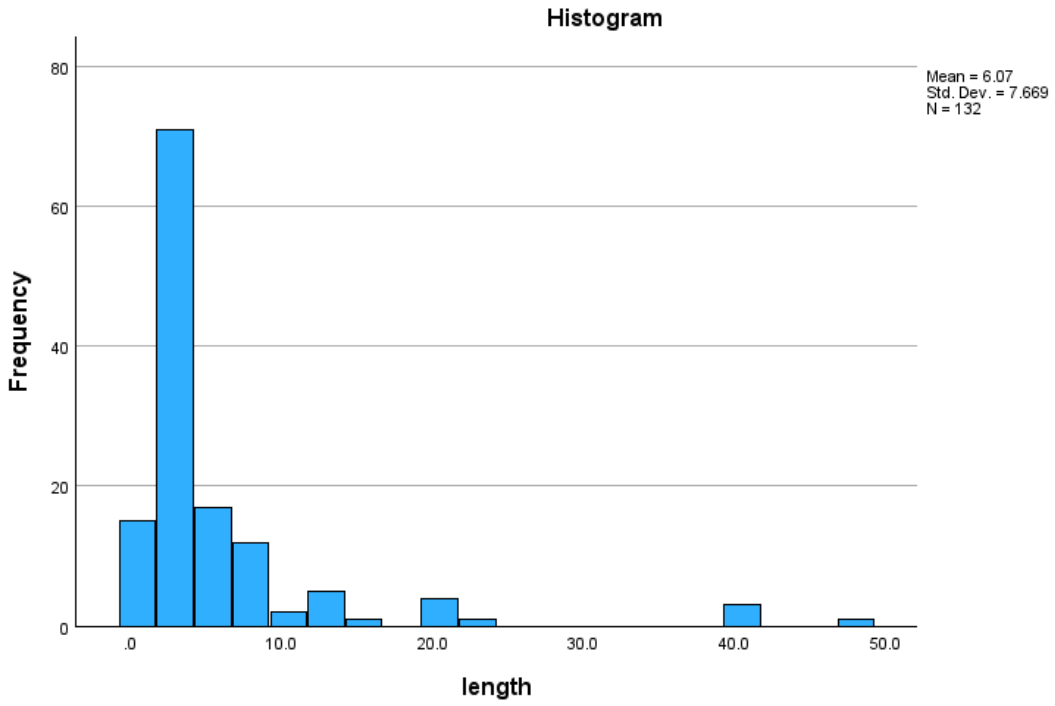


Figure 4.5

Histogram of Length of Orientation (n=132)



Research Question 1

What is the format (delivery method and length) of orientation of clinical adjunct faculty in prelicensure baccalaureate programs in the U.S.? To answer this research question, descriptive statistics were calculated and reported in Table 4.3 and Table 4.4. Of the 257 participants, 53.3% (n=137) reported having orientation to the role of clinical adjunct faculty. Of the participants who reported having orientation, participants predominantly had a face-to-face delivery method 65.4% (89/136). Fifteen participants reported online delivery method (11%), and 29 reported hybrid/blended delivery method (21.3%). Of those participants who reported online or hybrid/blended (n=44), 20 reported synchronous delivery (45.5%), 15 reported asynchronous delivery (34.1%), and nine reported both synchronous and asynchronous delivery (20.5%). Three

participants reported they did not recall the delivery method of orientation (2.2%). Of the 37 participants who reported having orientation, the mean length of orientation was 6 hours (SD = 7.67), with a range of 0.5 to 48 hours.

Research Question 2

What is the confidence level in skill acquisition of clinical adjunct faculty in prelicensure baccalaureate programs in the U.S.?

Descriptive statistics were used to report the results of the sample (see Table 4.5 for these results). Two hundred and forty-four clinical adjunct faculty completed all or some of the CNESAA, which measured confidence in skill acquisition and has a minimum score of 0 and a maximum score of 216. Eight did not complete the CNESAA fully, so no composite score could be calculated. The Cronbach's Alpha from all respondents (n=236) was 0.76, indicating that participants responded in a consistent manner. The confidence in skill acquisition of the participants ranged from 65 to 216 (M= 157.27). The distribution of the CNESAA scores was negatively skewed, indicating that participants' scores were clustered on the higher end of the scale, indicating more confidence in skill acquisition (see Figure 4.6). Results from individual items on the CNESAA are reported in Table 4.6.

Table 4.5

Descriptive Statistics of CNESAA Composite Scores (n=236)

Variable	N	Min	Max	Mean	SD	Median	Skewness	Kurtosis	*Normality
CNESAA Composite Score Scale (0-216)	236	65	216	157.27	33.84	162	-.45	-.31	< .001

Note. *Normality is the p value of Shapiro Wilks test.

Figure 4.6

Histogram of CNESAA Composite Scores (n=236)

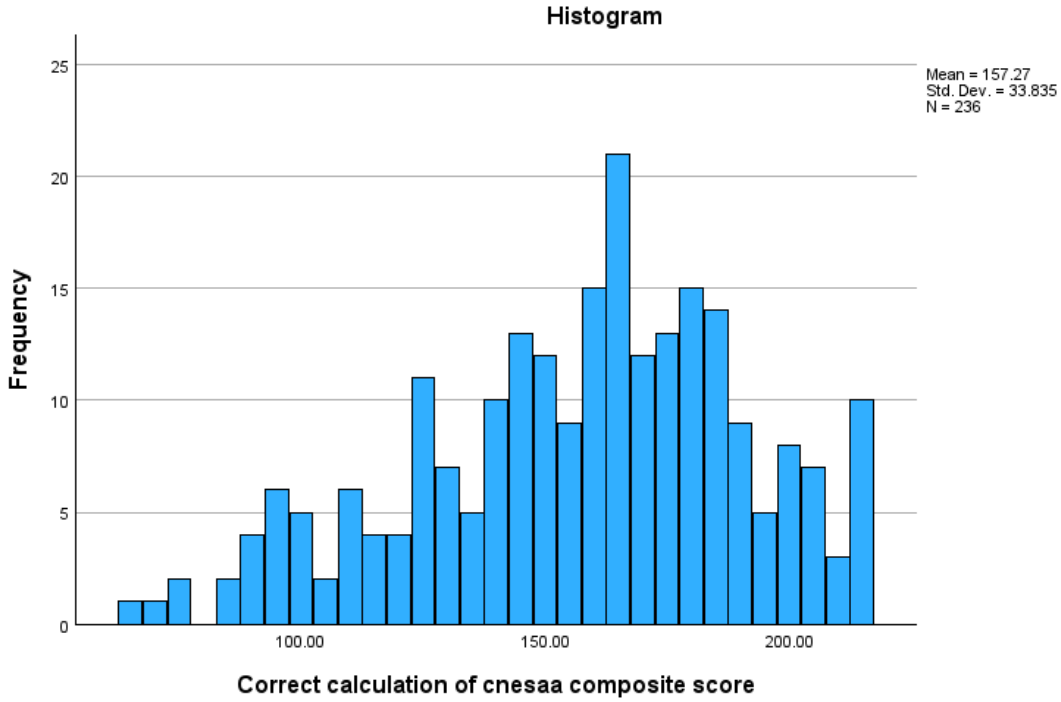


Table 4.6

Descriptive Statistics of Individual Items of CNESAA Responses

Variable	N	Min	Max	Mean	SD	Median	Skew	Kurtosis	*Normality
Enhancing Student Learning									
Designing new teaching strategies to improve quality of clinical education.	244	0	9	5.92	2.00	6	-0.437	-0.21	<.001
Designing learning opportunities to facilitate student socialization to clinical settings.	244	0	9	6.41	1.88	7	-0.79	0.58	<.001
Selecting appropriate teaching strategies to facilitate effective student learning.	244	0	9	6.55	1.79	7	-0.93	1.10	<.001
Developing a plan to assist students who have clinical learning difficulties.	244	0	9	5.85	2.14	6	-0.50	-0.48	<.001
Selecting assessment strategies that are effective and appropriate to different clinical situations.	244	0	9	6.42	1.76	7	-0.59	0.15	<.001
Providing timely and constructive feedback to students in clinical settings.	244	2	9	7.32	1.58	8	-1.09	0.97	<.001
Using assessment and evaluation data to enhance the clinical teaching process.	244	0	9	6.77	1.74	7	-.075	0.47	<.001
Relating Theory and Practice									
Understanding the links between different clinical placements within the course curriculum.	242	0	9	6.19	2.046	6	-0.67	-0.03	<.001

Variable	N	Min	Max	Mean	SD	Median	Skew	Kurtosis	*Normality
Understanding overall curriculum design and clinical placement design.	242	0	9	6.02	2.055	6	-0.50	-0.47	<.001
Understanding how clinical placement objectives meet curriculum objectives.	242	0	9	6.36	2.021	7	-0.85	0.42	<.001
Identifying teaching opportunities that meet clinical placement objectives.	242	0	9	6.68	1.834	7	-0.77	0.32	<.001
Engaging in Scholarship									
Using evidence and clinical knowledge to plan clinical teaching/learning activities.	239	0	9	6.94	1.729	7	-1.03	1.67	<.001
Participating in scholarly activities as a team member.	239	0	9	5.69	2.309	6	-0.56	-0.41	<.001
Designing and implementing research in the area of expertise.	239	0	9	5.00	2.501	5	-0.17	-0.98	<.001
Disseminating new information about nursing practice and education to colleagues and students.	238	0	9	6.24	2.137	7	-0.68	-0.19	<.001
Collaborating to influence development of nursing within academic and clinical settings.	238	0	9	6.16	2.165	6	-0.56	-0.32	<.001
Functioning as a Leader									
Identifying own leadership style as a clinical nurse educator.	236	1	9	7.16	1.66	7	-1.08	1.10	<.001
Serving as a mentor to students, new clinical educators and/or new nurses in clinical settings.	236	2	9	7.57	1.42	8	-1.13	1.27	<.001

Variable	N	Min	Max	Mean	SD	Median	Skew	Kurtosis	*Normality
Balancing academic commitments (clinical teaching, classroom teaching, scholarship and clinical practice).	236	0	9	6.67	1.95	7	-0.90	0.58	<.001
Building the climate of respect, collegiality, professionalism, courage and caring within your institution and clinical settings.	236	0	9	7.68	1.40	8	-1.56	3.81	<.001
Promoting change in clinical nursing education.	236	0	9	6.51	2.13	7	-0.80	-0.002	<.001
Participating in Professional Development									
Identifying your own professional development needs.	236	2	9	7.06	1.71	7	-0.89	0.22	<.001
Participating in professional development activities to meet your personal goals	236	0	9	6.89	1.92	7	-0.94	0.39	<.001
Demonstrating improvement of clinical teaching performance based on self-reflection, experience and life-long learning.	236	2	9	7.2	1.61	8	-0.96	0.45	<.001

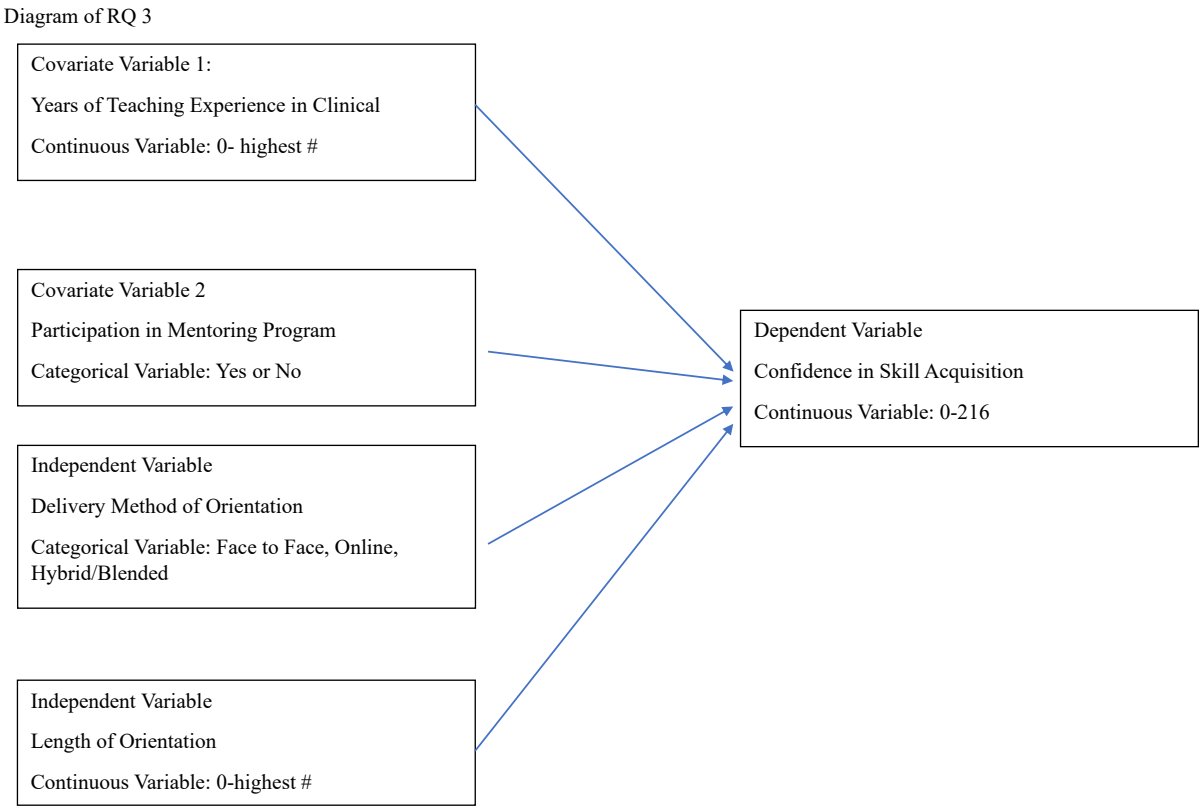
Note. Normality is the p value of Shapiro Wilks test.

Research Question 3

To what extent do length of orientation, delivery method of orientation, years of teaching experience, and participation in a mentoring program predict confidence in skill acquisition in clinical adjunct faculty teaching in prelicensure baccalaureate nursing programs? Figure 4.7 shows the research question displayed in a visual format. There were two hypothesis for this research question: (1) the delivery method of face-to-face orientation will have a more significant impact on the confidence of clinical adjunct faculty than online or blended/hybrid orientation, and (2) more time in orientation will have a greater impact on the confidence of clinical adjunct faculty.

Figure 4.7

Visual Display of Variables for Research Question 3



For this research question, simultaneous multiple linear regression technique was used on complete cases. This model was chosen because there are four predictor variables and one dependent variable (Mertler et al., 2022).

Participants were asked to mark "yes" for orientation to be included as a case. A total of 137 participants responded that they did receive orientation. Of these, 15 cases were removed for various reasons: three for delivery method of "do not recall"; one for missing data for delivery method; one for missing data for length; one because length of orientation was reported in days instead of hours; three because entries of length of orientation were not plausible; and six for incomplete CNESAA. After removing these cases, 122 cases remained for analysis. Table 4.7 presents a descriptive analysis of continuous variables from the sample for research question number 3.

Several steps were taken to determine if assumptions were met for the multiple linear regression (Mertler et al., 2022). These steps included: (1) checking the association of each predictor with the outcome variable; (2) reviewing for a linear relationship between the continuous predictors and the outcome; and (3) determining if there was multicollinearity between the predictor variables. For each association between the independent variable and the dependent variable, the directionality of the relationship, the magnitude, and the statistical significance ($p < 0.05$) were reported.

Mertler et al. (2022) suggested that a minimum of 15 records per predictor variable for a regression is needed to be adequately powered. This requirement was met. Next, scatter plots of each continuous independent variable and the continuous dependent variable were examined to determine if there was a linear relationship (Mertler et al., 2022).

Next, multicollinearity was checked with tolerance statistics to see if the independent variables were highly correlated with each other (tolerance >0.1) (Mertler et al., 2022). If the independent variables are highly correlated with each other, they should not be placed into the regression model together. None of the independent variables were highly correlated with each other, so this assumption was met.

Each independent variable was analyzed for a correlation with the dependent variable. Correlation coefficients were calculated using nonparametric testing, which measured strength and direction of a relationship and if changes in one variable related to changes in another variable. Each test is described in the next section. The regression estimates the impact of each independent variable while controlling for the effect of others. The distribution of the CNESAA scores remained positively skewed in this sample with a non-normal distribution (see Figure 4.8).

Table 4.7

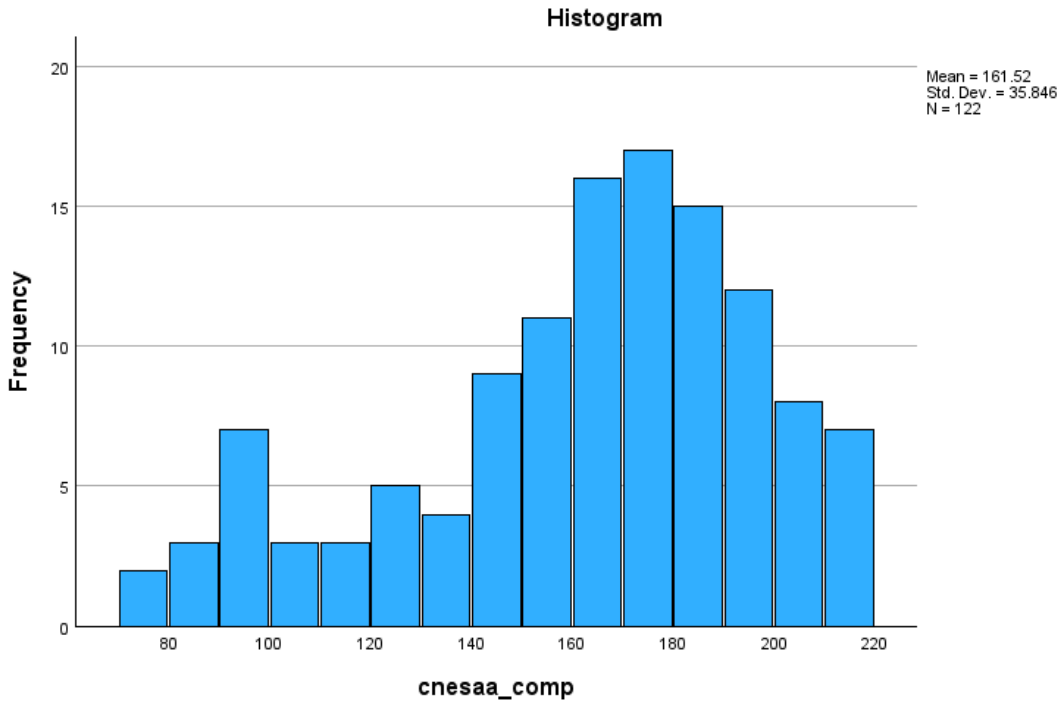
Descriptive Statistics of Continuous Variables for Research Question #3 (n = 122)

Variable	Min	Max	Mean	SD	Median	Skewness	Kurtosis	*Normality
Years of Teaching Experience in Clinical Setting	0	25	4.52	4.55	3	1.87	3.99	<.001
Length of Orientation	0.5	48	6.26	7.94	4	3.39	12.70	<.001
CNESAA Composite Score	72	216	161.52	35.85	167.5	-0.69	-0.27	<.001

Note. *Normality is the p value of Shapiro Wilks test.

Figure 4.8

Distribution of CNESSAA



Years of Teaching Experience

A histogram of the distribution of years of teaching experience in this sample shows a positive skew (see Figure 4.9). A scatterplot of years of teaching experience and CNESAA composite scores shows random scatter (see Figure 4.10). A Spearman's rho indicated a small, positive, yet not statistically significant association between years of teaching experience and CNESAA composite scores, r = .12, p = 0.186 (two-tailed).

Figure 4.9

Distribution of Years of Teaching Experience (n = 122)

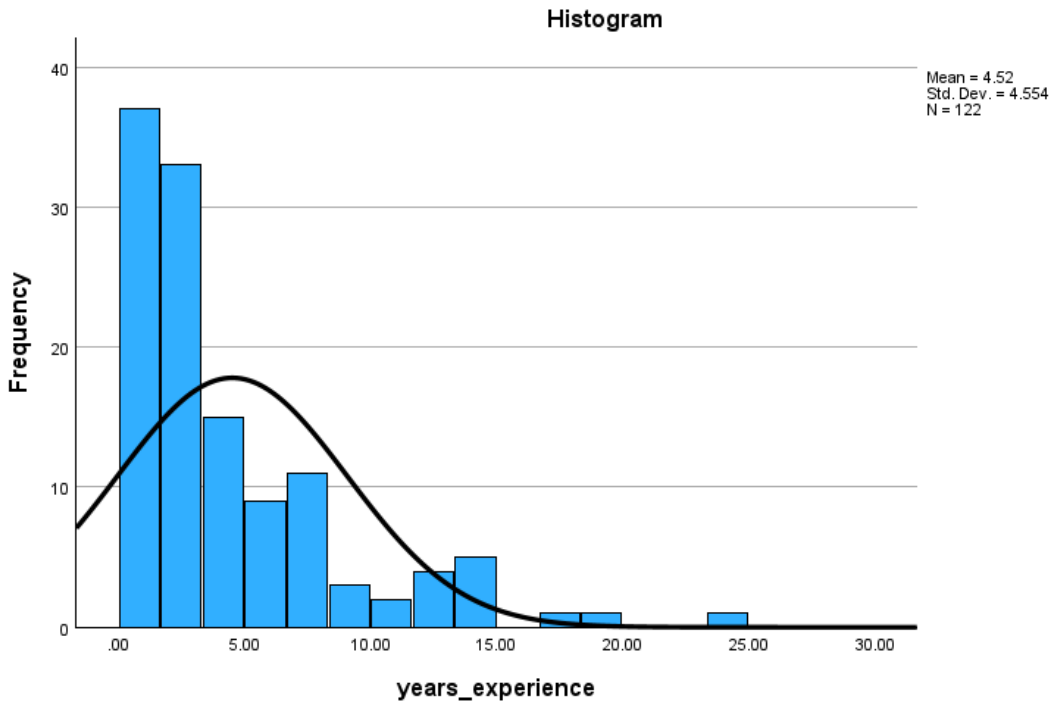
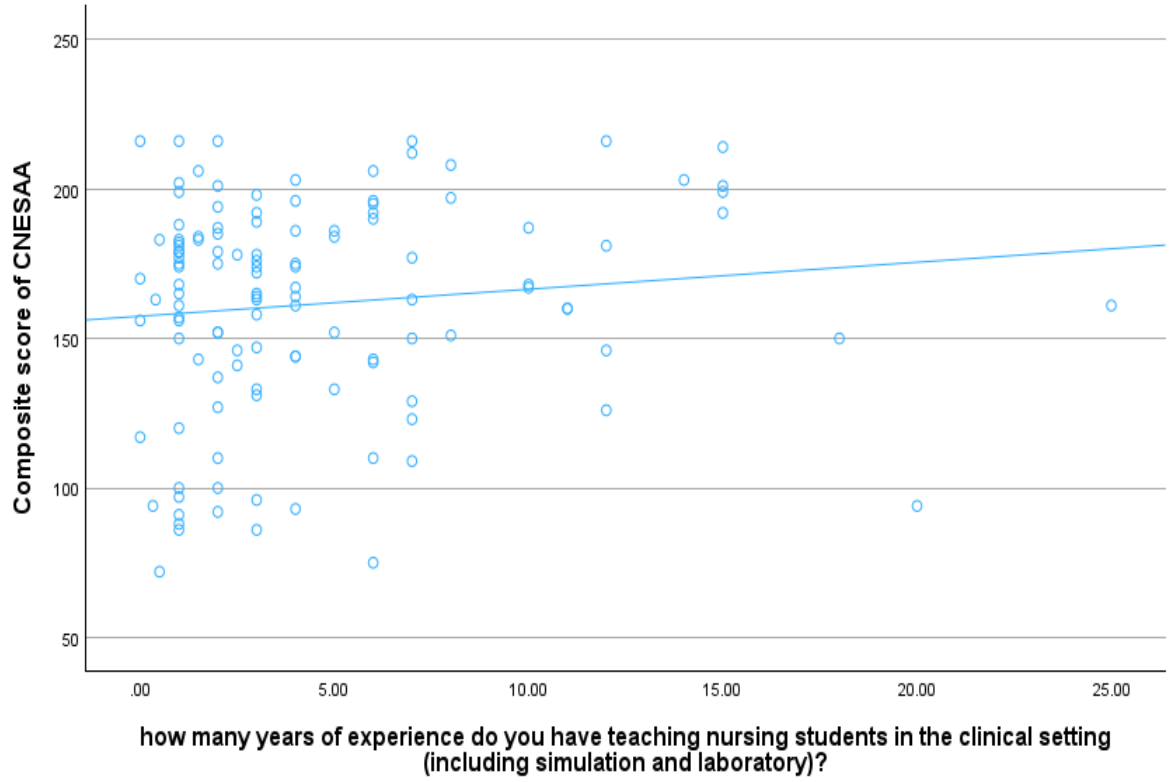


Figure 4.10

Scatterplot of Years of Teaching Experience and CNESAA (n = 122)



Participation in a Mentoring Program

In this sample, 114 (93.4%) faculty reported that they had not received mentoring during orientation to their adjunct faculty role, with eight participants (6.6%) reporting they participated in a mentoring program. Using a non-parametric test, the Mann-Whitney U results showed no significant difference (p = .213) in CNESAA composite score which measured confidence in skills between the two groups, with participants reporting no mentoring program as having higher CNESAA scores than participants who reported having a mentoring program (see Tables 4.8 and 4.9).

Table 4.8

Mentoring and CNESAA Composite Score (n = 122)

CNESAA	Participation in a Mentoring Program	*n*	Mean Rank	Sum of Ranks
	Yes	8	51.69	413.5
	No	114	62.19	7089.5

Table 4.9

Mann-Whitney U Results (n=122)

Mann-Whitney U	*z*	Exact Sig (2 tailed)
377.5	-.81	.425

Length of Orientation

The distribution of the sample regarding the length of their orientation to the role of adjunct faculty shows a positive skew, indicating a violation of normality (see Figure 4.11). The Shapiro Wilks test was significant, meaning there was not a normal distribution of the data for this variable (see Table 4.7). To test the association of the length of orientation with the CNESAA composite score with this sample, non-parametric testing was used due to lack of a normal distribution (Kellar & Kelvin, 2013). A two-tailed test was used to test the hypothesis that length of orientation had a positive relationship with confidence in skill acquisition. Spearman's Rho was used to calculate the correlation coefficient (r = -.01) with no statistical significance (p = .892).

The study findings did not support the hypothesis that adjunct faculty with more hours of orientation had a significantly higher confidence in skill acquisition. In addition, an ad hoc power analysis was completed using parametric testing of Pearson Correlation with r = 0.052,

indicating 2285 participants would be needed to power the study. The results do not indicate that the length of orientation is associated with confidence in skill acquisition in this sample.

Figure 4.11

Histogram of Length of Orientation (n=122)

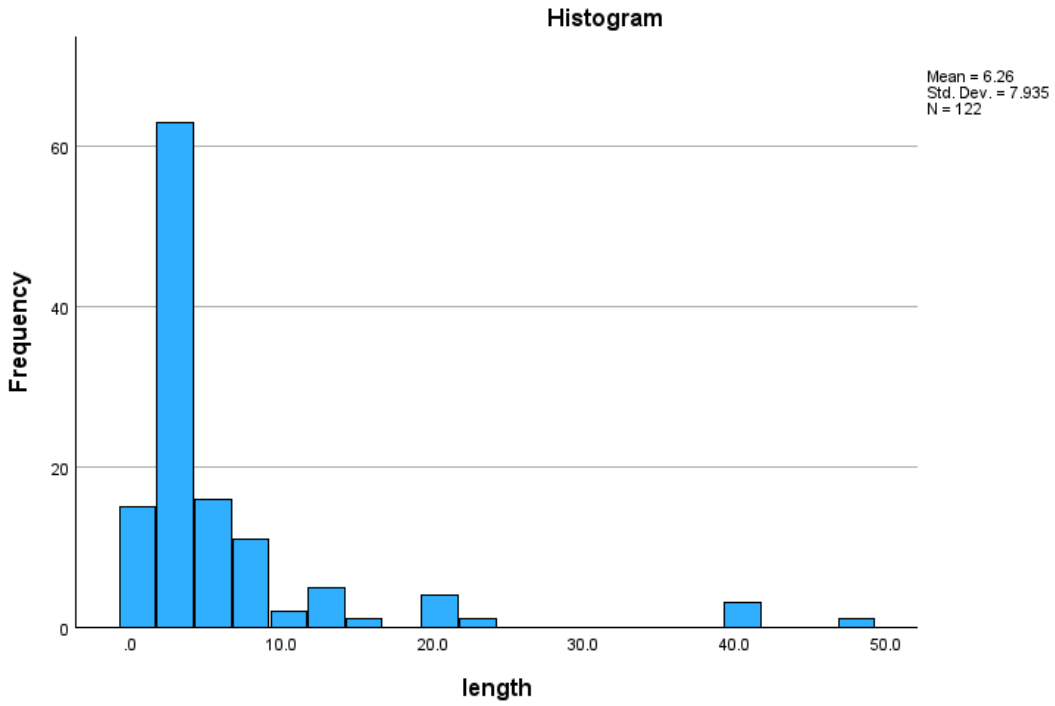
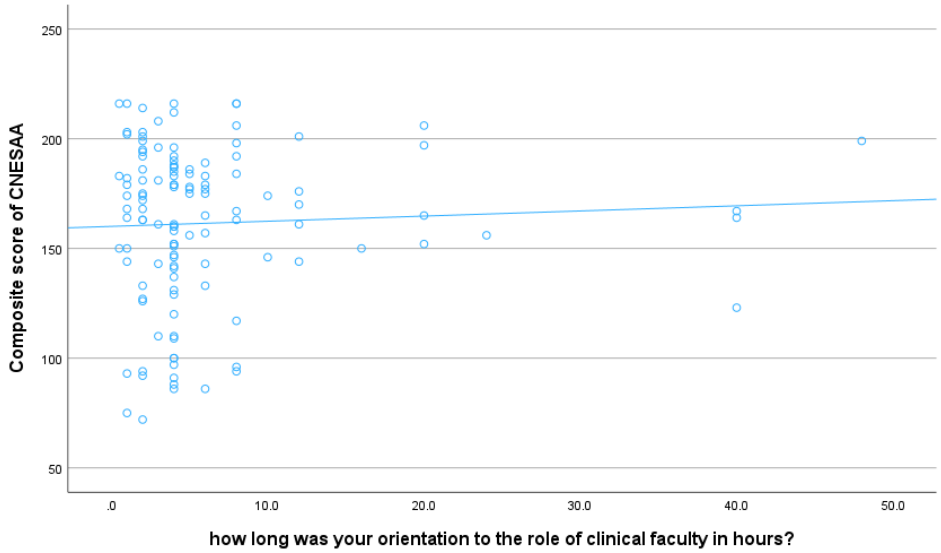


Figure 4.12

Scatterplot of Length of Orientation and Composite Score of CNESAA (n=122)



Delivery Method of Orientation

For delivery method of orientation, the sample was divided into two groups. In this sample of 122, 80 (65.6%) participants indicated receiving face-to-face orientation, and 42 (34.4%) reported non-face-to-face orientation including online or hybrid. Non-parametric testing (Mann-Whitney U) was used due to the skewed distribution of the CNESAA composite scores (Kellar & Kelvin, 2013). A Mann-Whitney U test indicated no significant difference in CNESAA composite score between face-to-face orientation and not face-to-face orientation ($U = 1563.5$, $Z = -0.638$, $p = 0.533$) (see Tables 4.10 and 4.11). There is no statistically significant difference between participants who reported having face-to-face orientation and participants who reported not having face-to-face orientation on confidence in skill acquisition in this sample.

Table 4.10

Delivery Method and CNESAA Composite Score Differences (n=122)

Mann-Whitney U

	n	Mean Rank	Sum of Ranks
Face-to-face	80	60.04	4803.50
Not Face-to-face	42	64.27	2699.50

Table 4.11

Mann-Whitney U Results (n=122)

Mann-Whitney U	*z*	Exact Sig. (2 tailed)
1563.5	-.63	0.533

Research Question 3

In the regression model, delivery method was dummy coded with face-to-face serving as the baseline for comparison. Participation in a mentoring program was dummy coded with yes serving as the baseline for comparison. Collinearity diagnostics were calculated with tolerance > 0.2 on all four predictor variables, indicating multicollinearity would not distort the regression model. Summary of the model fit, $R^2 = 0.04$, which is the variance in the CNESAA explained by predictors. Four percent of the variance in CNESAA composite scores is explained by these four predictors. The *p* value of the overall model is 0.306, indicating that the model is not significant.

Table 4.12

Coefficients for the Regression Model Predicting Confidence

	Unstandardized beta	SE	Beta	p
YOTE	1.13	.74	.14	.127
Length	.23	.41	.06	.539
Mentoring	-17.64	13.84	-.12	.205
Delivery Method	10.26	7.03	.14	.147

Table 4.13

Multiple Regression Model Summary

Model	R2	SE	R2 change	F change	Df1, df 2	p
1	.04	35.72	.04	1.22	4,117	.306

Summary

This chapter reviewed the participant characteristics including demographics and characteristics of orientation. Results related to each research question were reported with descriptions of statistical tests chosen and whether the results were significant. Further discussion on the implications of these results is presented in Chapter 5.

CHAPTER 5

DISCUSSION

This chapter discusses the study's findings, strengths, limitations, implications for theory, research, practice, and policy. The interpretation of study findings is organized by the research questions. This cross-sectional correlational study aimed to describe the orientation format and confidence in skill acquisition, as well as explore the predictive nature of orientation format, mentoring program participation, and years of teaching experience on confidence in skill acquisition among clinical adjunct faculty in the U.S.

Format of Orientation

The first research question for this study examined the format (delivery method and length) of orientation of a sample of current clinical adjunct faculty in the U.S. This study's findings are consistent with Carlson's (2015) cross-sectional study of 553 part-time clinical faculty, which found that over half of the participants had their orientation in a formal classroom setting. Both reported a small percentage (11%) receiving online or web-based instruction for their orientation. These findings could be due to the expected norms for nursing faculty orientation of classroom setting delivery, although empirical evidence is limited, and orientation practices vary widely (Ross & Dunker, 2019). The mean orientation length for non-full-time clinical nursing faculty increased from four hours in Carlson's (2015) study to six hours in the present study, suggesting a trend toward longer orientation periods.

Confidence of Faculty

The second research question focused on reporting the confidence level in skill acquisition of clinical adjunct faculty in the U.S. The CNESAA was used to measure this construct. This study is the first to report results on the confidence level in skill acquisition in

clinical adjunct nursing faculty in the U.S.. In the only other study of confidence in teaching skill acquisition in clinical adjunct faculty, Nguyen et al. (2018) conducted a cross-sectional study utilizing the CNESAA to measure confidence in skill acquisition of 334 clinical nurse educators in Vietnam. Confidence composite scores were aggregated into low, moderate, and high groups without the overall mean, as was done with this study, so comparison of results is not possible. Overall, confidence in this sample was moderate to high. The predominantly high confidence levels in this sample align with previous research demonstrating that nurse educators' substantial clinical experience contributes to strong perceived confidence in performing teaching-related competencies (Kim & Shin, 2017; Nguyen et al., 2018). Because the majority of the participants reported moderate to high confidence levels, the limited variability in the dependent variable reduced the ability of the regression model to detect meaningful relationships among the predictors.

Additional CNESAA results uncovered important aspects of clinical adjunct faculty confidence. The question on the CNESAA with the highest mean score was, "Building the climate of respect, collegiality, professionalism, courage, and caring within your institution and clinical settings." This question fell within the domain of leadership functioning. Functioning as a leader is also a skill of a nurse, which could explain the results. The individual question with the lowest average score was "Designing and implementing research in the area of expertise," which fell within the domain of engaging in scholarship. One explanation for why this question scored the lowest with this sample is that orientation content focuses on practical teaching and operational skills rather than on scholarly development (Owens, 2017; Roberts et al., 2013; Sousa & Resha, 2019) and therefore is new to clinical adjunct faculty in the role of a nurse educator, which could explain the lower confidence in comparison to other questions.

Predictors of Confidence

The third research question examined four potential predictors of confidence in skill acquisition. Although the lack of significance of the linear regression of delivery method and length of orientation, years of teaching experience, and participation in a mentoring program to confidence in skill acquisition might appear unexpected, it aligns with the notion in transitions theory that successful transitions are shaped by multifactorial conditions; personal, interpersonal, and contextual, rather than isolated variables (Meleis, 2010). The findings suggest that confidence may be influenced by multiple interacting conditions and factors which could include the quality of transition experiences, including relational support, reflection, and institutional culture, rather than by the presence or length of orientation or mentoring alone (Meleis, 2010).

Although several studies with nursing faculty have demonstrated that orientation and professional development can enhance confidence and self-efficacy, this study did not align with those results. For example, Roman (2018), using a pretest-posttest design of 37 clinical faculty, reported that participation in an online professional development community significantly increased perceived confidence among novice clinical faculty. Similarly, Hunt et al. (2015) found that simulation-based preparation improved 26 clinical faculty's confidence in guiding students and managing safety concerns, while Garner et al. (2018) documented substantial gains in teaching self-efficacy following an eight-hour simulation workshop design with 87 nursing faculty, with both using pretest-posttest designs. Each of these three studies used different tools to assess confidence, an author-created survey (Hunt, 2015; Roman, 2018) and the Self-Efficacy Towards Teaching Inventory (Garner, 2018). None of these studies used theory to design or support their findings. These findings differ from those of the present study, in which orientation delivery method and length were not significant predictors. Although, not tested, the difference

may reflect that confidence may depend more on the content and engagement quality of orientation, such as active learning, feedback, and relevance, rather than on its structure or duration. Another consideration is that this study was a cross-sectional survey and not pretest-posttest design, where confidence was measured directly after the educational program. The timing of when the knowledge was gained and the timing of when the confidence level is measured can affect the self-report of this construct. A pretest-posttest design incorporates an intervention and measures outcomes before and after its implementation, thereby allowing for stronger inferences about causality and the effectiveness of the intervention. In contrast, a cross-sectional survey represents an earlier phase in evidence development, in which the researcher seeks to identify relationships among variables associated with an outcome at a single point in time. Consequently, findings from a cross-sectional design are correlational rather than causal and serve primarily to inform hypotheses for future, more rigorous experimental or quasi-experimental studies (Polit & Beck, 2021).

Though this study did not find a significant relationship between years of teaching experience and confidence in skill acquisition, other studies have found contrary results. Previous research has frequently associated increased teaching experience with greater confidence. In a cross-sectional survey of 50 nursing faculty, Nugent et al. (1999) found a moderate, statistically significant correlation between years of teaching experience and teaching self-efficacy among novice nurse educators. Likewise, Kim and Shin's (2017) cross-sectional study of 263 nurse educators in Korea reported higher teaching efficacy among nurses with prior clinical teaching experience. Kim and Shin (2017) used Hwang's questionnaire to measure teaching efficacy and the Clinical Nurse Teacher Survey, which also used a Likert scale but was focused on perceptions of clinical teaching environments and teaching performance instead of

skills of clinical nurse educators. Additionally, Nguyen et al. (2018) identified years of experience as a positive predictor of confidence among clinical nurse educators in Vietnam, in a cross-sectional survey using the CNESAA of 334 clinical faculty in that country. Inconsistent findings regarding the relationship between years of teaching experience and confidence may result from differences in study design, sample characteristics, and other contextual factors influencing role development (Garner et al., 2018; Goodrich, 2014). An additional consideration may have been unfamiliarity with the domains of the CNESAA instrument.

Mentoring has been identified as a vital facilitator of confidence and role transition in academic nursing. In a review of mentoring literature, Nick et al. (2012) described mentoring as foundational in supporting new clinical faculty, while Busby et al. (2023) used a grounded theory design with 12 novice clinical nursing faculty to explore how mentoring supports transition, role clarity and confidence development and concluded that mentoring complements orientation by promoting skill acquisition and confidence. Mentoring extends learning and support beyond the initial introductory period. Although these two studies did not measure confidence directly as an outcome of a mentoring program, they reported confidence as positively associated with mentorship. Despite this, the present study found no significant relationship between mentoring participation and confidence. Contrary findings regarding the influence of mentoring on confidence may result from differences in how mentoring is defined, implemented, and measured across studies (Gazza, 2009).

Strengths

There are several strengths of the methods of this study. One strength is the use of a validated tool, the CNESAA, a psychometrically sound instrument with strong evidence of reliability and validity. In addition, the sample included clinical adjunct faculty from 37 states

and one U.S territory, thus the generalizability of the results is increased in comparison with a statewide or regional sample. The sample of the study was predominantly female (93.4%), which is similar and slightly higher than the NLN (2024a) annual survey which reported 87.57% of part-time nurse educators as female.

Limitations

The limitations of this study are several. The cross-sectional design limited the ability to establish causality between orientation format and confidence in skill acquisition, as data were collected at one single point in time (Polit & Beck, 2021). A longitudinal research design may be needed to examine how confidence evolves over time or in response to specific orientation programs.

A recruitment limitation was relying on the program administrators to forward the email to the clinical adjunct faculty. The researcher could not verify that all eligible individuals received the invitation and could not ensure consistent delivery across the multiple sites. The reliance on indirect recruitment constrained the sample size and increased the potential for sampling bias by limiting the researcher's control over who received the study invitation. It is possible that the program administrator did not forward the email to the clinical adjunct faculty. This also limited the ability to assess response and participation rates for the study sample. Another limitation related to recruitment is that REDCap does not track the number of individuals who click on a public survey link when the invitation is not sent through the REDCap Survey Distribution Tool. Because program administrators forwarded the link externally, the system could only capture respondents who completed the survey.

An additional limitation related to the results is that there is an assumption that all participants will be honest, but this is not guaranteed with survey research. The use of self-report

measures introduces the potential for response bias, which could affect the accuracy of the reported confidence in skill acquisition (Polit & Beck, 2021). Participants could have provided more socially desirable answers rather than fully accurate accounts.

Another limitation related to the results is that the associations between the independent variables and the dependent variables were small; therefore, the study was not adequately powered. The final sample was not sufficiently large to provide adequate power for the linear regression model, which may have limited the ability to detect statistically significant relationships among the predictors. In addition, since the length of time since orientation varied with a maximum of 12 years reported, recall bias could have impacted the accuracy of the details reported about the orientation format.

Implications

Theory

Anchored in Meleis's transitions theory, these findings contribute to understanding confidence as a pattern of response within the transition process rather than a direct outcome of program structure (Meleis, 2010). The non-significant relationships among the structural variables of delivery method and length of orientation highlight the importance of transition conditions, such as readiness, perceived support, and connection, in shaping patterns of response such as confidence. According to transitions theory, adjunct faculty undergo situational and organizational transitions that require adequate preparation, validation, and role clarity. Validation and role clarity were not measured in this study. This may occur due to the increased need for support due to the complex nature of a role transition. Thus, theoretical models of faculty transition should explicitly include perceived institutional support, belongingness, and quality of interpersonal interactions as variables that impact confidence growth. An additional

theory that would be beneficial in supporting research that measures those three constructs would be Bandura's social cognitive theory (Bandura, 1997) as it includes all three with self-efficacy as the outcome. The theory constructs would be measured to describe how environmental and social factors influence confidence among nursing faculty and can highlight how organizational and relational factors contribute to the development of self-efficacy in the faculty role.

Research

These findings inform nursing education research in several ways. This study provides additional support for using consistent terminology when studying clinical adjunct faculty orientation, namely "face to face," which is in line with others (Hinderer et al., 2016; Khatony, 2009) instead of "formal classroom setting" (Carlson, 2015)." It will be beneficial if nurse researchers are consistent with data collection on format of orientation so results can be easily compared. When inconsistent terminology is used, the ability to synthesize findings is limited. In addition, regular collection of these data would enhance the ability to identify trends in orientation practices and promote consistent terminology that supports evidence development in nursing education.

Moreover, this study helped reveal some additional variables that can be considered for future studies, including type of unit worked as RN, experience as preceptor, and if so, type of preceptor training provided. Participation in professional development activities at one's nursing school and any specialty certifications could also be considered (Nguyen, 2018). These types of variables can provide additional context about faculty education and experience and offer a more comprehensive view of factors that may influence confidence.

Future studies could explore the underlying mechanisms that contribute to confidence formation during the transition to teaching. Cross-sectional studies could incorporate constructs

such as perceived institutional support, role clarity, reflective practice, and sense of belonging as potential mediators or moderators for future interventional studies. Longitudinal research could further clarify whether confidence changes over time as adjunct faculty gain experience or move through successive transition phases. Replication across diverse program settings and larger samples will strengthen the generalizability of these findings and help distinguish contextual influences. Including additional faculty groups, such as clinical faculty teaching in associate degree nursing programs, would also be beneficial for generalizability of findings to this understudied group.

Another consideration for a future study is measuring an observable outcome immediately after orientation. Application of the knowledge learned in a teaching simulation, or an assessment of students could be observed in a pilot study of clinical adjunct faculty at one site, as Owens (2017) studied with new clinical faculty. This study could also inform similar work with clinical preceptor orientation in hospital settings.

Practice

The findings of this study provide early evidence to inform nursing education practice in that the delivery method and length of orientation do not support some of the previous literature related to predictive variables of confidence. These data can assist the nursing school program administrators and faculty as they design their faculty orientations for this population, because it showed that in this sample, there was no significant difference in confidence with groups with face-to-face orientation and longer orientation. If their goal is to increase confidence in skills, they may not have to use resources for face-to-face instruction, and could rely on online or blended delivery methods for clinical adjunct faculty in baccalaureate programs. Face-to-face

instruction requires more facilities, time, instructions, and financial resources than online learning (Khatony, 2009).

From a practical standpoint, these results indicate that nursing programs may want to focus on the quality and relational aspects of orientation and mentoring rather than on their duration or delivery format. Orientation should be viewed as an ongoing developmental process that includes active participation, feedback, and experiential learning opportunities (Rogers et al., 2020). Mentoring programs should be structured to foster authentic engagement, goal setting, and regular communication, allowing mentees to integrate feedback and reflect on teaching experiences (Schaar et al., 2015). Establishing peer learning communities and providing continuous, accessible professional development may further enhance adjunct faculty confidence by promoting belongingness and collaboration within the academic environment (Hunt et al., 2015)

Policy

The findings related to the orientation format can inform nursing education policy by illustrating the current state of the clinical adjunct faculty workforce and guiding the development of standards for orientation. At the policy level, findings suggest that institutions and accrediting bodies should emphasize outcomes and quality indicators related to orientation and mentorship, such as demonstrated improvements in faculty confidence, competence, and retention. Institutions might revise policies to reward effective mentoring through workload credit or professional recognition and to provide flexible pathways for adjunct engagement, including distance or peer-mentoring models (Nick et al., 2012) Aligning policies with transitions theory ensures that professional development initiatives address the relational, contextual, and emotional dimensions essential to successful faculty transitions (Meleis, 2010)

Conclusion

The simultaneous multiple regression analysis did not identify delivery method, length of orientation, years of teaching experience, or participation in a mentoring program as significant predictors of confidence in skill acquisition among clinical adjunct nursing faculty. Interpreted through the framework of transitions theory, these results highlight the complexity of faculty transitions and the importance of relational and contextual supports in fostering confidence. Confidence may develop not through structural characteristics such as orientation program length or delivery method but through additional factors such as meaningful interactions, reflective engagement, and institutional support that promote successful adaptation to the educator role. Focusing on these deeper transition dynamics better positions nursing programs to cultivate confident and competent faculty and enhance learning outcomes for students.

APPENDIX A

TRANSITIONS THEORY

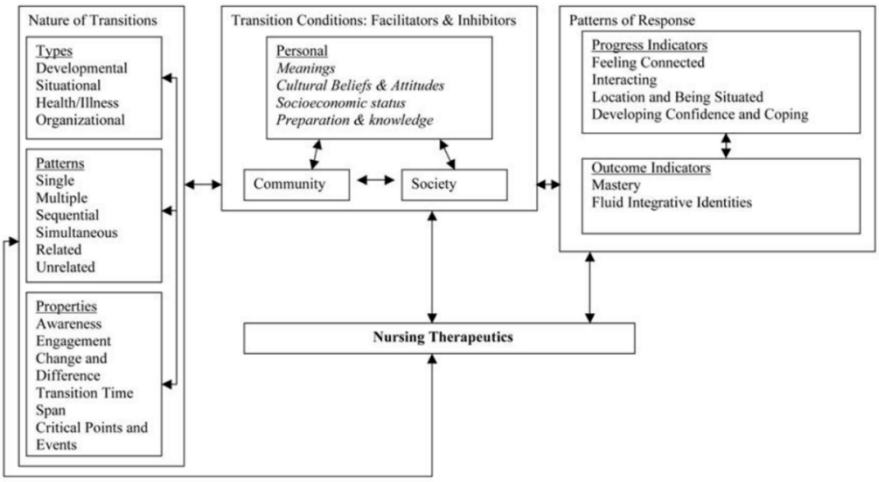


FIGURE 2.1.1 Transitions: A middle-range theory.

APPENDIX B

EMAIL TO CHIEF NURSE ADMINISTRATORS

Dear Nursing Program Administrator,

Hello, my name is Kelly Hantack. I am a UMKC PhD student. For my doctoral research, I am conducting a research study about clinical adjunct nursing faculty teaching in prelicensure baccalaureate nursing programs to gather information about their orientation to the role and their confidence in their clinical teaching skills. You may also view the survey questions by following the link below.

Please forward this email to prelicensure baccalaureate clinical adjunct nursing faculty employed at your school of nursing. Participation is anonymous, and the survey takes about 12 minutes to complete. No identifying data about the participant or their place of employment will be collected. Demographic questions related to employment include the state where they are currently teaching and if institution is public or private. Please ask your faculty to complete the survey on their own time. If you are unsure which faculty meet the criteria, please forward to all faculty, as the screening questions about their status of employment will assist with collecting the correct data from participants.

Your participation is entirely voluntary; you may skip any questions that you do not want to answer or choose to stop participating at any time. Your responses will be anonymous; there is no way for the research team to identify you or your responses to the survey. Please complete the survey during your personal time.

Do you have any questions about the research study? Please contact Kelly Hantack at . If you have questions about your rights as a research participant, you can call the UMKC Research Compliance at

For clinical adjunct faculty: If you want to participate in this study, click here to start the survey.

Gratefully,

Kelly Hantack, PhD-C, MSN, RN, CPN
PhD Student
School of Nursing and Health Studies
University of Missouri Kansas City
Kansas City, MO 64110

APPENDIX C

EXAMPLE EXCERPT FROM WEBSITE OF NURSING PROGRAMS: CCNE

Accreditor	School Name	Chief Nurse Administrator	Title	Email Address
CCNE	Abilene Christian University	Theresa Naldoza, PhD, RN, CNE	Associate Dean of the College of Health & Behavioral Studies & Executive Director for Nursing	tmn05a@acu.edu
CCNE	Adams State University	Kim Chacon, MS, RN	Director of Nursing	kchacon@adams.edu
CCNE	Adelphi University	Deborah Hunt, PhD, RN	Dean	dhunt@adelphi.edu
CCNE	AdventHealth University	Laura J. Fero, PhD, MSN, RN	Dean of Nursing	laura.fero@ahu.edu
CCNE	Allen College	Kendra B. Williams-Perez, EdD, RN, CNE	Dean & Professor	kendra.williams-perez@allencollege.edu
CCNE	Alliance University	Elizabeth Simon, PhD, RN, ANP-BC	Dean & Professor	elizabeth.simon@alliance.edu
CCNE	Alma College	Renee L. McCune, PhD, RN	Interim Director of Nursing	mccunerl@alma.edu
CCNE	Alvernia University	Linda Roy, PhD, CRNP, CNE	Associate Dean of Nursing	linda.roy@alvernia.edu
CCNE	Alverno College JoAnn McGrath School of Nursing	Laurie Kunkel-Jordan, PhD, RN, ANP-BC, CCRN	Dean	laurie.kunkel-jordan@alverno.edu
CCNE	American College of Education	Bette Bogdan, PhD, RN	Department Chair	bette.bogdan@ace.edu
CCNE	American International College	Ellen Furman, PhD, RN, GCNS-BC	Director	ellen.furman@aic.edu
CCNE	American Public University System	Stacey Malinowski, DNP, RN-BC, CCRN, PCCN, CNE	Director	smalinowski@apus.edu
CCNE	American University of Beirut Rafic Hariri School of Nursing	Samar Noureddine, PhD, RN, FAHA, FAAN	Professor & Associate Dean for Academic Affairs	sn00@aub.edu.lb
CCNE	American University of Health Sciences	Marilyn Uvero, EdD, MSN, RN	Chief Nurse Administrator	muvero@auhs.edu
CCNE	Anderson University - IN	Dana J. O'Keefe, DNP, APRN, FNP-c	Dean	djokeefe@anderson.edu
CCNE	Anderson University - SC	Cynthia R. Cross, DNP, MBA, MSN, RN	Interim Chief Nurse Administrator	ccross@andersonuniversity.edu
CCNE	Angeles College	Sasha A. Rarang, PhD, MSN, CCM, RN	Dean of Nursing	srarang@angelescollege.edu
CCNE	Angelo State University	Jennifer Braziel, DNP, RN, ACNP-BC, APRN	Interim Department Chair & Program Director	jennifer.braziel@angelo.edu
CCNE	Appalachian State University	Kathleen M. Rayman, PhD, RN	Department Chairperson	raymankm@appstate.edu
CCNE	Arizona College of Nursing	Amber Kool, KNP, RN	Associate Provost	akool@arizonacollege.edu
CCNE	Arizona State University College of Nursing & Health Innovation	Judith F. Karshmer, PhD, PMHCNS-BC, FAAN	Dean & Professor	judith.karshmer@asu.edu
CCNE	Ashland University Dwight Schar College of Nursing & Health Services	Carrie N. Keib, PhD, RN	Chief Nurse Administrator & Dean	ckeib@ashland.edu
CCNE	Aspen University	Nina Beaman, EdD, RN-BC, RNC, CNE	Dean	nina.beaman@aspen.edu
CCNE	Assumption University Froelich School of Nursing	Caitlin M. Stover, PhD, RN, PHCNS-BC, CNE, CNEcl	Dean of Nursing & Associate Professor	cm.stover@assumption.edu
CCNE	Athens State University	Mark Reynolds, DNP, RN, COI	Chief Nurse Administrator	mark.reynolds@athens.edu
CCNE	Auburn University	Gregg Newschwender, PhD, RN	Dean	gen0002@auburn.edu
CCNE	Auburn University at Montgomery	Jean D. Leuner, PhD, RN, CNE, FAAN	Dean	jleuner@aum.edu
CCNE	Augsburg University	Kathleen Clark, DNP, RN	Chair of Nursing Department	clarkk@augsburg.edu
CCNE	Augusta University	Beth NeSmith, PhD, RN	Interim Dean	bnesmith@augusta.edu
CCNE	Augustana University	Lynn L. White, PhD, RN, ACNS-BC	Associate Professor, Program Director	lynn.white@augie.edu
CCNE	Aultman College of Nursing & Health Sciences	Jo Ann Donnerwirth, EdD, MSN, ACNS-BC, CNE	Dean of Nursing & Allied Health	joann.donnerwirth@aultmancollege.edu
CCNE	Aurora University	Concetta Zak, DNP, MBA, FNP-BC	Dean	czak@aurora.edu
CCNE	Austin Peay State University	Eve Rice, DNP, MSN, CPNP-C	Director/Associate Professor	ricem@apsu.edu
CCNE	Averett University	Teresa Beach, EdD, RN	Dean	tbeach@averett.edu
CCNE	Avila University	Caryl Goodyear, PhD, RN, NEA-BC, CCRN-K, FAAN	Chair	caryl.goodyear@avila.edu
CCNE	Azusa Pacific University	Renee Pozza, PhD, RN, CNS, FNP-BC, FAASLD	Interim Dean & Professor	rpozza@apu.edu
CCNE	Baker College	Maria McCormick, DNP, CPNP	Dean	mccor10@baker.edu
CCNE	Baker University	Elizabeth Rosen, PhD, RN, IBCLC	Dean	lrosen@stormontvail.org
CCNE	Baldwin Wallace University	Yvonne M. Smith, PhD, APRN, CNS	Professor & Chair, Department of Nursing	ysmith@bw.edu
CCNE	Ball State University	Sheila Burke, DNP, MBA, MSN, RN	Interim Director	sheila.burke@bsu.edu
CCNE	Baptist Health Sciences University	Cathy Stepter	Dean	cathy.stepter@baptistu.edu
CCNE	Barnes-Jewish College Goldfarb School of Nursing	Kathleen Polley-Payne, PhD, MSN, RN, PNP	Interim Dean, Chief Academic Officer	kathleen.payne@bjc.org
CCNE	Barry University	Tony Umadhay, PhD, CRNA, APRN	Dean, Professor of Anesthesiology	tumadhay@barry.edu
CCNE	Barton College	Sharon Isenhour Shephard, PhD, RN	Professor & Dean	sisheparn@barton.edu
CCNE	Bay Path University The American Women's College - Health & Nursing	Linda Adams-Wendling, PhD, MBA, APRN, GNP-BC, NEA-BC, CNE	Chief Nurse Administrator	lwendling@baypath.edu
CCNE	Baylor University Louise Herrington School of Nursing	Linda Plank, PhD, RN, NEA-BC	Dean	linda_plank@baylor.edu

APPENDIX D

SCREENSHOT OF REDCAP SURVEY

Current instrument: **Demographics**

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* age

What is your age in years?

* must provide value

Validation type: Number

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* race

What is your race?

* must provide value

- ○ American Indian/Alaska Native
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Black or African American
- ○ White
- ○ More Than One Race
- ○ Unknown/Not Reported

reset

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* ethnicity

What is your ethnicity?

- ○ Hispanic or Latino or Spanish Origin
- ○ Not Hispanic or Latino or Spanish Origin

reset

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* gender

How do you identify your gender?

* must provide value

- ○ Female
- ○ Male
- ○ Non-Binary
- ○ Other

reset

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* highest_degree

What is your highest degree completed in nursing?

* must provide value

- ○ Bachelors
- ○ Masters
- ○ Doctorate

reset

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* clinicalexp

How many years of clinical experience do you have as a nurse?

Validation type: Number

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* state

In what state are you currently teaching?

* must provide value

Validation type: Letters only

Add Field | Add Matrix of Fields | Import from Field Bank

[ ] *Field Name:* institution_type

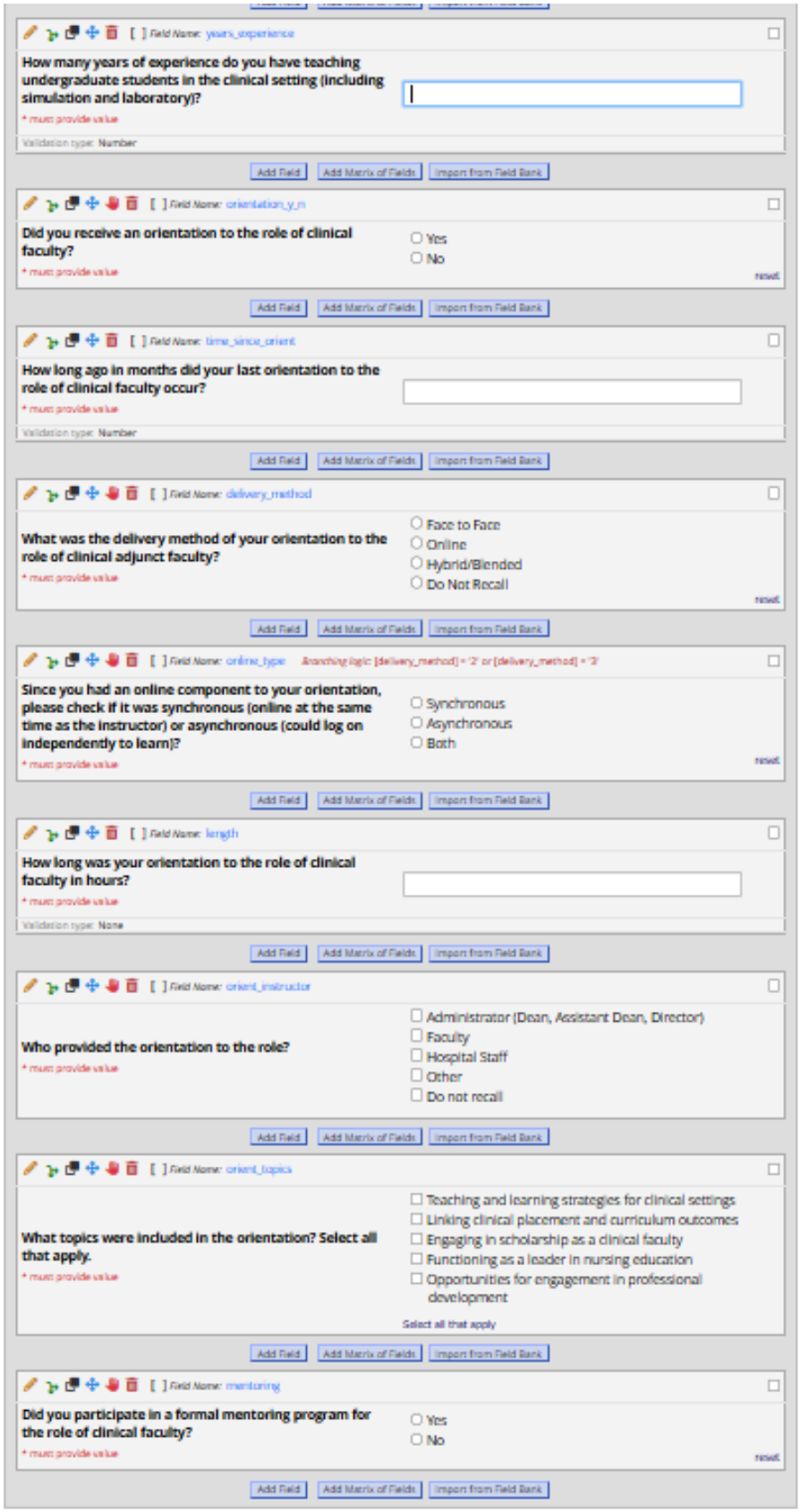
Is the nursing school you teach at a public or private institution?

* must provide value

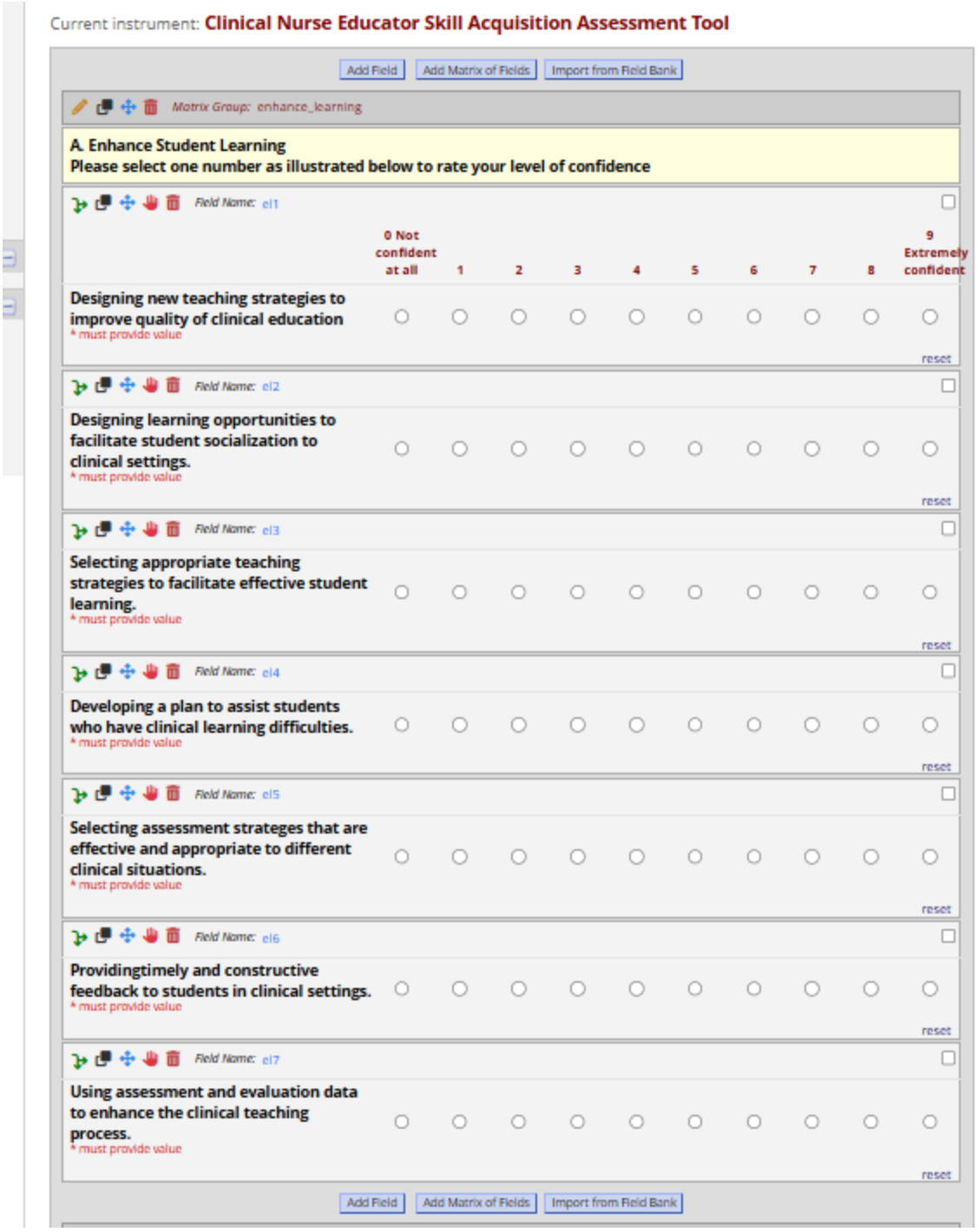
- ○ Public
- ○ Private

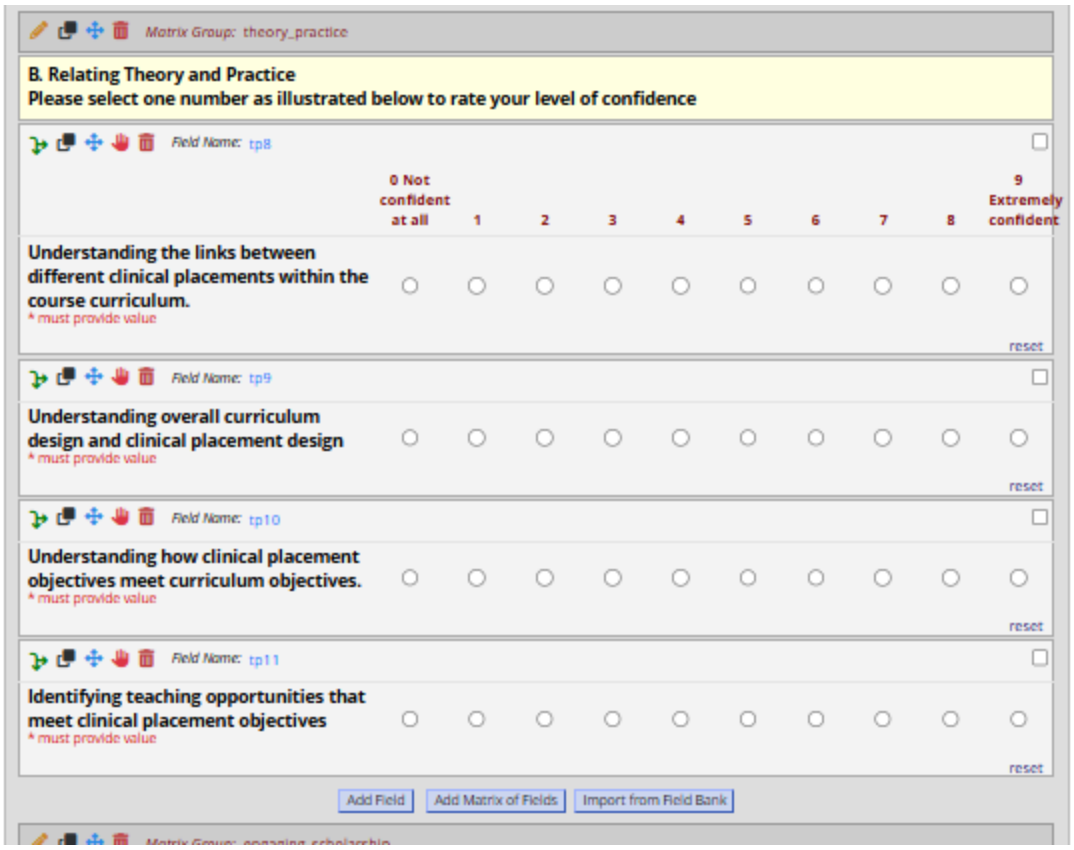
reset

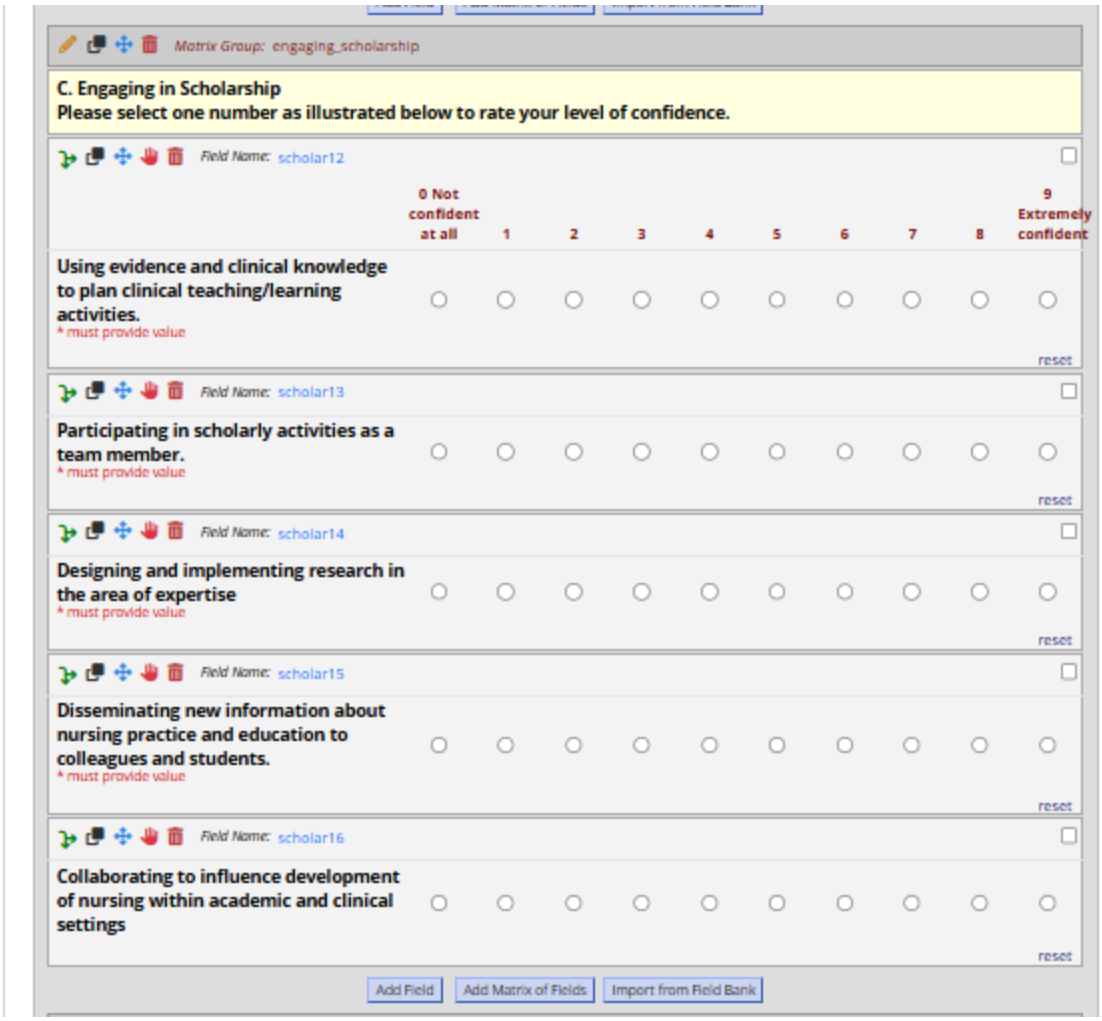
Add Field | Add Matrix of Fields | Import from Field Bank


Field Name: years_experience
How many years of experience do you have teaching undergraduate students in the clinical setting (including simulation and laboratory)?
* must provide value
Validation type: Number
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: orientation_y_n
Did you receive an orientation to the role of clinical faculty?
* must provide value
Yes
No
reset
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: time_since_orient
How long ago in months did your last orientation to the role of clinical faculty occur?
* must provide value
Validation type: Number
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: delivery_method
What was the delivery method of your orientation to the role of clinical adjunct faculty?
* must provide value
Face to Face
Online
Hybrid/Blended
Do Not Recall
reset
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: online_type
Branching logic: [delivery_method] = '2' or [delivery_method] = '3'
Since you had an online component to your orientation, please check if it was synchronous (online at the same time as the instructor) or asynchronous (could log on independently to learn)?
* must provide value
Synchronous
Asynchronous
Both
reset
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: length
How long was your orientation to the role of clinical faculty in hours?
* must provide value
Validation type: None
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: orient_instructor
Who provided the orientation to the role?
* must provide value
Administrator (Dean, Assistant Dean, Director)
Faculty
Hospital Staff
Other
Do not recall
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: orient_topics
What topics were included in the orientation? Select all that apply.
* must provide value
Teaching and learning strategies for clinical settings
Linking clinical placement and curriculum outcomes
Engaging in scholarship as a clinical faculty
Functioning as a leader in nursing education
Opportunities for engagement in professional development
Select all that apply
Add Field
Add Matrix of Fields
Import from Field Bank
Field Name: mentoring
Did you participate in a formal mentoring program for the role of clinical faculty?
* must provide value
Yes
No
reset
Add Field
Add Matrix of Fields
Import from Field Bank

Current instrument: **Clinical Nurse Educator Skill Acquisition Assessment Tool**




Matrix Group: theory_practice
B. Relating Theory and Practice
Please select one number as illustrated below to rate your level of confidence
Field Name: tp8
0 Not confident at all
1
2
3
4
5
6
7
8
9 Extremely confident
Understanding the links between different clinical placements within the course curriculum.
* must provide value
reset
Field Name: tp9
Understanding overall curriculum design and clinical placement design
* must provide value
reset
Field Name: tp10
Understanding how clinical placement objectives meet curriculum objectives.
* must provide value
reset
Field Name: tp11
Identifying teaching opportunities that meet clinical placement objectives
* must provide value
reset
Add Field
Add Matrix of Fields
Import from Field Bank



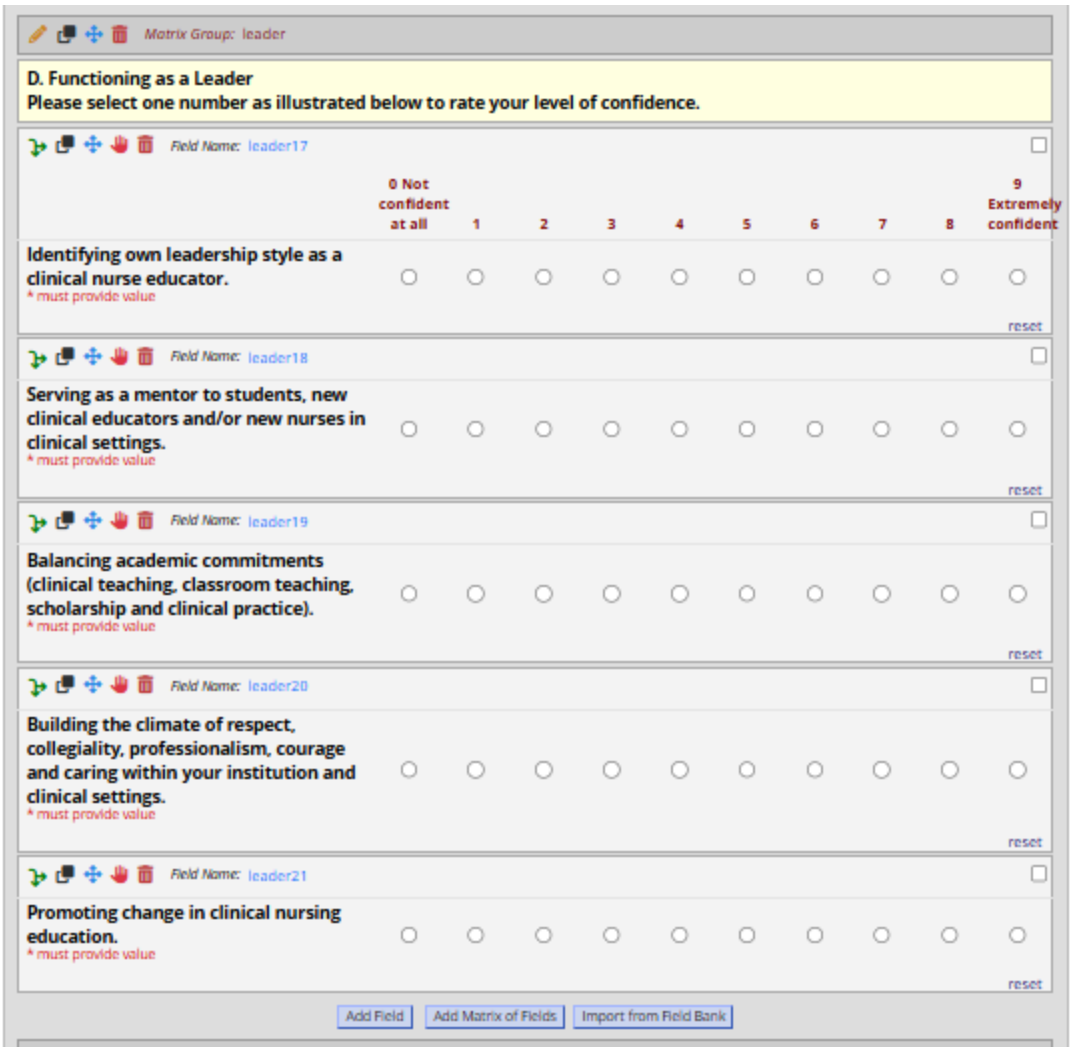
Matrix Group: engaging_scholarship

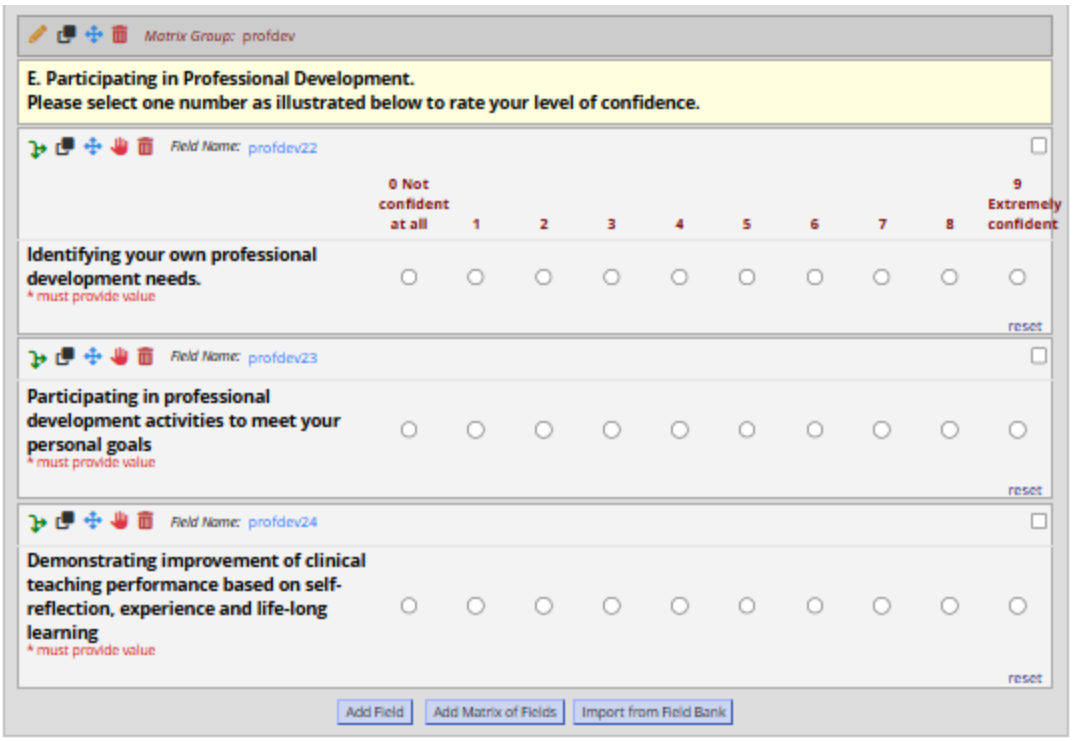
C. Engaging in Scholarship
Please select one number as illustrated below to rate your level of confidence.

	0 Not confident at all	1	2	3	4	5	6	7	8	9 Extremely confident
Field Name: scholar12 **Using evidence and clinical knowledge to plan clinical teaching/learning activities.** * must provide value	○	○	○	○	○	○	○	○	○	○
Field Name: scholar13 **Participating in scholarly activities as a team member.** * must provide value	○	○	○	○	○	○	○	○	○	○
Field Name: scholar14 **Designing and implementing research in the area of expertise** * must provide value	○	○	○	○	○	○	○	○	○	○
Field Name: scholar15 **Disseminating new information about nursing practice and education to colleagues and students.** * must provide value	○	○	○	○	○	○	○	○	○	○
Field Name: scholar16 **Collaborating to influence development of nursing within academic and clinical settings**	○	○	○	○	○	○	○	○	○	○

reset

Add Field | Add Matrix of Fields | Import from Field Bank


Matrix Group: leader
D. Functioning as a Leader
Please select one number as illustrated below to rate your level of confidence.
Field Name: leader17
0 Not confident at all
1
2
3
4
5
6
7
8
9 Extremely confident
Identifying own leadership style as a clinical nurse educator.
* must provide value
reset
Field Name: leader18
Serving as a mentor to students, new clinical educators and/or new nurses in clinical settings.
* must provide value
reset
Field Name: leader19
Balancing academic commitments (clinical teaching, classroom teaching, scholarship and clinical practice).
* must provide value
reset
Field Name: leader20
Building the climate of respect, collegiality, professionalism, courage and caring within your institution and clinical settings.
* must provide value
reset
Field Name: leader21
Promoting change in clinical nursing education.
* must provide value
reset
Add Field
Add Matrix of Fields
Import from Field Bank


Matrix Group: profdev
E. Participating in Professional Development.
Please select one number as illustrated below to rate your level of confidence.
Field Name: profdev22
0 Not confident at all
1
2
3
4
5
6
7
8
9 Extremely confident
Identifying your own professional development needs.
* must provide value
reset
Field Name: profdev23
Participating in professional development activities to meet your personal goals
* must provide value
reset
Field Name: profdev24
Demonstrating improvement of clinical teaching performance based on self-reflection, experience and life-long learning
* must provide value
reset
Add Field
Add Matrix of Fields
Import from Field Bank

APPENDIX E

CLINICAL NURSE EDUCATOR SKILL ACQUISITION ASSESSMENT

CLINICAL NURSE EDUCATOR SKILL ACQUISITION ASSESSMENT TOOL											
	Please circle one number as illustrated below to rate your level of confidence. *Not confident at all* → *Extremely confident* ***0*** *1 2 3 4 5 (6) 7 8* ***9***										
A. ENHANCING STUDENT LEARNING											
1	Designing new teaching strategies to improve quality of clinical education	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
2	Designing learning opportunities to facilitate student socialization to clinical settings.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
3	Selecting appropriate teaching strategies to facilitate effective student learning.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
4	Developing a plan to assist students who have clinical learning difficulties.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
5	Selecting assessment strategies that are effective and appropriate to different clinical situations.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
6	Providing timely and constructive feedback to students in clinical settings.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
7	Using assessment and evaluation data to enhance the clinical teaching-learning process.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
B. RELATING THEORY AND PRACTICE											
8	Understanding the links between different clinical placements within the course curriculum.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
9	Understanding overall curriculum design and clinical placement design.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
10	Understanding how clinical placement objectives meet curriculum objectives.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
11	Identifying teaching opportunities that meet clinical placement objectives.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*

C. ENGAGING IN SCHOLARSHIP											
12	Using evidence and clinical knowledge to plan clinical teaching/learning activities.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
13	Participating in scholarly activities as a team member	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
14	Designing and implementing research in the area of expertise.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*

15	Disseminating new information about nursing practice and education to colleagues and students.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
16	Collaborating to influence development of nursing within academic and clinical settings.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
D. FUNCTIONING AS A LEADER											
17	Identifying own leadership style as a CNE.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
19	Serving as a mentor to students, new clinical educators and/or new nurses in clinical settings.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
18	Balancing academic commitments (clinical teaching, classroom teaching, scholarship and clinical practice).	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
20	Building the climate of respect, collegiality, professionalism, courage and caring within your institution and clinical settings.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
21	Promoting change in clinical nursing education.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*

E. PARTICIPATING IN PROFESSIONAL DEVELOPMENT										
22	Identifying your own professional development needs.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
23	Participating in professional development activities to meet your personal goals.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
24	Demonstrating improvement of clinical teaching performance based on self-reflection, experience and long-life learning.	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*

Developed by Lisa Ramsburg, Ed.D, MSN, CNE.
Modified, piloted and validated by Van Nguyen, Helen Forbes, Mohammadreza Mohebbi, and Maxine Duke.
Authors' permission and citation where appropriate are required in the use or reproduction of this tool.

SCORING INSTRUCTION

A generic way of interpreting the perceived confidence score is based on the range and mean score of each domain and of total score of five domains. The table below can be used as a scoring instruction.

Domain	Minimum score (Not confident at all)	Mean score (Moderately confident)	Maximum score (Extremely confident)
A	0	31.5	63
B	0	18	36
C	0	22.5	45
D	0	22.5	45
E	0	13.5	27
Total	0	108	216

There could be multiple methods of interpretation depending on the purpose of investigation and/or comparison. Please contact the authors for further assistance.

APPENDIX F

PERMISSION TO USE CNESAA

Re: request

[redacted]

Tue 2/7/2023 5:23 PM

To:Hantack, Kelly (UMKC-Student) <marshk@umsystem.edu>

WARNING: This message has originated from an External Source. This may be a phishing expedition that can result in unauthorized access to our IT System. Please use proper judgment and caution when opening attachments, clicking links, or responding to this email.

Dear Kelly

It is lovely to hear from you,
I hope you are well and have a good start to the new year.

Yes you have my permission to use my CNESAA tool as-is (which means no major adaptation accepted) for the purpose of your PhD thesis with citation to the original publication as below in all communication/dissemination of findings:

Nguyen, VNB., Forbes, H., Mohhebbi, M., & Duke, M. (2017). Development and validation of an instrument to measure nurse educator perceived confidence in clinical teaching. *Nursing and Health Sciences*. 19*(4)*:498-508. doi:10.1111/nhs.12373.

In the event you require adaptation or revalidation, I am more than happy to collaborate and assist in that process. We then perhaps require a meeting to discuss steps involved.

I would love to hear about your experience with the use of the CNESAA and the outcome of your study too if you don't mind sharing.

Best wishes,

[redacted]

Lecturer

Monash University

Monash Nursing and Midwifery

Clayton, VIC 3800

Australia

To view my publications: https://orcid.org/0000-0002-0982-2532

On Mon, 6 Feb 2023 at 07:50, Hantack, Kelly (UMKC-Student) <marshk@umsystem.edu> wrote:

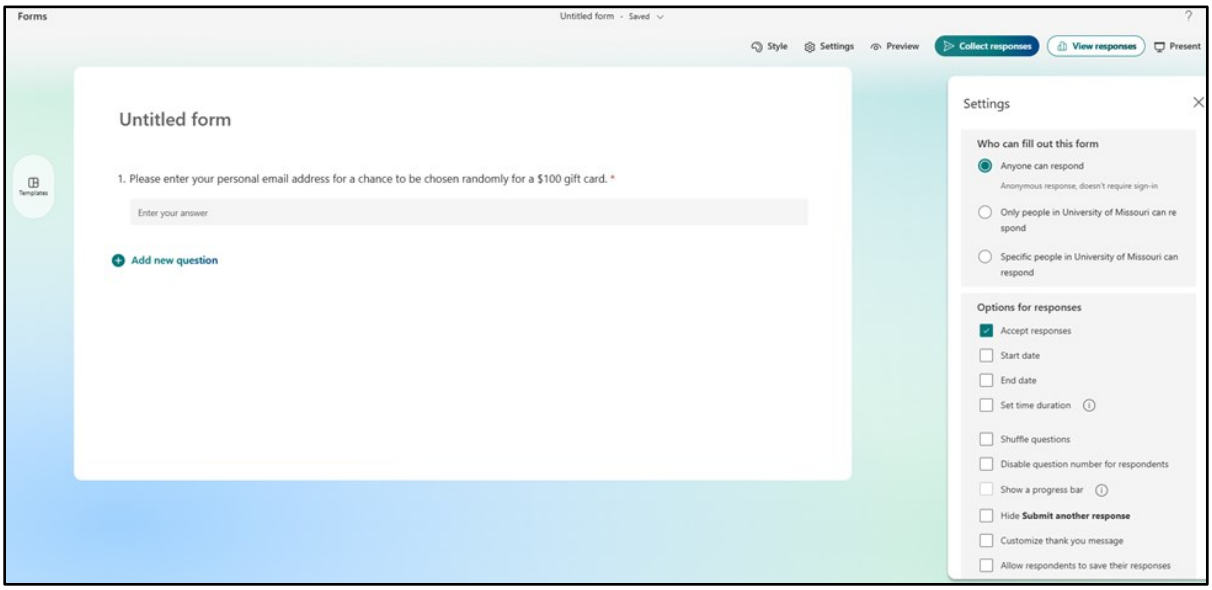
[redacted]

Thank you for responding so promptly last year when I was in my quantitative methods course and was learning about your tool. I am a third year PhD student at University of Missouri at Kansas City. I would like to request your permission to use the CNESAA in my dissertation study. The current title is

A Cross-sectional, Descriptive, Correlational Study of Orientation Length and Delivery Method and Perceived Confidence in Skill Acquisition with Clinical Adjunct Faculty in Nursing Education.

APPENDIX G

SURVEY QUESTION FOR GIFT CARD RAFFLE



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VITA

Kelly Lynn Hantack received an Associates Degree in nursing and a Bachelor of Science in nursing at Jewish Hospital College of Nursing and Allied Health in Saint Louis, Missouri in 2000 and 2002. In 2013, she earned a master's of science in nursing degree, with a concentration of nurse educator, at Goldfarb School of Nursing at Barnes Jewish College in Saint Louis, Missouri.

Kelly started her career in nursing at St. Louis Children's Hospital in Saint Louis, Missouri, in 2000, as a staff nurse. Next, she transitioned to a clinical nurse coordinator at Washington University School of Medicine in the department of pediatric endocrinology. After attaining her degree in nursing education, Kelly transitioned to nursing faculty at Goldfarb School of Nursing at Barnes Jewish College, where she is still employed. She has enjoyed teaching several courses for undergraduate students including fundamentals of nursing practice, nursing of children and families, and leadership role development. In 2000, she also added a coaching role to her teaching load in which she assists students with studying, test taking, and time management as they transition to a rigorous nursing program. Recently, she has helped to lead the undergraduate faculty in the transition to competency-based assessment framework.