



# Promoting Clinical Scholarship in the Clinical Arena

by

Jean-Paul Almaze

2017

# Promoting Clinical Scholarship in the Clinical Arena

A dissertation submitted to the School of Nursing & Public Health,  
University of KwaZulu-Natal in the fulfilment of the requirements:

Masters in Nursing

by

Jean-Paul Almaze

Student number 208519646

2017

Supervisor: Ms Waheedha Emmamally

Co-Supervisor: Professor Petra Brysiewicz

## **DECLARATION**

The work contained in this thesis titled “Promoting Clinical Scholarship in the clinical arena” has been solely and entirely compiled by myself. To the best of my knowledge, this thesis has not been previously submitted in whole or in part for any other degree or professional qualification, to the University or any other university. The preparation of this thesis has been my own work, except where it explicitly states otherwise by acknowledgment.

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Co-supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

## **DEDICATION**

I dedicate this work to the memory of my loving mother, Jeanne-D'arc Almaze. You magnificently made me the person I am, and although you are in your final resting place far from me, I know you are close. You will always be remembered for the gifted hands with which you raised me. I believe you must be smiling with joy and saying, "I knew you would make it my son."

I shall uphold the legacy!

## **ACKNOWLEDGMENTS**

This study would not have been possible without immeasurable help from certain people to whom I extend my sincere and heartfelt “thank you”. I would particularly like to express my gratitude to the following people, institutions and organisations who have each contributed in one way or another to my education in general, and to the completion of this study in particular:

First and foremost, I would like to thank Almighty GOD for giving me the wisdom and strength to carry through this study to the end. May His name be praised!

The Agency for National Human Resources Development for sponsoring my scholarship; the Seychelles Ministry of Health for granting me full time study leave.

The University of KwaZulu-Natal for admitting me to study.

My supervisors, Ms Waheedha Emmamally and Professor Petra Brysiewicz: your invaluable guidance, advice, encouragement, critique, and overall contribution towards my academic development will always be remembered and highly appreciated. Thank you for being so patient, believing in me and helping to make my dream come true.

The lecturers and students of the University: thank you all for your time, participation in, and contribution towards the study.

Many thanks to the Dean of the Nursing Department at Howard College, Professor Busisiwe Purity Ncama for the funding towards editing my work.

My family: Jean-Yves, Dr Johanna, Ny-Aina, Ny-Andy, Steven, Guillianne, Jeffrey, Salima, Jasmine and Daniel, for your priceless support. Thank you all for being part of my life and for your contributions to my education and most of all for believing in me and helping my dream to come true.

My friends who have supported me academically: Carol Dhanraj, school administrator of the nursing department Howard College, friends from Uganda studying media and communication,

Dr. Marion Alina, Dr. Fred Kakooza, Dr. Sara Namusoga, Dr. Brian Semujju, Dr. Samuel Kazibwe; Jeremiah Mpaso from Malawi and Dr. Bereket Yakob from Ethiopia: for always giving me the hope that I would reach the end of the journey one day.

Close friends: Denis H, Christelle R, Celeste M, Audrey H, Sara J, John D, Mrs. Flavie D, Jessy A and Mrs. Charlette M-Ali, Siphon Ngema and Lungelo Masinga for your advice, words of encouragement and support when I felt down and lost along the road of my study. You are friends indeed.

To the Fynn family, Paul's family and the workers at Glenmore Pastoral Centre: thank you for your support and for making my stay in Durban pleasant and comfortable; and last but not least to all the other people who have helped in one way or another.

## **ABSTRACT**

**Background:** Across healthcare, the importance of clinical scholarship has been increasing in the clinical arena. Applying clinical scholarship in daily nursing practice is vital.

**Aim:** The aim of the study was to explore and describe clinical scholarship in order to develop recommendations to promote clinical scholarship in the clinical arena.

**Methodology:** The study was conducted at a university in South Africa and adopted a sequential explanatory mixed-methods approach. Data collection was done in two phases. *Phase One*, the quantitative phase, focused on questionnaires involving eighty-one clinical specialist nursing students (CSNS). *Phase Two* focused on individual interviews with CSNS and clinical experts. Data saturation was reached after interviewing eight CSNS and four clinical experts. The interviews were analysed using latent-content analysis.

**Findings:** Quantitative findings revealed that funding was the most common barrier to clinical scholarship. Re-examining criteria for promotion and reward all forms of scholarship was identified as preferred solutions to clinical scholarship. Qualitative findings revealed nine categories that of: academic excellence, importance of research to practice, scholarship overlooked, poor communication, resources, encouragement of scholarship activity scholarship culture, responsive teaching and attributes in teaching clinical scholarship. These were further divided into subcategories.

**Recommendation:** In order to promote and develop CS, nurses should embrace a culture of CS as a fundamental principle in clinical practice. Further to that, the academic institution and clinical arena should support each other to promote nurses' progress on the CS front, and resources should be made available to encourage nurses to pursue a CS track.

**Conclusion:** The CSNSs and CEs are enthusiastic supporters of CS. Their support expressed a positive perspective towards clinical scholarship, where a synergy between academia and clinical management is needed to promote a CS culture

**Keywords:** Clinical scholarship, clinical specialist nursing students, mixed methods

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## Abbreviations

CE	---	Clinical Expert
CS	---	Clinical Scholarship
CSNS	---	Clinical Specialist Nursing Student
EBP	---	Evidence-Based Practice
ICN	---	International Council of Nurses
SA	---	South Africa
SANC	---	South African Nursing Council
SPSS	---	Statistical Package for Social Science
STTI	---	Sigma Theta Tau International
UK	---	United Kingdom
USA	---	United States of America
WHO	---	World Health Organization

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## **CHAPTER ONE**

### **INTRODUCTION TO THE STUDY**

#### **1.1 Introduction**

The focus on clinical scholarship (CS) to improve patient outcome has become a global initiative. In the literature, CS is defined as “an approach that enables evidence-based nursing and the development of best practices to meet the needs of clients efficiently and effectively. It requires the identification of desired outcomes; the use of systematic observation and scientifically-based methods to identify and solve clinical problems...”(Sigma Theta Tau International Clinical Scholarship Task Force, 1999:4). In order for CS to be achievable, nurses need to be actively engaged in CS activities such as research and the implementation of evidence-based nursing (Carter, Mastro, Vose et al., 2017). For activities to be considered scholarship, Glassick, Huber, Maeroff et al. (1997) found themselves in agreement with Boyer’s (1990) framework stipulating that scholarship should have clear goals, adequate preparation, appropriate methods, significant results, and reflective critique. Additionally, scholarship should submit itself to peer review and critical review (Shulman, 1999; Fincher & Work, 2006). Although the definition of CS is not well understood among nurses (Riley, Beal & Lancaster, 2008; Wilkes, Mannix & Jackson, 2013; Carter et al., 2017), efforts should be made to encourage nurses to engage in scholarship with a view to enhancing their knowledge base, thereby improving patient care and, ultimately, patient outcomes (Riley et al., 2008; Wilkes et al., 2013; O'Connor & Peters, 2014; Weston & Hudson, 2014; Roets, Botma & Grobler, 2016).

#### **1.2 Background**

Over the past 20 years there has been an increased demand for CS activities (O'Neil Munding, Starck, Hathaway et al., 2009; Weston & Hudson, 2014). This has required that the nursing profession emphasise CS activities that create a foundation of caring and lead to improved patient outcomes. This in turn has presented an opportunity for clinical leadership and clinical expertise to develop best practices designed to improve patient outcomes efficiently and effectively (Sigma Theta Tau International Clinical Scholarship Task Force, 1999; Waldrop, 2016). However, the relationship of clinical practice to scientific knowledge has changed over time, as is evident from the different terms used to discuss CS and clinical practice.

In 1990, the Carnegie Foundation President, Ernest Boyer, focused greater attention on clinical practice with a view to moving the clinical nurse beyond health care service delivery to teaching and research (Boyer, 1990); this, it was hoped, would lay a foundation for new ways of generating theory and knowledge development in nursing. The term coined to describe this initiative was CS (Jones, 2011). Later, the Clinical Scholarship Task Force sought to investigate the field of CS with an emphasis on how scholarship bridges the gap between the academic and clinical settings (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). There is growing interest in how translational research may offer insights into ways of guiding practising nurses to be active participants in the development of nursing knowledge (Jones, 2011; Limoges & Acorn, 2016).

Clinical scholarship is defined as the development of evidence-based nursing to improve patient outcomes, as well as an approach that may contribute towards the development of best nursing practices (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). It is an intellectual and professional process that goes beyond superficial explanations regarding the patients' behaviour and the nurses' actions (Dreher, 1999; Riley et al., 2008). Coupled with that, the American Association of Colleges of Nursing defines scholarship as "those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that is significant to the profession; is creative; can be documented; can be replicated or elaborated on, and can be peer reviewed through various methods"(1999: 373).

Clinical scholarship incorporates observation as a scientific approach to discover and explain clinical nursing problems. This involves finding answers to questions such as: why do nurses behave in a certain manner and why do patients or clients react the way they do? These answers may be of benefit to clinical practice and thereby improve health care outcomes (Turale, Shih, Klunklin et al., 2010). Clinical scholarship involves the activities of teaching, learning, practical orientation and research, with an eye to enhancing clinical knowledge, thereby advancing clinical practice in order. However, CS is not aimed at merely changing old ways of practice (Stockhausen & Turale, 2011) and clinical nurses need to appreciate the context of CS as foundational in the nursing profession to provide solutions to clinical problems (Jones, 2011). Moreover, observation, which is a major aspect of CS, gives clinical specialist nurses an opportunity to apply nursing theories to practice, with the aim of improving competency in clinical nursing practice

(Papathanasiou, Tsaras & Sarafis, 2014). In addition, clinical nurses can be involved in CS activities through discussions with colleagues, thereby helping them to rationalize their actions on the basis of research evidence and to inform their practice through involvement in research (Ax & Kincade, 2001; O'Connor & Peters, 2014), though without necessarily being involved in the process of doing the research.

In nursing practice, CS has been highlighted by Boyer's work. He looked at four components, namely: scholarship of discovery, scholarship of integration, scholarship of teaching and scholarship of application (Boyer, 1996a). These four components have been explained by Jacelon, Donoghue and Breslin (2010) as: *discovery* means creating an opportunity to conduct research in an appropriate environment; *integration* involves incorporating theory into practical knowledge of a subject; *teaching* implies that both students and staff are involved in the learning and teaching process and, further, that they be exposed to challenges within the clinical arena and *application* refers to the transference of research findings to clinical practice in order for new understanding to occur.

Clinical scholarship is recognised as capable of exercising an important and beneficial influence on clinical practice (Diers, 1995; Fiandt, Barr, Hille et al., 2004; Weston & Hudson, 2014). For instance, the most experienced and skilled clinical specialist nurses may mentor other clinical nurses so as to enhance their professional abilities (Jonsén, Melender & Hilli, 2013), develop their self-confidence and facilitate independence in clinical decision making. Smedley and Morey (2010) are in agreement with Ha (2015) that clinical nurse specialists should appreciate the need for enhanced nursing care in clinical practice and for keeping abreast of knowledge developments in order to apply the best recent findings to their practice (Papathanasiou et al., 2014). For clinical specialist nurses to achieve their full potential in clinical practice, they must develop perceptual skills that focus on what nurses observe, executive skills which involve what nurses do and conceptual skills that demonstrate how nurses make sense of what has been observed through critical thinking (Wright & Leahey, 2009).

As applied, Boyer's four components of CS could translate into "skills and knowledge", "skills of problem solving, reflection and decision making", "generation of new knowledge" and

“transmission of society’s values through literature, science and cultural activity” (Kitson, 1999:773). All four components are foundational to problem solving and critical thinking in the context of the present challenges in health care (Peterson & Stevens, 2013), and of bringing about positive changes in health care practice. Some of the changes associated with the application of CS include emphasising that better patient care should be based on scientific research and evidence-based nursing rather than on tradition or preconception (Mohide & Coker, 2005). For nursing care to be truly reflective and science-based, the clinical nurse should incorporate intuition, research, observation, theory, and analysis (Tymkow, 2010). This argument is supported by Austin, Wills, Blizzard et al. (2010) recommendation that oxygen therapy should be administered only at a concentration adequate to maintain sufficient oxygen saturation in patients with obstructive pulmonary disease. This recommendation was based on their study, which indicated that titrated oxygen therapy in the pre-hospital setting resulted in a 78% reduction in the risk of in-hospital respiratory failure and subsequent mortality, compared with high-flow oxygen. Such recommendations in response to convincing new research findings feed into the development of new guidelines designed to ensure improved patient outcomes in clinical practice (Biarent, Bingham, Eich et al., 2010). Much of the importance of CS has to do with the dissemination of findings into the clinical arena whereby nurses are equipped with the knowledge to justify their practice, and to show that it results in improved outcomes for the patient, his/her family and the health care system (Breimaier, Halfens & Lohrmann, 2011).

To be successful, CS requires input from both academic and clinical-health personnel. The American Higher Education discussion on CS was aligned to this premise, leading to the recommendation that activities within the universities be re-organised so that scholarship based on research could contribute to problem solving in clinical practice (Wise, Retzleff & Reilly, 2002; Stockhausen & Turale, 2011). The aim of this re-organisation was to motivate the clinical nurse to understand the importance of CS and to use CS to bridge the gap between theory and clinical practice (Fiandt et al., 2004; Limoges & Acorn, 2016; Carter et al., 2017). Its enhancement of clinical practice includes the sharing of nursing knowledge and a readiness to recognise and rectify errors (Mohide & Coker, 2005; Jacelon et al., 2010). Despite these benefits to clinical advancement, the process of knowledge transfer to practice encounters challenges. These include the type and availability of knowledge, the approach to facilitating its transfer, the person using it,

and the context in which transfer occurs (or does not) (Bucknall, Copnell, Shannon et al., 2001; Titler, 2008). Additionally, there has been a concern about clinical nurses finding the time for increased involvement in scholarly activities such as seminars and conferences where clinical specialist nurses can disseminate relevant findings and thus expand their nursing knowledge (Smesny, Williams, Brazeau et al., 2007; Ryan & Doody, 2014).

It was noted by Wilkes et al. (2013) that a major challenge associated with implementing CS is a general lack of knowledge and understanding of CS by clinical nurses; for some its definition remains unclear (Sevean, Poole & Strickland, 2005). Riley et al. (2008) assert that the meaning of CS is not really understood by clinical nurses owing to confounding issues such as a lack of structural and process support in the clinical setting. Without understanding CS, nurses will not be ideally positioned to transfer research findings to their practice (Fairman, 2008). In order to understand what CS entails one has both to engage with and define scholarship. McCormack (2011) argued that clinical nurses must first link theory and practice, and participate in clinical scholarship activities and, similarly, Van der Meer (2007) supports the idea that it is essential to minimise the gap between theory and practice. McCormack (2011) noted that the team producing the research (knowledge producer) needs to collaborate with the group using the findings (knowledge consumer) in order to create a milieu conducive to evidence generation, dissemination, decision making and meaningful, appropriate application of research findings to clinical practice. Kitson (2006) adds that CS requires an immersion in clinical practice while simultaneously requiring enough distance from it for describing and analysing what is occurring within clinical practice. For these activities to be recognised as scholarship, they should be evaluated and critiqued through peer review, made available to the public and accessible to other members of the discipline (Kennedy, Gubbins, Luer et al., 2003; Glanville & Houde, 2004; Limoges & Acorn, 2016).

Despite the challenges to CS, nurses should be mindful of a commitment to promoting scholarship by building a culture of CS (Kitson, 2006). It is against this background that this study seeks to explore and describe CS in order to develop recommendations about how it can be promoted in the clinical arena.

This research study involved post-basic-registration nursing students who are working in clinical arenas and progressing to the acquisition of a clinical speciality. Clinical specialty programmes involve a qualification in a clinical specialty that builds on the student's undergraduate nursing education and professional experience. Currently the Discipline of Nursing at the selected university offers clinical specialties under two degree programmes, namely, a Bachelor's degree in Nursing (Advanced Practice) or a Master's degree in a clinical speciality. These programmes incorporate the teaching of sociological strategies, advocacy training as well as management guidelines (South African Nursing Council, 2005; Nursing Midwifery Council, 2012). Students are required to complete coursework modules in statistics, research, epidemiology, and advanced patient assessment, thus acquiring skills that can be translated into health care services specific to the area of specialisation; graduates of either of the degree programmes mentioned above may be seen as agents of change in the clinical arena.

### **1.3 Statement of the problem**

Research has shown that CS is integral to evidence-based nursing and the development of best practice standards for the needs of patients (Fiandt et al., 2004; Tymkow, 2010). This has led to the recognition of CS as an approach that achieves positive patient outcomes (Makic, Martin, Burns et al., 2013). These positive patient outcomes include a decrease in morbidity and mortality rates and shorter stays in hospital (Leufer & Cleary-Holdforth, 2009). If patient care is not based on scientific knowledge, there is potential for harm to the patient. In the United States of America (USA), it has been shown that as much as 20-25% of nursing care was not aligned with evidence-based best-care practices and hence was viewed as inappropriate (Schuster, McGlynn & Brook, 1998). This was supported by Grol and Grimshaw (2003) and, persistently in Australia, by (Breimaier et al., 2011).

Despite such findings, the application and promotion of CS in the clinical arena has been limited. This may be attributed to a misunderstanding of what CS entails and to an under-rating of its importance for the personal and professional growth of clinical specialist nurses (Irvine, Gracey, Jones et al., 2008). Although clinical specialist nurses are aware that clinical practice should be evidence-based, they are unsure of how to get involved in CS. This is often due to limited research

resources for knowledge development (Jones, 2011; Mannix, Wilkes & Jackson, 2013) and to the difficulty of implementing CS in unprepared clinical environments (Grol and Grimshaw, 2003).

A need to focus on clinical specialist nurses was identified as they appear to be perfectly positioned between the clinical and academic worlds. Their position provides insight into both the barriers - and the possible solutions – presented by CS.

#### **1.4 Aim of the study**

The aim of the study is to explore and describe clinical scholarship in order to develop recommendations for promoting clinical scholarship in clinical arenas.

#### **1.5 Research objectives**

1. Explore and describe clinical specialist nursing students' and clinical nurse experts' perceptions of clinical scholarship.
2. To develop recommendations to promote clinical scholarship in the clinical arena.

#### **1.6 Research questions**

1. What does clinical scholarship mean to clinical specialist nursing students and clinical nurse experts?
2. What are the barriers to clinical scholarship as perceived by clinical specialist nursing students and clinical nurse experts?
3. What are the enablers of clinical scholarship as perceived by clinical specialist nursing students and clinical nurse experts?
4. How can clinical scholarship in nursing be promoted in the clinical arena?

#### **1.7 Significance of the study**

The study is of relevance to several areas of nursing:

##### **1.7.1 Nursing education**

It is hoped that the study's findings can be incorporated into clinical teaching and learning policy at the undergraduate and postgraduate levels, with a focus on the development of a CS ethos in the

clinical arena. It is also hoped to identify ways that educators can liaise and network with clinical staff in capacity building for CS. Furthermore, this study may encourage undergraduate and post-basic-registration nursing students to reflect on the meaning of CS and its importance in their everyday work. It may also offer ideas about how aspects of CS can be incorporated into nursing education curricula, so that students are given the opportunity to acquire the knowledge and skills base necessary for the facilitation of CS in the clinical arena. Additionally, it is hoped that the study can identify the requirements for planning, organising and catering to the educational needs of CS students. It is hoped, finally, that the study may help the clinical experts (CEs) to impart more effectively to clinical nurses the necessary skills and knowledge associated with CS – as well as a positive attitude towards it.

### **1.7.2 Nursing practice**

The research may contribute towards the development of professional clinical knowledge guided by its findings and recommendations. It may assist clinical specialist nurses to broaden their knowledge regarding CS and its application in the clinical field. Clinical nurses may be spurred to identify, assess and correct health care problems by applying scientific knowledge to their everyday practice. The study may encourage the managers of the clinical arena to set up practice environments that favour lifetime learning prospects and continuous professional and personal development within a CS framework for the clinical specialist nurses.

### **1.7.3 Nursing research**

The findings of the study may encourage nurses in the clinical arena to view research as an important element of CS and to appreciate its usefulness in addressing clinical problems and finding solutions for them, so as to improve the safety, quality and efficiency of patient care (as well, of course, as advancing nursing practice). These benefits may stimulate nurses to actively engage in clinical research studies. It is hoped that by pointing up the relative sparseness of research in the area of CS, this study will spur nurses to pursue research in this field.

### **1.7.4 Nursing management**

It is envisaged that the results of the study may initiate the development of policies that could help guide clinical scholarship within the nursing profession. There are many challenges facing the

nursing-education system, specifically in the clinical arena, hence it is important to develop policies and guidelines for clinical scholarship that will be relevant where the need is greatest. Policy and guideline development within organisations may allow for institutional change from which CS research will benefit.

## **1.8 Operational definitions**

In the context of this study, clinical scholarship, clinical specialist nursing student, clinical nurse expert, clinical arena and recommendation are defined as follows:

### **1.8.1 Clinical scholarship**

In this study clinical scholarship (CS) refers to an approach where clinical nurses use their clinical skills to observe and identify health-related issues and then apply scientific knowledge to rectify the problems, enhance clinical standards and ultimately improve patient care and outcomes. It is also viewed as a process whereby nurses generate new knowledge and disseminate it to their colleagues so as to optimise its use in the clinical arena.

### **1.8.2 Clinical specialist nursing student**

In this study, a clinical specialist nursing student (CSNS) is a nurse registered with the South African Nursing Council (SANC) as a professional nurse working in the clinical arena. At the same time this person is registered with the university for a Bachelor's degree in Nursing (Advanced Practice) or for a Master's degree in a clinical speciality in one of the following programmes offered by the university: Critical Care and Trauma, Oncology and Palliative Care, Advanced Midwifery.

### **1.8.3 Clinical expert**

In the context of this study, clinical expert refers to a lecturer teaching students at the university. He/she is seen as a person capable of imparting to students a positive attitude to their profession. Clinical nurse experts typically have the dedication, knowledge and aspirations for their students that can inspire a thirst for knowledge. They are expected to teach the CSNSs to think critically and to explore different angles of knowledge with a view to improving health care and producing better patient outcomes.

#### **1.8.4 Clinical arena**

In this study, clinical arena refers to an area where professional clinical nursing activities occur and, more specifically, to all areas where clinical specialist nurses practise. Included under this head are the critical care unit, trauma/emergency department, oncology and the oncology clinic (including palliative care), midwifery (antenatal clinic and ward, labour ward, postnatal normal delivery and caesarean section).

#### **1.8.5 Recommendations**

For the purposes of this study, recommendations will encompass an aggregate of suggestions made by the participants involved in the study as to how CS can be promoted in the clinical arena. These suggestions are linked to the quantitative and qualitative findings and to Boyer's framework for scholarship.

#### **1.9 Chapter summary**

This chapter described what clinical scholarship involves in terms both of its main features and of the impediments to its implementation, the aim being to develop recommendations to promote clinical scholarship in clinical arenas. The statement of the problem, the research objectives, the research questions and the significance of the study were also explained.

Chapter two discusses the conceptual framework used to guide the study as part of a literature review on clinical scholarship.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

As part of the research process, the literature review is an important feature of any academic research project. It provides an overview and understanding of the research problem and the research topic under study. It creates a foundation for knowledge, whilst taking cognizance of existing research and unmasking the areas where there is a need for research (Webster & Watson, 2002). It justifies the need for the research study and shows how the research can contribute to new knowledge in the specific area. Further, this chapter highlights how the researcher incorporates the literature review into the research project, as well as considering the role played by the organising conceptual scheme in the research (Clark & Creswell, 2015). This, together with the literature review, has enabled the researcher to position the study so that it is able to address areas of deficit in CS.

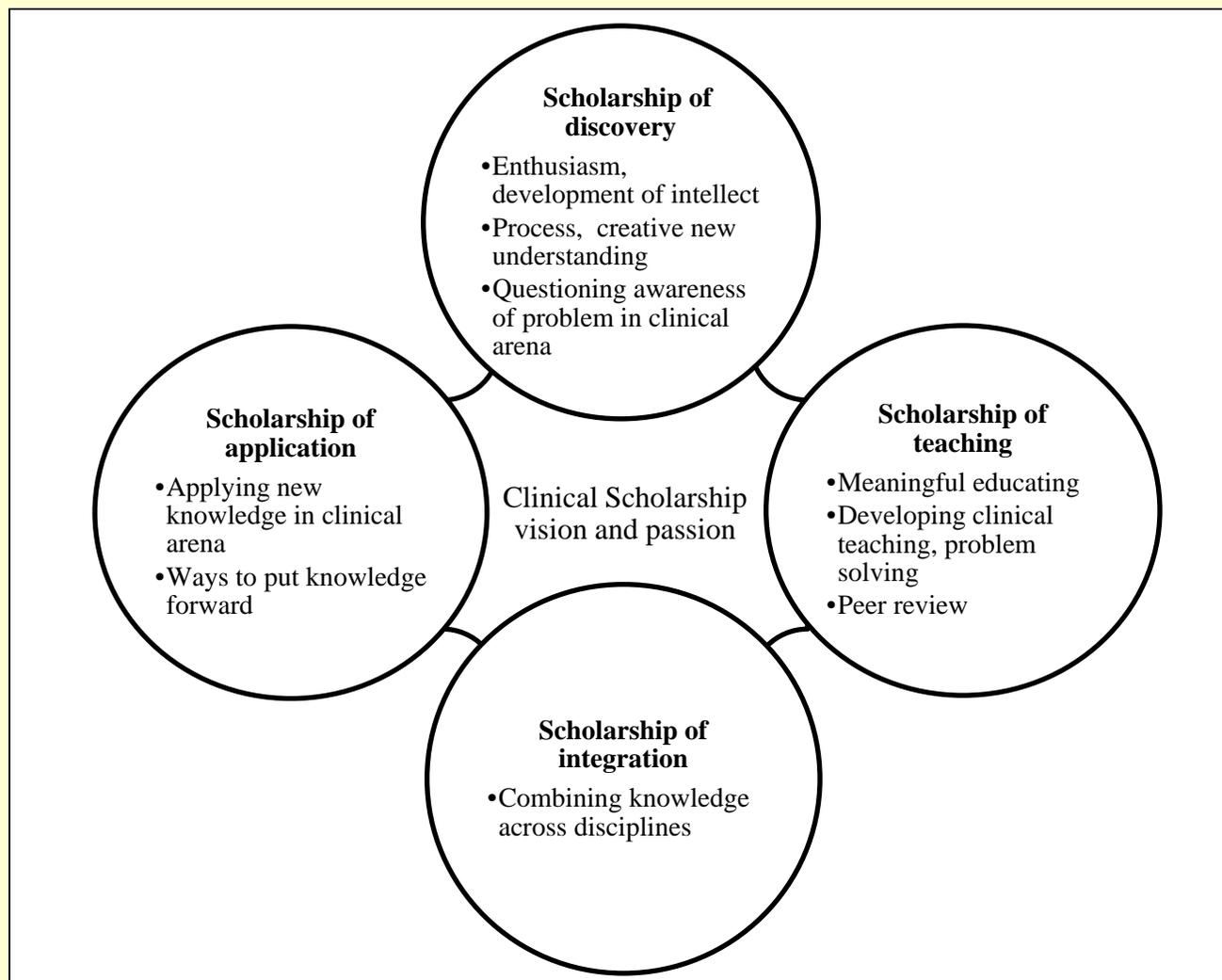
#### **2.2 Search strategy**

A total of seven databases were used to search for the literature and included: ScienceDirect, Pub Med, OVID MD, Sage Journals Online, Wiley Online, ProQuest New Platform and the university search engine as well as Google Scholar. The reference lists, and the most cited references within articles were also used to identify other articles that were relevant to the study. The keywords used to guide the search were; *clinical scholarship*, *clinical nurse*, *clinical scholarship in the clinical arena*, *research in clinical scholarship* and *clinical practice*. More than 200 articles were retrieved. However, only those articles relevant to the research topic were included in the literature review. The literature search is dated from 1980 till the most recent relevant article. The terms used to indicate relevance were: clinical scholarship, research in clinical area/scholarship, clinical nurse research/researcher, clinical scholar.

#### **2.3 Conceptual framework**

This study was guided by Boyer's (1990) Framework of Scholarship which consists of four components, namely; scholarship of discovery (searching for problems and explanation of research); scholarship of integration (interpreting the findings of the research and sharing with and

across the discipline); scholarship of teaching (creating interaction between the one delivering the knowledge and the one receiving the knowledge) and scholarship of application (translating the knowledge such that it impacts positively on society).



**Figure 2.1: Boyer’s Framework of Scholarship (1990)**

The application of Boyer’s conceptual framework to this study was displayed in the formulation of the research objectives and questions. Furthermore, the choice of Boyer’s Framework of Scholarship was used in this study because Boyer in 1990 proposed that a scholar engages in four interrelated areas of scholarship in the pursuit of knowledge that is responsive to human problems and societal needs. The four components of CS (discovery, integration, teaching and application) are essential in nursing as it involves more than just research and publication. All four components

of scholarship are essential as they can be used in isolation or can overlap one another (Wilkes et al., 2013), meaning that if CSNSs claim to be active in CS they cannot be limited to activities in an isolated component and should not limit themselves to participating in a single track. The researcher found the four components of scholarship ideal for the study, as Boyer (1990) claimed that knowledge develops in a two-way process where practice and theory rely on each other. This is further supported by Gray and Pratt (1995) and Kelsey (2016) who state that knowledge involves research, practice and teaching. Further to this, the recommendations developed included aspects focusing on the four components of the framework.

Even though the researcher decided to use Boyer's Framework of Scholarship (1990), he was mindful of the criticism against the framework. The criticism included that of Schön (1995) who argued that more people are concerned with "how we get to know what we know", rather than with research. Furthermore, Jacelon et al. (2010), who also utilised Boyer's framework, suggested greater engagement with the community whereby knowledge can be retrieved from the community by the expert to serve the needs of the community and institutions. In addition, Spanier (1997) also emphasised engagement between the community and the university. Boyer (1996b) however, had already argued that CS should create a climate where civic and academic could continuously and creatively engage with each other, thereby enriching societal culture .

Furthermore, Fincher and Work (2006) postulated that scholarship of teaching should not be seen as an independent form of scholarship, but should be viewed as involved in the scholarship of application, discovery or integration. This reflects on interaction, assessment, transmission, development and design from well-designed strategies and integration of ideas (Shulman, 2000b). In contrast, Shulman (1999) claimed that the scholarship of teaching is only validated when the work of the scholar (teacher or lecturer) becomes known to the public, can be critiqued, and peer reviewed, as this is the way in which the building-blocks of knowledge are raised up. In support of Boyer's position on the scholarship of teaching, Ochoa (2011) postulated that scholarship of teaching is not merely for publishing research but incorporates all components of academic work with a view to closing the gap between clinical practice and theory and thereby imparting knowledge more effectively to students.

The components of Boyer's framework may work in isolation or may overlap; the framework goes beyond research and publications:

1. Scholarship of Discovery involves research with the aim of contributing to the intellectual life of the university, discipline or college.
2. Scholarship of Integration involves educating specialists as well as nonspecialists; it involves making connections across the discipline and putting them in perspective.
3. Scholarship of Application concerns how knowledge can be helpful to individuals.
4. Scholarship of teaching aims to narrow the gap between the student's learning and the teacher's understanding.

### **2.3.1 Scholarship of Discovery**

The scholarship of discovery is explained as a process of enthusiasm that gives meaning to the process itself, going beyond its outcomes; and it contributes to the development of human intellect (Boyer, 1990). Storch and Gamroth (2002) view scholarship of discovery as asking the question "What is to be known?" Therefore the scholarship of discovery is a creative enterprise, producing new knowledge intended to be integrated into the clinical field (Jacelon et al., 2010). In this way, theory is translated into practice (Thoun, 2009).

Scholarship of discovery not only contributes towards human knowledge (Boyer, 1990; Glassick, 2011), it assists the scholar to find answers to questions and to have an understanding of the world (Boyer, 1996a). Scholarship of discovery goes beyond research or the questioning of current practices in the discipline (Hofmeyer, Newton & Scott, 2007; Coulton, 2011). Discovery creates awareness of the need to keep abreast of recent developments (skills and theory) in clinical practice, thus highlighting the rationale behind placing a question mark over certain aspects of current practice and validating the need to find answers based on evidence (Pape, 2000; Mtawa, Fongwa & Wangenge-Ouma, 2016). In scholarship of discovery, clinical nurses should be equipped to identify the type of research or data that will improve the efficiency and quality of patient care (Robert & Pape, 2011). New knowledge is founded on discovery, enabling evidence-based practice (American Association of Colleges of Nursing, 1999). The scholarship of discovery provides a measure for evaluating clinical nursing practices and facilitates the development of new strategies within the clinical arena (Fincher & Work, 2006).

### **2.3.2 Scholarship of Integration**

This involves the synthesis and application of information across disciplines and of topics within a discipline. The scholarship of integration is best seen as the interaction between clinical nurses in the practice arena, and with clinical nurses in other disciplines, with a view to the sharing of clinical knowledge (Storch & Gamroth, 2002; Jacelon et al., 2010). It is through this connectedness that the sharing of information and ideas across disciplines may be consolidated so that new knowledge and perspectives can then be generated and tested (Boyer, 2004). Scholarship of integration focuses more on meaning and effect, giving new direction and answers to questions that seemed initially to be insoluble (Hofmeyer et al., 2007). Presentations, publications and reports of interdisciplinary programmes are activities of the scholarship of integration that guide clinical practice (Nelson, 2001; Berry, 2015).

Integration is not a solitary activity it involves the participation of other clinical staff across the field as they amalgamate ideas to form new knowledge and new visions. This brings in the element of communication among nurses and other health professionals that is crucial in patient care, and which goes beyond the mere content of the knowledge imparted to include the human dimensions of communication and participation (Nadzam, 2009). Integration can be achieved by discussions among the multidisciplinary team members prior to patients' rounds in order to identify problems and solutions related to patients' issues. The positive spin-off of this approach is affirmed by Robert and Pape (2011), where discussions regarding the patient between the team handing over and the team taking over reduced misunderstanding and duplication (Robert & Pape, 2011). This integration enables the team taking over to provide continuing care avoiding misunderstandings about patient management and to prioritise specific tasks as needed.

### **2.3.3 Scholarship of Application**

Despite acquiring knowledge, Storch and Gamroth (2002) were concerned about how this knowledge could be helpful to society when applying ideas, principles and theories in the real world. Boyer believed strongly in the application of knowledge to the realities of life. His intention was to move theory to the "real world" and move from the "real world" back to theory as these two components cannot be separated (Boyer, 1996a). When clinical nurses engage in scholarship

of application, they must show a willingness to find solutions to problems in the clinical arena and demonstrate good communication skills in imparting these solutions when engaging with colleagues and other health care professionals (Austin & McDaniels, 2006). The scholarship of application creates opportunities for nurses to consider how, through collaboration, new ideas can be formulated for improving nursing practices and bringing about advances in healthcare (Peterson & Stevens, 2013). In scholarship of application, clinical nurses also learn the techniques of conveying distressing news to patients and families, in addition to answering patients' doubts (Fincher & Work, 2006). Scholarship of application is important for coaching nurses to be role models and change agents, and for implementing better clinical practice (Robert & Pape, 2011).

#### **2.3.4 Scholarship of Teaching**

Scholarship of teaching is seen as an act that involves a sharing of knowledge that becomes meaningful when transferred to other users (Boyer, 1996a). The activity involves sound planning such that educators and CSNSs are continuously researching, engaging intellectually and closing the gap between teaching and learning (Storch & Gamroth, 2002). Proper planning is necessary to translate theory into practice, as this is a dynamic, scholarly enterprise where the teacher conveys knowledge to students and in return learns from them (Storch & Gamroth, 2002; Jacelon et al., 2010). Teaching is essential for the development of improved clinical practice provided that those who are delivering the service are knowledgeable in that particular area of service delivery (Boyer, 1990).

This component of CS should go beyond the transfer of information to clinical nurses; it should stimulate clinical nurses to be active learners, critical thinkers and, most of all, be committed to the learning process (Hofmeyer et al., 2007). Moreover, teaching is justifiably recognised as a component that invites peer reviews on current knowledge and current findings (Fincher, Simpson, Mennin et al., 2000). It should, additionally, be committed to information sharing with peers across disciplines (Robert & Pape, 2011).

#### **2.4 Characteristics of clinical scholarship**

The following section discusses the characteristics of CS.

### **2.4.1 Value driven**

Clinical scholarship encourages nurses to interact with their patients through caring encounters which imply passion, affection, love, and dignity (Dreher, 1999; Riley et al., 2008). When nurses engage in caring encounters with patients, the needs of the patients and their significant others take precedence over other emotions (Freshwater & Stickley, 2004). The nurse-patient relationship should be therapeutic, involving family in the care of the patients to provide company (Dreher, 1999; Weston & Hudson, 2014). In order to achieve value-driven patient care, the clinical nurse specialist needs education and skills in the field (Sabatino, Stievano, Rocco et al., 2014), the knowledge needed to connect with patients and their environment physically and spiritually so as to facilitate a healing response (North, 2015).

### **2.4.2 Autonomy**

Clinical scholarship is about autonomy, which includes self-governing behaviour, where clinical nurses feel more empowered in their decision making. Nurses feel less enthusiastic when they are not in command of the activities that impact on their practice (Dreher, 1999). This is supported by a study which found out that equipping nursing students or clinical nurses with the necessary theoretical skills related to nursing practice creates self-confidence, which improves their practice and hence patient care (Brown, Kim, Stichler et al., 2010). Similarly, nurses add that they are more confident in information sharing with patients and families when they can claim ownership to the information. Equipped with necessary knowledge they feel confident to participate fully as part of a multidisciplinary team (Balakas, Sparks, Steurer et al., 2013).

### **2.4.3 Honesty and integrity**

Clinical scholarship involves honesty and integrity. The values of honesty and integrity are crucial to the development of new knowledge generated from research. The scholar should remain committed to these values throughout the process of collecting and interpreting data. It is unethical for a scholar to be dishonest and make false claims for his/her research (Conard & Pape, 2014). False interpretation of data can lead to mismanagement of patient care and as a result jeopardise the integrity of the health care system. Other forms of misconduct that scholars should avoid when conducting research are: concealing data (all data should reported); vague explanations derived

from the data (clear explanations should be given), and collecting data without the informed consent of the participants (Habermann, Broome, Pryor et al., 2010).

## **2.5 Promoting clinical scholarship**

All nurses must be committed to CS activities irrespective of their status in the profession, specialisation or clinical area. Scholarship is no longer confined to academia; it ought to be viewed as indispensable for the clinician, clinical practitioner, researcher, mentor and teacher (Tahan, 2006).

O'Connor and Peters (2014) agree that CS is an intellectual activity that provides nurses with different ways of acquiring knowledge across the nursing profession, resulting in the construction of new concepts aimed at improving patient outcomes. Nurses who acquire the knowledge and skills relevant to their clinical practice will be optimally positioned to meet present and future challenges to improve clinical practice using the best available evidence and technology, thus promoting and sustaining advances in clinical practice. Nurses must take responsibility for keeping abreast of the latest developments in health care (Nursing Midwifery Council, 2010). They should guard against complacency and inertia and should be proactive in moving the profession forward through activities such as research, role-modelling, critical thinking and mentoring. They should relinquish practices based on untested belief and tradition and embrace evidence-based nursing where emphasis is placed on CS activities (Tahan, 2006).

The extent to which CS can be incorporated into practice is dependent on the nature of the setting. Its incorporation is best in an environment where some of the following features are present (Sigma Theta Tau International Clinical Scholarship Task Force, 1999; Tahan, 2006): the importance of CS is understood by the administration; there is willingness and consistency in sharing knowledge with colleagues, resulting in the development of CS and in research projects and publications; there is support for evidence-based practice and a willingness to apply it to patient care and decision making within the health care environment and challenges are welcomed and innovation is encouraged.

Grigsby and Thorndyke (2011) state that CS is the way forward in helping nurses to solve clinical problems and eventually improve health care practice. Agreeing, Weston and Hudson (2014) stress that CS focuses not only on solving immediate issues related to illnesses but explores how nurses can improve clinical practice on a broader scale. This can be achieved by identifying problems through the lens of scientific research and through systematic observation. Bell (2003) and (Tymkow, 2010) argue that CS, while not a substitute for clinical research, should be seen as an intellectual activity worthy of being valued within the nursing profession.

Even though efforts are being made to promote CS, clinical nurses from Australia, Canada and the United Kingdom contend that CS is difficult to conceptualise (Wilkes et al., 2013). One of the reasons for this could be a general undervaluing of scholarship and a culture that does not support scholarship in the clinical setting (Kitson, 2006). Other issues identified included: unclear guidelines for practice standards, limited resources (funding and expertise), time constraints inhibiting involvement in scholarly activity (Riley et al., 2008). In their study aimed at identifying CS guidelines for practice, Fiandt et al. (2004) revealed that when scholarship guidelines were clearly described, nurses were better able to meet practice standards. Nonetheless, CS in nursing appears to be still not well understood and not well defined for most nurses (Jones & Van Ort, 2001; Riley & Beal, 2013). Grigsby and Thorndyke (2011), in promoting CS, point out that it is broad in scope, extending beyond the clinical arena/practice and offers an enhanced means whereby the scientific method can be used to identify and solve clinically-related issues. They added that CS embraces knowledge from other disciplines to expand understanding; and highlights the need for peer-reviewed documentation, logical presentation and effective dissemination.

Supporting earlier studies, Weston and Hudson (2014), state that in order for CS to gain support, the clinical arena should value the generation of knowledge aimed at enhancing clinical practice in a clinical scholarship programme designed to improve capacity among palliative care health professionals, O'Connor and Peters (2014) discovered that clinical nurses needed to be supported financially to enable them to pursue further studies and gain the requisite level of professional knowledge.

In a study aimed at assessing resources and building a culture of clinical CS, O'Neil Mundinger et al. (2009) postulated that management in clinical arena need to work with academia to develop Masters and doctoral programmes for students geared in enabling them to translate research findings into clinical practice. Furthermore in a study conducted in Mozambique, Bruce, Dippenaar, Schmollgruber et al. (2017) developed a model to help the specialist and general nurse to practise more effectively in the domains of clinical teaching, research and practice. Similarly, in a South African study on CS, Roets et al. (2016) stated that enhancing CS within the nursing profession entails support for university-(degree) graduates that possess knowledge and skills for undertaking CS. Limoges and Acorn (2016) study on transforming practice through CS takes the view that linking Boyer's framework to gain a clearer perception of CS may help nurses rectify clinical issues effectively and timeously.

## **2.6 The importance of clinical scholarship**

The nursing profession requires nurses to constantly improve their competency and practice in all disciplines of nursing (Jormsri, Kunaviktikul, Ketefian et al., 2005; Ryan & Doody, 2014). Zhi-xue, Luk, Arthur et al. (2001: p. 469) explained competence as “job-related, referring to a person's capacity to meet a job's requirements by producing qualified output”. Clinical judgement, critical thinking, motivations, behaviours and intellect are needed to perform clinical practice effectively in different clinical settings. Competence is not only about knowing but the “thirst” to put theory into practice (Zhi-xue et al., 2001; Rejeh, Ahmadi, Mohamadi et al., 2009). Indeed, Turale, Ito, Murakami et al. (2009) study in Japan agreed that strategies are needed to better support scholarship, professional development and bridge the theory-practice gap.

Furthermore, in New York, Tahan, (2006) postulated that nurses need to continuously bring qualities of their specialisation to assist in resolving clinical issues and improving patient outcomes and further contributing towards developing new nursing knowledge. Regardless of the nurse's qualifications, scholarship is becoming every nurse's concern and responsibility (Tahan, 2006). Clinical scholarship is recognised as an approach that enables evidence-based practice (EBP), education, mentoring, policy and leadership by determining desired results that are investigated and tested through scientific procedures or, alternatively, through quality management processes. It further involves assessment and using methodical analysis and scientific techniques to identify

problems and to find solutions for them, and the publication and documentation of results and enhancements using various means, among them publications, counselling, presentations and information (Tahan, 2006). These are regarded as processes that apply throughout the nursing profession where clinical nurses simultaneously gain the confidence and ability to analyse their practice and make changes where and when necessary in their clinical area (Solum, Maluwa, Tveit et al., 2015). Additionally, in the study conducted in the United Kingdom (UK), Australia and Canada, by Wilkes et al. (2013), the clinical nurses postulated that knowledge gained by clinical nurse should be made known to other users. In so doing nurses would be able to be independent and able to make their own clinical judgements (Karabulut & Aktaş, 2015).

## **2.7 Nurses' perceptions of clinical scholarship**

A study in China, the nurses indicated that an understanding of the concepts of CS assisted them in informing policy makers about what needs to be done to improve patient outcomes and nursing practice, and to enhance nursing research (Turale et al., 2010). Nurses have found CS to be a guide that leads nursing practice and motivates them to provide patients with care based on evidence so that the care is more efficient and effective (Turale et al., 2010). According to Allgood (2014) CS helps nurses to focus on the patient holistically and not only on the illness (pathophysiological) of the patient. Studying the patient holistically as opposed to their illness, encourages the observational skills of CS, which results in the nursing students gaining knowledge beyond the illness of the patient (Allgood, 2014). Strout (2005) added that nurses perceived CS to challenge themselves, by looking for alternatives in managing the patients, and asking questions about improving nursing practice. This is also reflected in Riley et al. (2008) study in the USA describing scholarly nursing practice from the perspective of experienced nurses, where they discovered that nurses are enthusiastic about discovering, knowing and understanding new knowledge that can be used in practice.

Jones and Van Ort (2001) state that in an environment where CS is well understood, nurses support and salute the idea of CS. They see scholarship as a valuable and important part of their professional development, in that it is intellectually stimulating, enriching their knowledge, and creating superior clinical skills. Translation of knowledge into practice creates a friendlier

environment for nurses to share knowledge, hold discussions and formulate new meanings which benefit patient outcomes (Duhamel, 2010).

## **2.8 Closing the gap between research and clinical practice**

Since the beginning of the 21<sup>st</sup> century, healthcare organisations and healthcare professionals have started to search for new information to address doubts and reshape health care (Fineout-Overholt, Melnyk & Schultz, 2005; Melnyk & Fineout-Overholt, 2011). Despite acknowledgment of the usefulness of research evidence in real-world practice, strategies still need to be refined for successful implementation (Kitson, Harvey & McCormack, 1998). A number of authors have emphasised applying theory to practice for better patient outcomes (Sackett, Rosenberg, Muir Gray et al., 1996; Estabrooks, 1998; Fineout-Overholt et al., 2005; Strout, 2005; Mannix et al., 2013; Stevens, 2013). Moch and Cronje (2010) proposed CS student-enabled practice as a change in nursing curricula with the aim of extending research beyond theory into the clinical arena whilst Marteau, Sowden and Armstrong (2002) suggested that interactive continuing education such as problem solving and reflective practice enhances involvement in clinical activity and makes available the opportunity to develop critical-thinking skills.

Grimshaw, Eccles, Lavis et al. (2012) believe that closing the gap between research and clinical practice is more likely to be achieved if an assessment of the potential obstacles informs the knowledge-translation strategy. The authors postulate that translating knowledge into practice has been difficult when guidelines and policies do not accommodate new practices in daily clinical practice. A bridge is needed to overcome the gap between research and clinical practice (Natarajan, 2014), and this can be achieved through encouragement of clinical nurses to participate in research activities and utilise research in their daily practice (Wilkes et al., 2013).

An example of translating research to improve practice is the use of Epinephrine (Adrenaline) during Cardio-Pulmonary Resuscitation (CPR) (Attaran & Ewy, 2010). The current administration of Epinephrine during CPR ranges from 0.05 to 0.2mg per kilogram of body weight while the standard dose is 0.01mg per kilogram. However this was not always the case. as when using 0.01mg of Epinephrine per kilogram failed, a higher dose was administered to realise rapid pharmacological change (Perondi, Reis, Paiva et al., 2004). However, research has shown that

giving a high dose (0.2mg/kg) of Epinephrine offers no extra benefits to patient survival during CPR compared to the standard dose (Perlman, Wyllie, Kattwinkel et al., 2010). Keeping abreast of current best practice has not only equipped clinical nurse specialists to make appropriate judgements in this situation but has also minimised the waste of resources in the clinical facilities.

Although vast amounts of healthcare information are generated daily, clinical nurses face difficulties in finding, retrieving and using the existing scientific evidence to support clinical judgements to professional standards (Farokhzadian, Khajouei & Ahmadian, 2015). Participating in CS activities enables clinical nurses to overcome these difficulties (Wilkes et al., 2013). CS is an on-going process of knowledge development that requires practice, reflection and study. Through reflective practice, the clinical nurse may gain better insight into how theory and individual experience can contribute to knowledge development and best practice (Sevean et al., 2005).

Clinical scholarship provides an ideal milieu for generating new knowledge through engagement in scientific research activity and social exchange that raises the standard of practice in the profession (Tymkow, 2010; Grigsby & Thorndyke, 2011). It is an intellectual process which allows clinical nurses to inquire when there is uncertainty, predict outcomes and try out new ideas (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). Furthermore, clinical scholarship activities improve teaching, research and practice in the nursing profession as a whole since they can be documented by expert opinion and disseminated (American Association of Colleges of Nursing, 1999).

The world has been moving towards understanding what constitutes quality health care since the early 1990s. This has been in relation to evidence-based medicine (Nelson, 2014) which is viewed as the “conscientious, explicit and judicious use of the best evidence in making decisions about the care of individual patients” (Sackett et al., 1996:71), as well as the use of theory-derived, research-based information in making decisions about care delivery to individuals or groups of patients reflective of individual needs and preferences (Ingersoll, 2000). Evidence-based practice has also been used as a resource to answer uncertainty and as a long-term problem-solving guide to clinical practice as it involves scientific research, critical evaluation and synthesis of the best

appropriate practice (Melnyk & Fineout-Overholt, 2011). The definition of EBP has been well recognised and adapted for patient care in making clinical decisions, which is in line with the definition of CS, as scholarship is not solely about what exists but about the meaning of things (Tymkow, 2010).

Evidence-based nursing practice permits nurses to deliver high-quality care founded on the best evidence that exists, which in turn leads to positive nursing intervention. For improvement of patient outcomes it is important to integrate an EBP strategy with clinical nursing (Elarab, El Salam, Behalik et al., 2012). In their support of EBP, Urden, Stacy and Lough (2010) emphasise “efficiency”, “cost effectiveness”, “quality of life”, and “patient satisfaction rating”. It has become increasingly important for nurses to use researched scientific evidence to make decisions about patient care and perform the necessary interventions. By applying evidence with its potential to justify and forecast patients’ outcomes, nurses will be able to deliver research-based intervention with more positive outcomes based on best practices.

In health organisations and services, “best practice” is knowledge that is used in specific circumstances by adopting and implementing solutions to similar health problems in other circumstances (World Health Organization, 2008). It is worth noting that best practices are “gold standards” contributing to improved patient outcomes. In order for best practice to become a norm in clinical practice, Kiwanuka, Boyar and Jensen (2013) remind clinical nurses that practice must be based on current research findings. Secondly, information which is significant to clinical practice and is in the best interests of patient care, should be gathered and formulated into guidelines easily accessible to those endeavouring to achieve excellence.

As CS emphasises generating new knowledge through research activities, scholars should be encouraged to go beyond research activities and to link research findings to practice (Honig, Smolowitz & Larson, 2013). Although the interpretation of EBP has changed from time to time, it should be borne in mind that patients’ values as well as the values of the care providers, their experience and decision making run parallel with scholarship (Tymkow, 2010). An effective translation of research into practice helps in the prevention, diagnosis and treatment of illness. True scholarship is about meaning obtained by “intuition, observation, theory, research, intelligent

analysis and judgement” grounded on the information which nurses use to deliver patient care that is authentically “individualized, reflective, and evidence-based” (Tymkow, 2010:66).

## **2.9 Barriers to clinical scholarship**

A major barrier to the implementation of CS lies in the lack of clarity regarding its definition. Consequently CS is not easy to implement, interpret, and assess (Glanville & Houde, 2004; Ochoa, 2011; Oermann, 2014). Improperly understanding of CS, creates a boundary and limits the potential to identify, acknowledge, support and use knowledge (Limoges & Acorn, 2016). On the contrary improved understanding of CS can help generate new knowledge and clear doubt in clinical practice (Wilkes et al., 2013). A study by Smesny et al. (2007) in Canada indicated that the fields of dentistry, pharmacy medicine and nursing all shared similar barriers to CS. These included: lack of funding for scholarship, few role models for teaching scholarship, re-examined criteria for promotion of clinical faculty, and time allowed for scholarship activity and creating synergy between research and practice.

Shulman (2000) added that a further barrier to CS was in its dissemination, stating that in spite of CS contributing towards the development of knowledge in one’s own discipline, the uncertainty remained on how this knowledge could be disseminated to other disciplines and colleagues. In order to enable the implementation of CS, one needs to exchange or share knowledge with colleagues (Shulman, 2012). As a recommendation, Oermann (2014) suggested that CS should involve not only educational research but should acknowledge other activities (e.g. reflective teaching practice) that are discussed and shared with colleagues. Waldrop (2016) agreed that sharing experiences relating to the care of patients through the process of peer review contributes to CS.

Furthermore, in a study conducted in the USA, Anderson, D’Alessandro, Quelle et al. (2013) noted that too often researchers are faced with lack of funding for their scholarly activities (publications, peer-reviewed articles and small projects) (Jacelon et al., 2010; Anderson et al., 2013). Simarlaly in a study in Egypt, El-Badawy and Kassam (2008) discovered that lack of funding in the clinical arenas was the most challenging barrier to research. In an Australian study, more than 90% of

participants were unable to pursue further educational training towards scholarship development due to a lack of financial aid (O'Connor and Peters (2014).

Another impediment to scholarly activity encountered by clinicians is a lack of skill in academic research writing, and with such a limitation clinicians often find it difficult to publish their work (Smith, Crookes, Else et al., 2012). Brown, Wickline, Ecoff et al. (2009a) study in California asserted that nurses do indeed lack knowledge about research and need expert guidance on the processes and protocols of research so as to surmount their uncertainty about work presentation and to iron out the difficulties of navigating the process of getting published. This is consistent with Kehrer and Svensson (2012) findings on advancing pharmacist scholarship and research, that the second most obvious barrier to scholarship was the research expertise. Therefore Smith, Barry, Williamson et al. (2009) and Ay, Gençtürk and Turan Miral (2014) argued that if researchers lack knowledge and yet wish to get their work published. there should be assistance for their scholarly activity. Additionally, to undertake scholarly activities within Boyer's framework of discovery, integration, application and teaching is very demanding of time, and this problem often makes it impossible to complete work intended for publication on schedule (Riley et al., 2008; Chalmers, 2011; Kehrer & Svensson, 2012; Peterson & Stevens, 2013).

Also noted as an impediment by Fitzpatrick and McCarthy (2010) is that very little attention is given to a culture of scholarship. With the lack of a supporting culture, scholarly connectedness between disciplines may be circumscribed, which diminishes CS engagement (Boyer, 1990). In fact, establishing a culture of scholarship is vitally important for the nursing profession (Forbes & White, 2012), as this could help in knowledge dissemination across the discipline, in the use of knowledge, in its incorporation into clinical practice, and in the teaching arena (Fitzpatrick & McCarthy, 2010).

## **2.10 Clinical scholarship and the nursing process**

The nature of CS is about asking questions and challenging practice guidelines, policies and theories. The idea is to search for better ways to improve patient care and not accept practices that are not founded on scientifically researched principles (Courtney, Rickard, Vickerstaff et al., 2010). The nursing process includes scientific knowledge where clinical nurse specialists engage

in observation, analysis and synthesizing of information during assessing, planning, implementing and evaluating care and patient outcomes. This further emphasises the idea that the nursing process is actually embedded in CS principles - which now need to be explicitly embedded in it.

### **2.10.1 Observation**

Observation is an important element of CS in the care and management of the patient (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). One of the essential practical lessons that can be taught to nurses is to impress on them “what to observe – how to observe – what symptoms indicate improvement – what is reverse – which are of neglect – and what kind of neglect” (p. 150). Observation can be viewed as a means of assuring that the appropriate actions are taken with regard to patient care; and it is fundamental to the nursing profession (Nightingale, 1860). Further to that, Iglesias, de Bengoa Vallejo and Fuentes (2010) emphasise that it is the nurse’s responsibility to assess and monitor the patient’s condition (mentally, physically, physiologically and spiritually) and make necessary changes in response to treatment and management. Through observation, nurses acquire skills such as good understanding, interpreting, communicating and responsiveness to a diversity of information in order to solve particular situations through the application of knowledge. Such activities promote CS (Tahan, 2006; Iglesias et al., 2010).

### **2.10.2 Analysing**

Analysis can be viewed as a continuation of interpreting the observation by comparing similar phenomena, looking for similarities, differences and patterns. Whether the comparison is drawn from clinical experience or from acquaintance with the literature, clinical nurse specialists must interpret the observation and, through this process of analysis, aim for better results (Dreher, 1999). The process of analysis requires the clinical nurse to have a strong knowledge base in clinical nursing and not merely previous experience. Analysis facilitates a creative thinking process that contributes to CS throughput into the clinical arena (Dreher, 1999; Tahan, 2006; Dunwoody, Krenzischek, Pasero et al., 2008).

### **2.10.3 Synthesizing**

In the context of CS, the action of synthesizing is defined as the process of explanation, finding meanings based on observation and bridging the chasms between theory, research and practice. Synthesizing builds on the process of analysis to create an understanding of a phenomenon through comparing one's observations with existing research and through integrating knowledge. From observation clinical nurse specialists can interpret the findings and discuss them among team members from different perspectives (Dreher, 1999). Through the exchange of ideas with colleagues across the discipline, clinical nurse specialists are able to gain different insights and enrich their interpretations. Synthesizing can also be achieved through the interaction of existing nursing knowledge with the clinical and research literature (Tahan, 2006; Grimshaw, 2010).

### **2.10.4 Applying and disseminating**

High-quality care for patients is dependent on the application of research. Currently, however, the transfer of knowledge to clinical practice is deficient. Decision making based on research findings is lacking across the profession - among nurses, researchers and other health care providers (Wilson, Petticrew, Calnan et al., 2010). Clinical scholarship, like clinical research, is based on intellectual inquiry, analysis, knowledge building and explanation. The sharing of this clinical knowledge requires that clinical nurse specialists demonstrate creativity, courage and leadership skills (Dreher, 1999; Austin & McDaniels, 2006). The improvement of clinical practice based on new evidence is important and therefore a clinical nurse must be innovative in transforming practice through the application of theory (Bauer-Wu, Epshtein & Reid Ponte, 2006). When applying and disseminating research findings, one needs to take into consideration the lay public to whom, as hospital patients, the research findings are going to be applied (Wilson et al., 2010). Interestingly, the public - and not only health professionals - scrutinises the outcomes produced by research and their potential to solve a health-related problem (Burgener, 2001; Berry, 2015). Dissemination is viewed as public that builds trust.

## **2.11 Chapter summary**

This chapter has surveyed the pertinent literature in terms of the conceptual framework chosen to guide the study. The principal aspects discussed were: clinical scholarship and the nursing process, the characteristics of clinical scholarship, the context and quality of practice in clinical scholarship,

the promotion of clinical scholarship, the attitudes of clinical nurses to clinical scholarship, their perceptions of it, closing the gap between research and clinical practice, the relationship between clinical scholarship and evidence-based practice, barriers to clinical scholarship and suggested solutions.

Chapter three will give an account of the methodology used in this study.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

In this chapter the researcher describes the research design chosen to address the research question, and methodological aspects of sampling, data collection tools, data analysis and data interpretation. Data management and ethical considerations pertinent to the study are also elaborated on.

#### **3.2 The research paradigm**

The research paradigm is a set of basic beliefs that underlie the researcher's action in regard to the question under investigation. The paradigm that underpins this study is that of pragmatism. Pragmatists claim that the problem is as important as the methods used, and the researcher uses the most appropriate approaches to understand the problem. In true pragmatic fashion, the present researcher believed in identifying the "root" of the problem in order to call forth the best solution(s). In that way, the choice of methods, techniques and procedures of research remained at the discretion of the researcher, who decided what would best answer the research questions.

Moreover, the researcher found pragmatism more suitable for the study as it is concerned with identifying problems and solutions in a practical manner that tries to distance itself from personal beliefs and preconceptions. The pragmatist view is that inquiry is open to multiple realities, and it orients itself to the solution of practical problems happening in the real world (Yvonne Feilzer, 2010). In this way the researcher had some freedom of choice and did not commit to one approach alone, rather looking at different approaches to collecting and analysing data, with the aim of best answering the research problem (Creswell, 2014). Additionally, the pragmatic approach allowed the researcher to have a wider and deeper understanding of the research problem than if he had used a single approach. Pragmatism also enabled the researcher to involve different participants so as to get multiple views on CS.

Furthermore, as CS is interested in questioning practice and not just accepting things as they are, pragmatism was suitable for the study as it is interested in identifying how things are and how knowledge can be useful for the user. For this study, both subjective and objective data generated

through both quantitative and qualitative methods produced a better representation of the actual situation of CS in the clinical arena. This approach also guided the study based on the research question for the development of knowledge through induction and deduction. It allowed the researcher to identify a value-oriented lens geared towards improving reality and in this instance improving clinical practice.

The pragmatic epistemological stance enabled the researcher to collate data from CSNSs actually practising in the clinical arena, thereby providing answers that were appropriate to the study's research questions. The pragmatic ontology served the research well as it elicited multiple viewpoints from clinical nursing practitioners operating in diverse clinical settings. This further helped the researcher not to be tethered to one research method of enquiry, but to be open to multiple methods. "To a pragmatist, the mandate of science is not to find truth or reality, the existence of which are perpetually in dispute, but to facilitate human problem-solving" (Powell, 2001:884).

### **3.3 Research design**

The choice of research design flows directly from the particular research questions under investigation. The research design used for this study was a mixed-methods or multi-method design. The use of mixed method research is increasingly gaining recognition in the world of research, especially in health care, the social and behavioural sciences and education (Collins, Onwuegbuzie & Sutton, 2006; Clark, 2010). It is considered suitable where a single approach may not fully answer the entire research question, and it creates an opportunity for the qualitative and quantitative approaches to be combined (Onwuegbuzie & Leech, 2004). So, by using a mixed approach, the overall strength of a study is greater than if either the quantitative or qualitative approaches were used alone (Creswell, 2009). The multi-method design enabled the researcher to collect, analyse and combine quantitative and qualitative data for this study in order to better understand and address the research problem. Furthermore, the researcher viewed the mixed method as appropriate for the study, as he believed that neither the quantitative method nor the qualitative one, each on its own, would have yielded sufficient information on how CS can be promoted in the clinical arena. The choice of a mixed method in this study was based on the

premise that the quantitative and qualitative methods would complement each other with regard to data collection, making for reliable findings.

The quantitative phase included close-ended questions which limited the researcher to collecting just enough information to address the basic aim of the study. By adding the qualitative phase the researcher had the option to have open-ended questions to further explore and elaborate on the problem. In this way, the participants were in a position to express themselves more fully, and this yielded new and deeper empirical insights into CS. Further to this, as recognised by Collins et al. (2006), the mixed-methods approach provided an avenue for participant enrichment through active involvement in data generation. On the other hand, the mixed method option was not without its disadvantages: it was more expensive, collecting and analysing the data took longer and, most of all, as a novice, the researcher needed substantial guidance in the conduct of the study.

Once the researcher had ascertained that the research questions to be addressed call for a mixed methods approach, the researcher made a decision on whether data would be collected whether concurrently or sequentially. For the purpose of this study, the researcher applied the explanatory sequential design. The sequential design was found to be more appropriate for a number of reasons. To start with, the research was conducted in three phases. This enabled the researcher to get back to the participants to collect qualitative data in the second phase after collecting the quantitative data in the first phase. The quantitative data provided a general picture of participants' perceptions of CS, barriers to its realisation and possible solutions, while the qualitative data generated in-depth coverage of participants' views. Further to that, the sequential method allowed the researcher to probe the question in a way that could best answer the research aim. The researcher was able to develop and put emphasis on the new questions that arose from the quantitative findings, and which could not be answered using the quantitative data (Creswell & Plano Clark, 2011). This allowed the researcher to explore potential problems and solutions in greater depth and detail. Where more clarity and understanding were needed, this was sought during the qualitative phase. The data were collected and at the same time analysed, which made the study more manageable for a single researcher.

### **3.4 The research setting**

A study usually takes place in either a controlled or a naturalistic environment (Polit & Beck, 2012) and a researcher should select a setting that yields the information most relevant to the question under investigation. In this study, the research was conducted at a selected university. The university is located in KwaZulu-Natal and provides an enabling academic environment for innovative research. From the selected university, the students participating in the study were CSNSs pursuing a Bachelor's degree in Nursing (Advanced Practice) or a Master's degree in a clinical speciality. Clinical experts teaching at the university also took part in the study.

### **3.5 Phases of research**

The process involved three phases as explained in the following sections.

#### **3.5.1 Phase One: Process of quantitative data collection**

This phase involved collecting quantitative data focusing on barriers to CS and possible solutions.

##### 3.5.1.1 Research participants

The choice of study-population involved a decision on which group would provide appropriate and rich information for the purposes of the study (Ritchie, Lewis, Nicholls et al., 2013). The population targeted for this study were all students undertaking the Bachelor's degree in Nursing (Advanced Practice) or a Master's degree in a clinical speciality. All the clinical speciality streams offered by the university were covered in the population sample (which included clinical experts teaching in the various clinical streams). The total number of students in the sample (as of December 2015), broken down by clinical stream, is presented in **Table 3.1** below.

The population was selected using purposive sampling. The researcher's intention was to involve participants who would be able to provide the most relevant, in-depth and comprehensive information for the study (Lewis, 2013). Following advice from a statistician, considering the small population size, all eligible participants were invited to contribute to the study (Israel, 1992).

**Table 3.1 Courses and number of participants**

<b>Programmes</b>	<b>Number of students</b>
<b>Bachelor in Nursing (Advanced Practice)</b>	
Critical Care and Trauma	43
Oncology and Palliative Care	21
Advanced Midwifery and Neonatal Intensive Care Nursing Science	29
Nursing management	56
<b>Masters in Nursing by Coursework</b>	<b>Number of students</b>
Critical Care and Trauma Specialty	3
Advanced Midwifery & Maternal, Child & Women's Health	10

The inclusion criteria were: all currently registered students undertaking the Bachelor in Nursing (Advanced Practice) degree and the Master's degree in a clinical speciality, and all lecturers teaching a clinical speciality. The exclusion criteria were: students and lecturers unwilling to participate and students and lecturers involved in non-clinical nursing streams.

#### 3.5.1.2 Data collection instrument

Data for the study were collected with the use of a self-administered questionnaire. Section A, developed by the researcher, focused on the demographics of the participants and included seven items; gender, age, level of study, years of study, years of experience in nursing, years of experience in nursing clinical specialty, and area currently working in. Section B, developed by (Smesny et al., 2007), sought to identify barriers to scholarship and to elicit solutions. The questionnaire covered four disciplines, namely, nursing, dentistry, pharmacy and physiotherapy. It presented 29 statements: 13 dealt with barriers to CS, the remaining 16 with solutions. Participants were required to rate their responses on a four-point Likert scale ranging through 1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree (**Annexure 5**).

#### 3.5.1.3 Data collection process

The data collection process commenced after obtaining gatekeeper permission from all three authorities, the Registrar of the College of Health Sciences, the Academic Leader of the Discipline

of Nursing at the selected university, as well as ethical clearance from the University Ethics Committee (Ref: HSS/1550/016M). The researcher then liaised with the facilitators of each of the clinical streams in the Bachelor of Nursing (Advanced Practice) programme and the Masters programme in a clinical speciality to arrange a date and time to address the students. At this meeting, the researcher explained the aim of the study to the students and invited them to participate in it. Arrangements regarding the venue, date and time for data collection were made with the individual volunteers. On the agreed date the information sheet was discussed with the participants and they were given time to read it prior to signing the consent form (**Annexure 3**). The researcher allowed 15-20 minutes for the participants to complete the questionnaire.

The completed questionnaires were placed in a sealed envelope which was collected by the researcher. Participants were invited to volunteer for *Phase Two* by furnishing their contact details (email address or telephone number or both) at the end of the questionnaire. They were assured that this information would be kept confidential and shared only with the researcher's supervisors.

### **3.5.2 Phase Two: Process of qualitative data collection**

This phase involved semi-structured interviews with the participants, these being clinical specialist nursing students and clinical experts.

#### 3.5.2.1 Research participants

Four clinical experts participated and also eight clinical specialist nursing students (some in the Bachelors programme, some in the Masters) who had given their consent in the quantitative phase.

#### 3.5.2.2 Data collection instrument

Interview guides were used to collect data from the participants (see **Annexures 1 & 2**). The interview guide, stemming from responses to the *Phase One* questionnaire, focused on issues that needed additional probing, as well as being shaped by the objectives of qualitative data collection. The interview guide proved to be a suitable format as participants could freely express their views about CS, about ways to promote it, and about developing concrete recommendations for doing so. The information gathered accurately reflected the participants' views.

### 3.5.2.3 Data collection process

For this phase the CSNSs and the CEs were contacted by the researcher to arrange a date and time for the interview. The researcher made provision for a venue within the discipline's premises to ensure convenience for the participants. At the beginning of the individual interviews, the information sheet was again discussed prior to obtaining consent. As an additional item requiring consent, permission to audio-record the interview was included (see **Annexure 4**). The researcher faced unexpected challenges during this phase: a major one was the forced cancellation and rescheduling of interviews owing to strikes and the cancellation of lectures at the university. This left the researcher with no choice but to wait until the interviewees felt that it was safe to return to the university campus.

### **3.5.3 Phase Three: Development of recommendations**

This phase focused on the development of recommendations for CS in the clinical arena.

#### 3.5.3.1 Research participants

The participants were four clinical specialist nursing students and four clinical experts.

#### 3.5.3.2 Process of development of recommendations

The researcher compiled and drafted recommendations for promoting CS in the clinical arena based on the data collected from *Phase One* and *Phase Two*. The draft recommendations were guided by Boyer's (1990) Framework of Scholarship and the literature review. Two workshops were conducted: the students were invited to workshop one, the CEs to workshop two. The recommendations developed to promote CS in the clinical arena were interrogated and refined and were aligned to the four components of Boyer's Framework of Scholarship, namely scholarship of discovery, integration, teaching and application. The recommendations were presented in the form of a pamphlet.

### **3.5.4 Study plan**

Table 3.2 summarises the plan for data collection in all three phases of the study.

**Table 3.2 Summary of study phases**

<b>Phase</b>	<b>Methodology</b>	<b>Participants</b>	<b>Research questions</b>	<b>Tools</b>
Phase One	Quantitative	All students registered for the clinical speciality in Bachelor in Nursing (Advanced Practice) and Master's degree in a clinical speciality	What are the barriers to CS as perceived by CSNSs?  What are the enablers to CS as perceived by CSNSs?	Barriers and solutions to Clinical Scholarship (Smesny et al., 2007)
Phase Two	Qualitative	Students registered for Bachelor in Nursing (Advanced Practice) and Master's degree in a clinical speciality, and clinical experts at the selected university	What does CS mean to CSNSs and CEs?  How can CS in nursing be promoted/developed in the clinical arena?	Individual interviews
Phase Three	Development of recommendations to promote CS in the clinical arena	The researcher, students registered for Bachelor in Nursing (Advanced Practice) and Master's degree in a clinical speciality, and clinical experts at the selected university	How can CS in nursing be promoted in the clinical arena?	Workshop One – clinical specialist nursing students  Workshop Two – clinical experts

### **3.6 Data analysis**

Data analysis refers to the systematic organisation and synthesis of research data (Burns & Grove, 2011). Through data analysis, the researcher categorised and summarised the data that had been obtained in order to derive meaning from the data.

### **3.6.1 Phase One: Quantitative data analysis**

For the analysis of the quantitative data, the researcher used the Statistical Package for the Social Sciences, Version 23 (SPSS). The researcher also consulted his supervisors and a statistician for guidance in analysing the data. Prior to data analysis, the researcher made arrangements to meet with the statistician to obtain advice on whether the tools were in line with the research questions. Descriptive and inferential statistics were used to interpret the data. Association between demographic data was also done.

### **3.6.2 Phase Two: Qualitative data analysis**

The coding of data was done manually using content analysis (Graneheim & Lundman, 2004). The data collected were transcribed verbatim by the researcher. Content analysis assisted the researcher to form related categories. Creating categories generated understanding for consensus in interpretation of data (Graneheim & Lundman, 2004). The researcher immersed himself in the data by reading through the material over and over again. This helped him to gain an in-depth understanding of it, which reduced the risk of filling categories with unnecessary information or leaving out important information. To better interpret and understand what the participants were saying, the researcher condensed and coded the transcribed interview materials and formulated categories from them. Condensation is the process whereby a researcher abridges a text while preserving its fundamental points; coding extracts from a text a key word or phrase that conveys its core meaning; constructing a category involves assembling under a single head ideas/perceptions of a similar kind. When the categories are viewed in relation to one another the key meanings inhabiting the data ought to emerge with a high degree of clarity (Graneheim & Lundman, 2004).

### **3.7 Academic rigour**

“Trustworthiness is defined as a method of establishing or ensuring scientific rigour in qualitative research without sacrificing relevance” (Guba & Lincoln, 1985:290). Graneheim and Lundman (2004) claim that when research is evaluated, its findings should be trustworthy in relation to the procedures used to generate them. The researcher must attempt to enhance the trustworthiness of his/her study by observing the principles of dependability transferability, credibility and

confirmability (Mabuza, Govender, Ogunbanjo et al., 2014) in seeking to represent accurately the opinions of the study's participants.

### **3.7.1 Credibility**

According to Lincoln and Guba (1985) this refers to the truthfulness of the data from the interpretation, where the researcher should be truthful in the findings. In this study the researcher used multiple methodologies to ensure credibility. Data collection occurred using interviews and survey questionnaires to provide a better understanding of the phenomenon. Also peer debriefing was used ((Lincoln & Guba, 1985). This allowed the researcher and the supervisor to have discussions on the project which could widen the researcher's vision. The researcher addressed the concept of peer debriefing by getting advice from the supervisors who have greater knowledge in analysing qualitative data. The researcher also ensured that the research findings captured are truly representative of the context that was studied (Shenton, 2004). This was achieved by using an audio recorder to minimise the chances of misinterpreting the participants' statements. Furthermore, the researcher provided feedback about the data collected to the participants to ensure that the information collected was a true reflection of their opinion. Throughout the study, the researcher maintained the credibility of the data through continuous data collection until redundancy and data saturation was reached. To further increase credibility the researcher chose the appropriate method which was the mixed method, which has helped the researcher to have multiple views. Further, the researcher established trust with participants as he had met them previously for the questionnaire, which further helped to engage with them for the interview.

### **3.7.2 Dependability**

Dependability relates to the stability or consistency of data over time and conditions. If the work has to be repeated in a similar situation, using identical procedures and using the same group, it should result in identical findings. In addition, the researcher provided a detailed methodological description to allow for the replication of the study (Shenton, 2004). Dependability supports credibility (Lincoln & Guba, 1985). In addition to addressing the dependability of this study, the researcher sought guidance and support from the supervisors to interpret data, so as to avoid the researcher's own bias in interpreting the data. Additionally, the researcher and the supervisors monitored the research process throughout data collection until the interpretation of the findings

was done. The researcher also kept all the materials such as the interview transcripts, recruitment criteria for research participants and data analysis decisions. In so doing, the researcher created transparency to allow peer examination on whether the proper procedures were respected. Furthermore, a proposal of the research project was submitted to the university ethics committee for approval, in order to ensure that the research conducted was appropriate in response to the research inquiry.

#### 3.7.2.1 Dependability audit

According to Polit and Beck, (2003), a dependability audit is the scrutiny of the data by an external reviewer. In the context of this study, the researcher submitted copies of the transcripts to the supervisors for their expert opinion as they are experts in qualitative research. In that way guidance was given to the researcher as to whether the information being collected was satisfactory or not.

### **3.7.3 Confirmability**

According to Polit and Beck (2012), the data presented and interpreted represent the information from the participants, not the opinion of the researcher. The researcher used an audio recorder so that the information was better captured with regard to clarity. Also the recorded data were presented so that the process would be transparent, verifiable and based on evidence. Additionally, the researcher used member checking to avoid misunderstanding and researcher misinterpretation. Collecting data in a variety of ways (questionnaires and interviews) provided a rich description which may give the reader a clear picture of what is happening.

### **3.7.4 Transferability**

Transferability implies researcher responsibility to ensure a rich coverage of the research findings so as to help the reader to transfer the findings to other situations. In this study, the researcher addressed transferability through a thick description of the study in quantity and rich in content, thereby facilitating proper apprehension for the reader to compare the findings to a similar situation (Shenton, 2004). The researcher provided in-depth information about the context of the research, study setting, research design and approach, data collection analysis and the interpretation of the findings, the procedure and participant lists, to enable replication of the study in different contexts.

### **3.8 Reliability and validity**

Below is an explanation of reliability, validity and content validity of the questionnaire.

#### **3.8.1 Reliability**

Reliability relates to the consistency of results. If the same research procedure were applied to a different research project, it would yield similar results. This method of measurement is achievable when constantly used by the researcher and when the participants respond in the same way (Keyton, 2011).

A pilot study was conducted as a means of testing reliability. The pilot study involved five students from the total research population. The data that were obtained from the pilot study were not included in the final research analysis. The students were randomly chosen from the target population after permission had been obtained from the Ethics Committee. The students were given the questionnaire to complete and thereafter the completed questionnaire was collected for analysis. The researcher's interest was to ensure that the questions were clearly understood by the students prior to conducting the major study. The researcher contacted the statistician to assist with establishing the reliability of the questionnaire. Cronbach's alpha test was used to establish the internal consistency of the questionnaire. The Cronbach's alpha was calculated at 0.94, indicating excellent internal consistency (Clark & Creswell, 2015).

#### **3.8.2 Validity**

Validity is not a solitary or universal concept but it is an important component in quantitative research to analyse the meaning, usefulness and appropriateness of a research study (Onwuegbuzie & Johnson, 2006; Polit & Beck, 2012). Kimberlin and Winterstein (2008) recommended that an instrument should measure what it is supposed to measure in order to produce reliable information and meaningful research components.

According to Bollen (1989), validity needs to be supported to show whether a measure is in line with the concept. Bollen (1989) explained content validity as a "qualitative type of validity where the domain of a concept is made clear and the analyst judges whether the measures fully represent the domain" (p:185). For this study, content validity was achieved through discussions with the

supervisors to ensure that the research instrument met the research questions and objectives. Further to this content validity was achieved through aligning the questions and objectives of the study to the conceptual framework. (Table 3.3)

**Table 3.3 Content validity**

Research Questions	Conceptual Framework Boyer (1990)	Section B #Items No#
What are the barriers to CS as perceived by CSNSs?	Discovery	#6,8,11#
	Integration	#13,14,17#
	Teaching	#9,12,15,16#
	Application	#7,10,18#
What are the solutions (enablers) to CS as perceived by CSNSs?	Discovery	#19,25,26#
	Integration	#27,28,33,34#
	Teaching	#20,21,22,23,24,29#
	Application	#30,31,32 #

### 3.9 Ethical considerations

In conducting research, it is the obligation of the researcher to protect the right of the subject participating in the research. The university research ethics committee requires that the research be carried out in a manner that does not violate the participants' participation, and that no one will be harmed in the event of withdrawing from the study. To ensure that the right of the study participants were protected, prior to the implementation of the project, approval was sought from the University Ethics Committee (Annexure 11) as well as gatekeeper permission from the Registrar of the university (Annexure 10) and the Academic Leader in the Discipline of Nursing (Annexure 9). Once all the necessary permissions were granted, the data collection commenced.

Ethical principles of social value, scientific validity, fair subject selection, favourable risk-benefit ratio, informed consent and respect for the potential and enrolled subject were adhered to throughout the study (Emanuel, Grady, Crouch et al., 2008).

#### 3.9.1 Collaborative partnership

Clinical research is done with the aim of serving good and enhancing health care. It is a way to improve the well-being of people (Emanuel et al., 2008). For this study, the researcher

communicated to participants the aim and importance of the study. Further to that, he highlighted how the participants and other colleagues might benefit from the study. As such, the clinical nurses may better understand how to generate knowledge and disseminate this knowledge to colleagues so they may use it to improve nursing practice.

### **3.9.2 Scientific validity**

Research should follow a methodological process for it to be ethical. If a methodological process is not properly followed, the results produced may be scientifically unreliable or invalid. The objective should clearly be based on scientific knowledge and feasibility (Emanuel, Wendler & Grady, 2000). In that regard, the aim of the study was to explore and describe clinical scholarship in order to develop recommendations to promote clinical scholarship in the clinical arena. This may help clinical personnel to base their day-to-day practice on scientific knowledge.

### **3.9.3 Social value**

From the ethical perspective, research should have protocols based on scientific values to show that the study is not only valid but of some value (Freedman, 1987). This study may be useful not only to students in the Bachelor's degree in Nursing (Advanced Practice) and Masters in a clinical specialty programmes, but also to policy makers in developing guidelines that may promote CS. Hopefully, the information obtained from the students of Bachelor's degree in Nursing (Advanced Practice) and Masters in a clinical specialty may greatly benefit all nurses by finding ways to help them promote CS and thus improve patient care.

### **3.9.4 Favourable risk-benefit ratio**

The level of risk within the research should be assessed prior to conducting the research. No participants should be exposed to any risk throughout the research. The benefit for the participants should focus on the development and improvement of the organisation or practice (Emanuel et al., 2000). The risk-benefit ratio for a particular study should be high where the organisation or individual values the research (White, 1999; Emanuel, Wendler, Killen et al., 2004). There were no identifiable risks associated with participation in this study. The study will, however, position clinical nurses to promote CS and base their practice on evidence-based research.

### **3.9.5 Fair subject selection**

The participants' selection had no bias. Emanuel et al. (2000) suggested that for fair selection, the participants selected should be in position to best answer the research questions. To comply with this suggestion, the participants in the study were purposively selected. This enabled the researcher to select participants who provided rich and in-depth information about the research topic.

### **3.9.6 Informed consent**

The researcher followed the fundamental principle of informed consent where the researcher is to provide information about the project to which the participants have been invited to participate of their own free will. It also assures all the participants that they are under no obligation to participate in the study and can withdraw before the end of the project if they so wish without any consequences for them (Crow, Wiles, Heath et al., 2006). To allay doubt, informed consent gives the participants a picture of what the project is all about, before attending to the research project's question(s). The informed consent document was written in language that would be clearly understood by the participants (Emanuel, 2004). To this end, the medium of communication was English, which is the official university language.

### **3.9.7 Confidentiality and anonymity**

Confidentiality and anonymity give protection to the voluntary participation of participants in the study. All data were carefully stored in a locked cupboard in the locked office of the supervisors at the selected university. No personal details were used, and participant responses were labelled with numbers or codes. When it came to recording the interviews, the real names of the participants were not used in the interview process.

### **3.9.8 Voluntary participation**

Participation in this study was voluntary. Participants were informed about the research and were not coerced into participation. Participants were made aware that there would be no reward attached to participation in the research. The participants were oriented about the aim of the research, which was to guide the future development of research in CS. They were also informed that withdrawal from participation would not affect their studies in any way. (Annexures 3, 4 & 5)

### **3.10 Data dissemination**

The research findings were used in a dissertation that the researcher submitted as a full requirement for the Master's degree. Access to that dissertation will be through the university library at the university. Another dissemination platform will be academic journals where the researcher will write and submit papers for publication. Most importantly, the findings of the research will be distributed in the clinical arena on which the study was focused. Additionally, the researcher will give dissertation copies to his country of origin, the Seychelles.

### **3.11 Data management and security**

All the research materials were stored in a safe and locked up in a private place by the research supervisors at the university. During this time the data were made available for review only under valid circumstances in the presence of the researcher and supervisors. A backup is available and kept on the computer. Access to the backup is only through using a password, which will be available only to the researcher and the supervisors. After a period of 5 years the stored data will be destroyed by shredding hard copy documents and permanently removing all data from flash drives, hard drives and electronic clouds. The recorded interviews stored on the computer will also be deleted from the computer hard drives.

### **3.12 Chapter summary**

This chapter has addressed the whole methodological process and methods that have been applied in the execution of this study. The research design was based on the objective of the research. This chapter has also included the justification of the research approach, sampling, data collection and data analysis. The findings obtained from the data are presented in Chapter four.

## CHAPTER FOUR

### PRESENTATION OF THE FINDINGS

#### 4.1 Introduction

This chapter outlines the findings of this study. The findings of the study have been presented in two sections, namely: quantitative findings and qualitative findings. For quantitative findings which is *Phase One*, this is illustrated in descriptive statistics followed by inferential statistics. The qualitative findings, which is *Phase Two*, were explained by using content analysis. Qualitative findings are explained after the quantitative findings.

#### 4.2 Phase One: Quantitative findings

Data was gathered from clinical specialist nursing students (CSNS) registered for a Bachelor's degree in Nursing (Advanced Practice) and Master's degree in a clinical specialty. The clinical specialties in the Bachelor's degree comprised Critical Care and Trauma, Oncology and Palliative care, Advanced Midwifery and Neonatal Intensive Care, Nursing Science and Nursing Management. The Master's degree by course work included specialities in Critical Care and Trauma, Advanced Midwifery and Maternal, Child and Women's Health, at the selected university. A total of 81 CSNSs returned the questionnaires, representing a 100% response rate. This was achievable because the researcher waited on site as the questionnaires were being filled in and he collected them on completion.

##### 4.2.1 Socio-demographic data of the participants

Socio-demographic information obtained from participants included gender, age, level of education, years of experience in the nursing profession and clinical speciality, area currently working in and the programme and clinical speciality that the participants were registered for.

###### 4.2.1.1 Gender, Age, Years of experience in nursing and experience in specialty

With regard to gender, the majority of the participants were female 97.5 % (n=79). The findings indicated that above the age 41 was the largest group of participants (n=28, 34.6%). The largest group, 55.6% (n=45), had between 0-10 years of experience in nursing compared to only 3.7% (n=3) who had between 31-40 years of experience in nursing. The findings also revealed that the largest group (60.5%; n=49) of the participants had 0-10 years of experience in their clinical

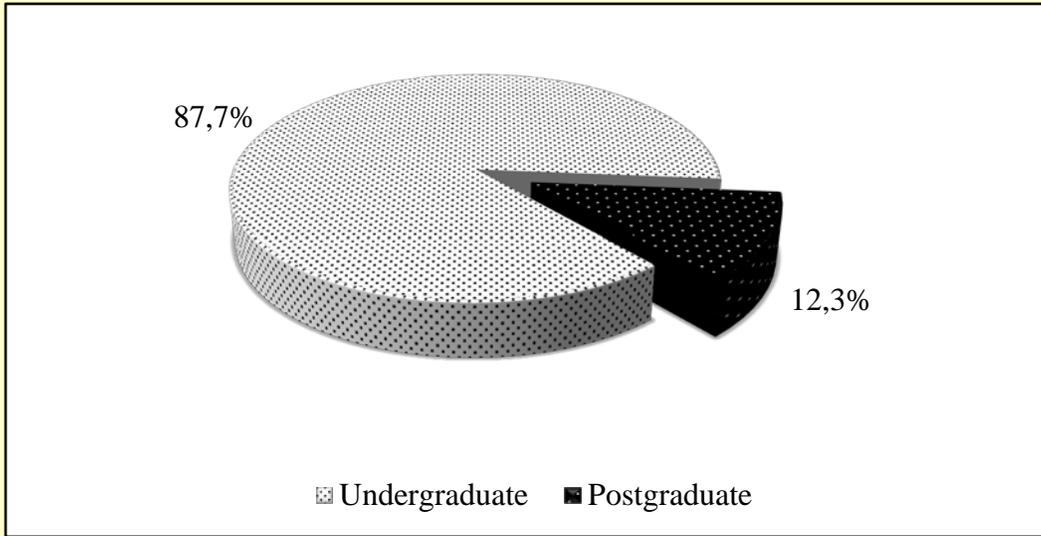
specialty as compared to (n=17, 21.0%) of the participants who indicated that they had no experience in a clinical speciality. This is shown in *Table: 4.1*:

**Table 4.1 Gender, Age, Years of experience in nursing, and years of experience in specialty**

<b>Gender</b>	<b>Number of participants (n)</b>	<b>Percentage %</b>
Male	2	2.5
Female	79	97.5
<b>Age</b>		
20-25	3	3.7
26-30	15	18.5
31-35	19	23.5
36-40	16	19.8
41>	28	34.6
<b>Years of experience in nursing</b>		
0-10	45	55.5
11-20	23	28.4
21-30	10	12.3
31-40	3	3.7
<b>Years of experience in clinical specialty</b>		
0-10	49	60.5
11-20	7	8.6
No experience	17	21.0
No response	8	9.9
<b>Total</b>	<b>81</b>	<b>100</b>

#### 4.2.1.2 Level of education

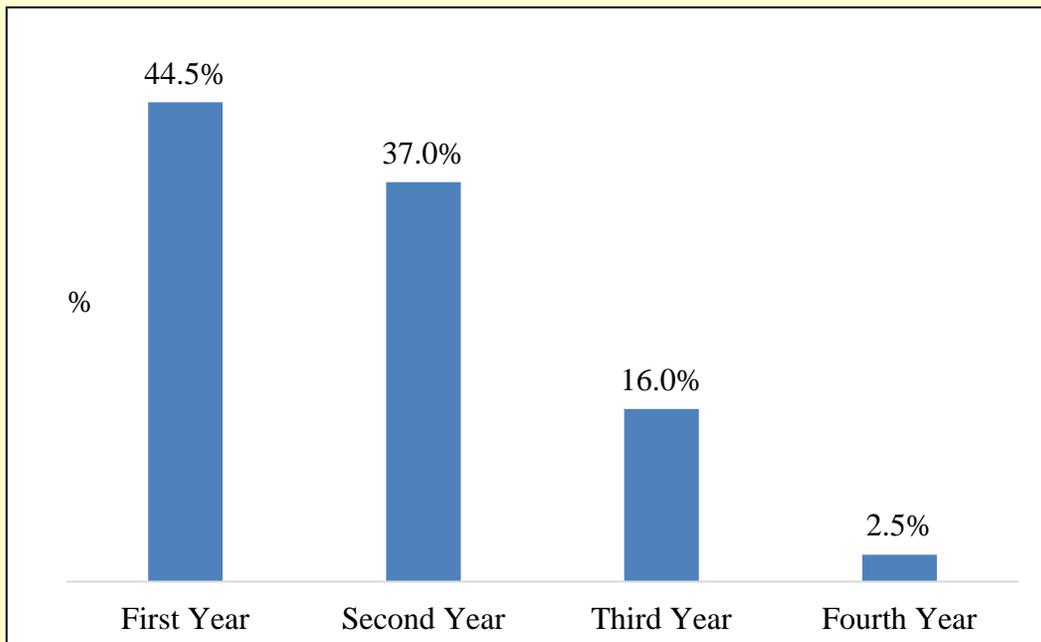
In relation to the level of education, the findings in *Figure 4.1* indicate that the majority of the participants were undergraduate students (87.7%, n=71) as opposed to the 12.3% (n=10) who were postgraduate students.



**Figure 4.1 Level of education**

4.2.1.3 Year of study

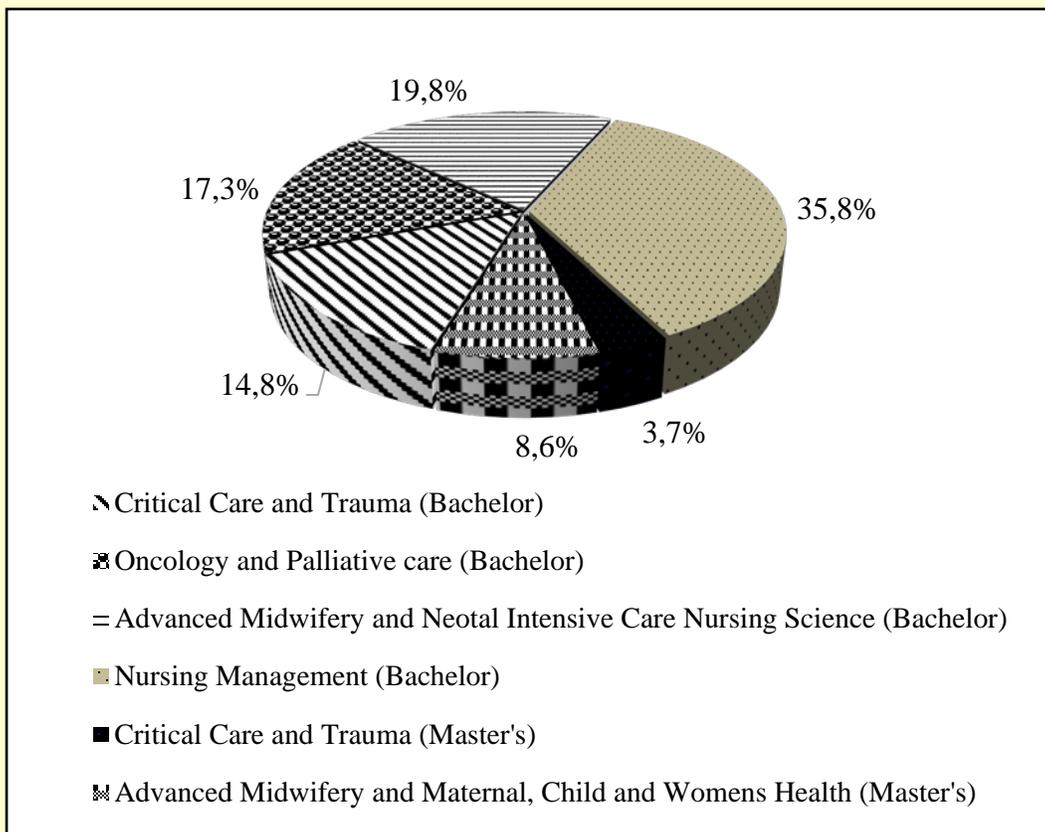
In **Figure 4.2**, the analysis of the year of study shows that most of the participants, 44.5% (n=36), were in the first year of their degree, followed by 37.0% (n=30) of the participants who were in the second year; 16.0% (n=13) were in their third year while only 2.5% (n=2) were in the fourth year of study



**Figure 4.2 Year of study**

#### 4.2.1.4 Area currently studying

In response to current area of study, students were registered either for a Bachelor's degree in Nursing (Advanced Practice) or Master's degree in a clinical specialty by course work. The results displayed in **Figure 4.3** show that in the Bachelor's degree in Nursing (Advanced Practice), the largest group of participants (42.0%, n=34) were registered for the management specialty, followed by (19.8%, n=14) for advanced midwifery and neonatal intensive care, and (17.3%, n=14) for oncology and palliative care. The smallest group (14.8%, n=12) consisted of Critical Care and Trauma students. Similarly, for the Master's degree in a clinical speciality, the largest group of participants (8.6%, n=7) was in advanced midwifery and maternal, child and women's health, while the smallest group (3.7%, n=3) comprised students in Critical Care and Trauma (**Figure 4.3**):



**Figure 4.3** Area currently studying

## 4.2.2 Phase One: Presentation of quantitative findings

This section will present the findings of Section B of the questionnaire, namely the barriers to, and enablers of CS.

As previously discussed, the questionnaire contained 29 questions of which 13 addressed the perceived barriers to clinical scholarship while the remaining 16 focused on enablers of CS. The information (responses) in **Table 4.2** is organised in descending order from the most common barriers to clinical scholarship to the least common, while **Table 4.3** shows the responses to the solutions, also presented in descending order. Owing to very few observations in some of the categories, the categories of strongly agree and agree, were combined as agree, while disagree and strongly disagree were combined as disagree, to improve stability and generalizability. This is supported by Allen and Seaman (2007) and Boone and Boone (2012).

### 4.2.2.1 Barriers to clinical scholarship

The most common barrier identified by the participants (84.0%; n= 68), was the lack of support to support scholarship, with 16.0% (n=13) disagreeing that this was a barrier. This was followed by “clinicians need assistance or mentoring in writing publications related to scholarship”: 82.7% (n=67) were in agreement with this statement, while 17.3% (n=14) disagreed. The third most common barrier identified by 79.0% (n= 64) was “no mechanisms to reward or recognise scholarship”. Only a small group 21.0% (n=17) disagreed.

The least common barriers to CS mentioned by the CSNSs were: the lack of interdisciplinary cooperation between clinician and academic: 65.4% (n=53) as opposed to 34.6% (n=28) who disagreed. This was followed by “time frames for promotion”: agreed to by 61.7% (n=50), while 38.3% (n=31) disagreed; “clinical services requirements and teaching reduce opportunities for scholarship” received a 58.0% (n=47) agreement as opposed to 42% (n=34) who disagreed. This is shown in **Table 4.2** below.

**Table 4.2 Barriers to clinical scholarship (n=81)**

Barriers to Clinical Scholarship	Disagree		Agree	
	(n=)	%	(n=)	%
Lack of support or funding mechanisms to support scholarship of application or teaching in funding agencies or organisations.	13	16.0	68	84.0
Clinicians need assistance or mentoring in writing publications or other mentoring activities related to scholarship	14	17.3	67	82.7
No mechanisms to reward or recognise scholarship of teaching or scholarship of application locally or nationally	17	21.0	64	79.0
Health student debt load or salary is too low leading to a lack of interest in positions requiring scholarly activities.	18	22.2	63	77.8
Few role models/mentors for scholarship and clinical activities.	19	23.5	62	76.5
Discipline members are unaware of other forms of scholarship as it relates to promotion and tenure.	20	24.7	61	75.3
Difficulty in becoming a competent clinician who can keep up with complexity of sciences	23	28.4	58	71.6
Work of clinician educator is less amenable to publication or to presenting their scholarship or activities.	24	29.7	57	70.3
Promotion and tenure guidelines are not consistent with clinical practice job specification	27	33.4	54	66.7
Institutional culture does not foster or promote scholarship.	28	34.6	53	65.4
Lack of interdisciplinary cooperation between clinicians and academics; lack of collegiality	28	34.6	53	65.4
Time frame for tenure and promotion related to development and demonstration of scholarship of application, teaching, etc. may be longer than current time frames.	31	38.3	50	61.7
Clinical services requirements and teaching reduce opportunities for scholarship.	34	42.0	47	58.0

#### 4.2.2.2 Solutions for clinical scholarship

The three most common solutions identified were: re-examine criteria for promotion and reward all forms of scholarship: agreed to by an overwhelming 92.6 % (n=75). A small minority 7.4% (n=6) disagreed with the statement. The statements referring to being more involved in CS, providing sufficient time to undertake scholarship and creating a collaborative mentoring programme which may include training in how to approach writing papers, both received equal agreement values (91.4%, n=74).

The CSNSs identified “create a model of scholarship that requires a high level of discipline-related expertise, breaks new ground or is innovative, can be replicated, documented, peer reviewed, and has a significant impact” as the three least common solutions 83.9% (n=68) compared with 16.0% (n=13) disagreed. This was followed by “design postgraduate residencies to be geared more towards research rather than education and establish more research training fellowships”: 82.2%

agreed (n=67); very few disagreed 17.8% (n=14). The use of Boyer's model of scholarship to work in four areas of scholarship received a positive response rate of 81.5% (n=66) as opposed to 17.3% (n=14) who disagreed. This is illustrated in **Table 4.3** below.

**Table 4.3 Solutions for clinical scholarship (n=81)**

Solutions for clinical scholarship	Disagree		Agree	
	(n=)	%	(n=)	%
Re-examine criteria for promotion of clinical faculty and create a structural framework within the School/College as well as the Institution to foster, assess, and reward all types of scholarship.	6	7.4	75	92.6
Provide more protected time and/or uninterrupted time and resources to perform scholarship of all types.	7	8.6	74	91.4
Using senior faculty role models, create a collaborative mentoring programme which may include training on how to approach writing papers.	7	8.6	74	91.4
Create synergy between research and practice.	8	9.9	73	90.1
Assign more importance to the special contributions of clinician educators and use a variety of methods to assess their abilities (i.e. teaching skills, clinical skills, mentoring, developing clinical educational programmes).	9	11.1	72	88.9
Include a similar reward system for all forms of scholarship and educate clinicians and administrators on the different forms of scholarship.	10	12.4	71	87.6
Develop new faculty positions to foster various types of scholarship and clinical practice (i.e. "clinician-educator researcher").	10	12.4	71	87.6
Encourage interdisciplinary cooperation and create cross disciplinary initiatives to link the physician scientist and/or basic researcher to the clinician.	10	12.4	71.	87.6
Create a clinician-educator researcher by providing training in Master's levels or PhD in the area of education and time for research endeavours.	11	13.6	70	86.4
Develop and implement a two-track system (clinical track and research track).	11	13.6	70	86.4
Regularly review balance of activities in academic posts, particularly between service work, teaching and research.	11	13.6	70	86.4
Develop criteria for recognising and rewarding scholarship related to service such as clinical activities, community service and professional organisation activities.	12	14.8	69	85.2
Develop a thematic based faculty development curriculum to catalyse clinician faculty to become involved in scholarly projects that increase enthusiasm for research.	12	14.8	69	85.2
Create a model of scholarship that requires a high level of discipline-related expertise, breaks new ground or is innovative, can be replicated, documented, peer reviewed, and has a significant impact.	13	16.0	68	83.9
Design postgraduate residencies to be geared more towards research rather than education and establish more research training fellowships.	14	17.8	67	82.2
Using Boyer's model of scholarship to work in four areas of scholarship.	15	18.5	66	81.5

### 4.3 Correlation between socio-demographic variables and perceptions of CS

The Pearson product moment correlation indicated a positive relationship between perception, age, year of study, years of experience in nursing, and years of experience in a specialty. This indicated that as the age, year of study, years of experience in nursing and years of experience in a specialty increased, the perceptions of the CSNSs became more positive towards CS. P values were determined for the socio-demographic variable with p-value <0.05 considered statistically significant. Statically significant values were obtained for age and perception (p-value=0.02) and for years of experience in nursing (p-value 0.02). **Table 4.4:**

**Table 4.4: Correlation between social-demographic variables and perceptions of CS**

		Age	Year of study	Years of experience in nursing	Years of experience in specialty
Perception	N	81	81	81	81
	Pearson Correlation	0.26*	0.07	0.25*	0.22
	Sig. (2-tailed)	0.02	0.55	0.02	0.05

#### 4.4 Phase Two: Presentation of qualitative findings

This section presents qualitative findings from interviews with CSNSs and the clinical experts.

##### 4.4.1 Demographic profile of participants

A total of 12 participants were interviewed until it was determined that saturation was reached. The participants interviewed were eight CSNSs and five CEs. *Table 4.5* below shows the demographic profile of the 12 participants.

**Table 4.5 Demographic profile of the participants**

Code	Age group	Years of nursing experience	Specialisation
<b>Clinical specialist nursing students (Bachelor)</b>			
CSNS 1	>41	15	Critical Care and Trauma
CSNS 2	31-35	8	Critical Care and Trauma
CSNS 3	>41	10	Critical Care and Trauma
CSNS 4	>41	20	Nursing Management
CSNS 5	36-40	10	Critical Care and Trauma
CSNS 6	31-35	7	Critical Care and Trauma
CSNS 7	>41	20	Oncology
<b>Clinical specialist nursing student (Masters)</b>			
CSNS 8	36-40	5	Advanced Midwifery & Maternal, Child & Women Health
<b>Clinical experts</b>			
CE 1	>41	40	Midwifery & Maternal, Child & Women's Health
CE 2	>41	36	Oncology & Critical Care
CE 3	>41	39	Critical Care
CE 4	>41	29	Midwifery & Maternal, Child & Women's Health

#### 4.5 Research categories and sub-categories

The findings gathered from the interviews are presented according to categories and sub-categories which reflect the words of the participants. Quotes from the participants are *set in italics* and give the exact wording as spoken. *Table 4.6* shows the categories and sub-categories that emerged from the data:

**Table 4.6: Summary of Categories and Sub-Categories**

<b>Categories</b>	<b>Sub-Categories</b>
<b>Meaning of CS</b>	
Academic excellence	Scientific knowledge and improved outcomes
	Critical thinking
Importance of research to practice	Context-driven evidence/EBP
	Practice informs education
	Better way of doing things
<b>Barriers to CS</b>	
Scholarship overlooked	Limited resources
	Research is not important and difficult
	Resistance to change
	Increased workload and limited time
Poor communication	Lack of confidence
	Lack of team work
<b>Solutions to CS</b>	
Resources	Access to library (information)
	Clinical facilitation
	Adequate funding
Encouragement of scholarly activity	Promotion
	Need for guidelines
Culture of scholarship	University and institutions should work together
	Doctors and nurses working together
Responsive teaching	Integration of theory and practice
	Continuous professional development
	Incorporating CS in the curriculum
Attributes in teaching clinical scholarship	Knowledgeable in specialty
	Critical thinkers
	Positive role model

**4.5.1 CSNS and CE perceptions of CS**

In this study two categories emerged from the data analysis and each was further sub-divided into sub-categories.

#### 4.5.1.1 Academic excellence

Under this category, two sub-categories emerged: scientific knowledge and improved patient outcomes, and critical thinking.

##### *4.5.1.1.1 Scientific knowledge and improved patient outcomes*

The participants explained that through clinical scholarship new scientific discoveries are made regarding patient management. They further explained that through scholarship, there is a transfer of knowledge which is necessary in the management of patient care, thus improving patient outcomes. One participant said:

*...Clinical scholarship mean application of scientific knowledge to rectify the problems and hence clinical standard and ultimately improve patient outcome...  
[CSNS 3]*

Another participant described clinical scholarship as support to improve patient outcomes.

*For me, the practice should be evidence-based right. For me clinical scholarship.... you [are] looking at support, you [are] looking at improving patient outcomes, you [are] looking at improves standards, but where are you getting that information from, it has to be scientific based on evidence[CE 4]*

Participants also viewed clinical scholarship as an avenue for nurses to acquire the best knowledge that could help them in delivering the best nursing care for the patient. A participant said:

*Also clinical scholarship is a way for nurses to acquire scientific knowledge that could best for maintaining the standard of care with the hope to improve patient outcome as we don't want the standard to drop ... [CSNS 5]*

##### *4.5.1.1.2 Critical thinking*

Data that emerged showed that participants viewed clinical scholarship as a mode that could help them to develop their thinking skills and apply it under specific circumstances. Through clinical scholarship, the participants asserted that they could acquire the skills needed to provide better care for patients. Participants said that with emerging trends in epidemiology, CS further motivates them to develop critical thinking which could enable them to identify erratic and new challenges in clinical arenas and simultaneously try to rectify them. Participants offered the following comments:

*clinical scholarship is just to develop that critical thinking, to form that specialist nurses, so that now they can be able to think... and be able implement whatever changes they can to improve practice clinical area...and able to help others [CE 1]*

*...clinical scholarship it's an approach where nurses can use their own critical thinking in practice to solve problem in the clinical setting... [CSNS 7]*

*...[clinical scholarship] enable student to develop critical thinking so that they can apply that critical thinking in practice. [CSNS 4]*

#### 4.5.1.2 Importance of research to practice

The second category produced three sub-categories that are linked to an appreciation of research, as discussed below:

##### *4.5.1.2.1 Context-driven evidence base/evidence-based practice*

The participants believed that CS also involves evidence-based practice, especially when it comes to research. They noted that CS is a vehicle that aids the nurses to acquire knowledge based on evidence which can then be applied in their daily nursing practice. Commenting on the principle that that nursing practice should be evidence-based, one participant said:

*...it involves evidence base practice through research where we use critical, thinking so that we can be able to attend to the problem of the patients and then to be able to get new information which can be used to broaden the new knowledge in nursing... [CSNS 4]*

Another participant explained that the purpose of CS is to produce knowledge and

*give the knowledge, theory combine in the clinical area so that everything being done in the clinical area is been support by research not just doing things in their own [CSNS 5]*

Another participant added that CS is essential as it produces evidence that can be used to teach colleagues:

*Education must be based on what is happening in the practice because it the context that is important when you are implementing the practice, if you are going to rely on theory, theory is going to tell you about, Russia, America, UK, yet if you use*

*practice, it will talk to your own context one...[therefore]...clinical scholarship it is very important because it will also give you context driven evidence to use for teaching...[CE 3]*

#### 4.5.1.2.2 *Practice informs education*

The participants defined CS as a practice that informs education. They view it as an activity that systematically contributes to research and teaching. Additionally, CS integrates theory with practice and helps to find solution(s) on how best to improve patient care. On this point participants commented as follows:

*...clinical scholarship as [an] activities that systematically and advance the teaching and research and practice of nursing through vigorous enquiry that is significant to the profession and nursing education... [CSNS 3]*

*...[by] sending students to clinical practice and make them use their knowledge from the clinical area from the practice area to generate knowledge in class [CE 3]*

*...clinical scholarship brings the whole things together, we looking at clinical but we also looking on how we can improve it by using research by using teaching by using all different methods to try and improve things to make it better for our patient. [CE 2]*

#### 4.5.1.2.3 *Better way of doing things*

Participants repeatedly viewed CS as a vehicle that could guide them to identify better ways of performing clinical practice. Participants asserted that nurses could compare old with recent knowledge to identify how best nurses can perform in the clinical arena. Participants commented as follows:

*a hospital is doing things one way but meanwhile we've researched it and we found through evidence-based medicine that there is a better way of doing it [CE 2]*

*...is a way forward to evaluate clinical nurse's practices and for new development of strategy and new ways of doing things within clinical area.... [CSNS 3]*

*...to gets new information or either than the one that is available like, maybe we still based on old theory that were established by Florence Nightingale time, if maybe they [there] can be a new research than, then things [nursing practice] can be done[based on evidence] in a more modern way, [rather than on traditional nursing practice] than it was done before... [CSNS 2]*

#### **4.5.2 Barriers to clinical scholarship as perceived by CSNSs and CEs**

The various barriers to clinical scholarship as perceived by the CSNSs and CEs were divided into two broad categories and then sub-divided into six sub-categories.

##### 4.5.2.1 Scholarship overlooked

The first category indicated that participants felt that CS has been overlooked. This category was further sub-divided into four sub-categories, namely: limited resources, research is not important, resistance to change and increased workload and time constraints.

###### *4.5.2.1.1 Limited resources*

The participants felt limited resources to be a huge problem for nurses which effectively debarred them from scholarship development. Two main deficiencies that the participants reported: lack of clinical instructors/facilitators and lack of funding to help nurses to pursue further studies. One participant said that

*...the clinical instructor should be right in the clinical area, because if we don't have the clinical instructor in the clinical area, those nurses in the clinical area. They [clinical nurses] are over burden. They can't even have enough time to demonstrate the skills to the students because they have to take of so many other patients themselves and this becomes a burden when they are expecting to demonstrate the knowledge, skills to students. [CSNS 6]*

Without the assistance of clinical instructors/facilitators, the road to clinical scholarship has become more difficult. Another participant said:

*...we really we need our instructors or our facilitators to guide us as a students in clinical arena and there is no way how we can achieve clinical scholarship without the help of our instructor... [CSNS 1]*

Another participant stated that even the few clinical facilitators who are available make themselves too busy for students to approach them:

*...I think they don't make themselves sufficiently available, and they err...they are making it students responsibility to come to them... [CSNS 7]*

Participants said that much as they wanted to be involved in CS and pursue further studies, they just cannot afford it due to lack of funding. Participants commented as follows on this point:

*... another problem of not been motivated to [pursue further] study and involved in clinical scholarship...is the lack of money which most of the time is the case....sometime they [clinical nurses] just cannot afford to further their studies due to lack or no funding... [CSNS 8]*

*resources that could be a barrier will be if we don't have expert, people who are knowledgeable about clinical scholarship that would help transfer the knowledge about clinical scholarship to student as well as funding for research project and hmm at time lack of technology such as computer in the hospital and available material like journal article...[CSNS 4]*

#### 4.5.2.1.2 *Research is not important and difficult*

Evidently some nurses did not see the importance of research, as one participant explained:

*They [nurses] are out there [working] making money and research was nice to know, have to do it for the university and complete the study... sometime [now] they don't see what is the use of research [in clinical practice]...[CE 2]*

Another participant said that nurses have negative thoughts about research. She criticised nurses for thinking that research is meant for academia and for those nurses pursuing graduate studies:

*Nurses should be involved in research, we should not think it is only for researcher or only when you are doing master or doctorate... [CSNS 2]*

Furthermore, a participant noted that some nurses think that research is too difficult to conduct and is sometimes overrated. The participant also explained that research findings are often impossible to implement:

*...hmm people don't think that research findings are possible to implement in clinical area... [CE3]*

#### *4.5.2.1.3 Resistance to change*

The participants viewed resistance to change as a barrier to scholarship. One participant said that it is difficult, at times, to interact with senior nurses, who have been in the field for a long time. According to the participants, these nurses have been in the field for a long time and they do not find any problem with what they are doing. Therefore, they do not see a reason for any change if nursing practice is doing well in their understanding. On attitudes to change, participants commented as follows:

*Some [nurses] don't feel comfortable with changing, because they like doing their comfort thing, they are comfortable in their old attitude and ways of doing things, which they developed their routine that they don't want to change... [CSNS 3]*

*...clinical scholarship helps us [nurses] to change the old ways or old habit [of nursing practice] by of doing things by introducing the new evidence base practice on which the research has been done, fortunately some nurses don't want to change the old way of practice... [CSNS 5]*

*We've been doing things like this for years, so what's the point of changing them you know, not realising time are changing, drugs are changing, techniques are changing, surgeries are changing [CE 2]*

#### *4.5.2.1.4 Increased workload and limited time*

The participants (mainly CEs) claimed that their workload reduced time to spend in scholarship activity. They expressed that they find themselves doing more than one task at a time, namely, teaching, setting exams, among other tasks. One participant stated that the workload made it difficult for them to cope with scholarship activities. They find themselves occupied with preparing academic work (setting exams, marking) for the students. This is what one participant contributed:

*Lecturers are expected to be clinical facilitators, setting exams, she's [then] taking away to mark exams, she's [most of all] teaching as well... [CE 4]*

Similarly, another participant viewed the combination of clinical supervision and academic scholarship as too much to handle at the same time. She stated:

*I used to do my own clinical, I never had a clinical instructor, so that issue I think must be off, if I could help it, because it becomes a load when you have to do research or scholarship in academic scholarship and then do also clinical supervision... [CE 3]*

Another CE asserted that students feel suffocated by the idea of research. They think research is too demanding, therefore, they just want to sit back and do not want to get involved in scholarship:

*...students are tired and they just want to get over and done with it, practice mostly all the students are hesitance of research, they worry about it, there so much work to be done... [CE 2]*

Another participant felt there was an imbalance of time between theory and practice:

*...currently what I see, more time is given to theory we [students] learn a lot of things theoretically but when it comes to apply that theory, apply the skills, I'm not able to apply enough skills, because I am not exposed too much of clinical practice to apply the skills in area of practice... [CSNS 1]*

A participant felt that she needed more time in the clinical area to acquire the necessary practical skills:

*I felt and think that more time should be given or allocate to apply the practical skills in the clinical area, give the students more time in the clinical area to apply what they have learned theoretically into the clinical area so I could acquire more skills...[CSNS 6]*

#### 4.5.2.2 Poor communication

The second category that emerged in relation to barriers to CS was poor communication among clinical nurses. This category was divided into two sub-categories, namely, lack of confidence and lack of teamwork.

#### 4.5.2.2.1 *Lack of confidence*

According to one participant, clinical nurses too often are afraid of the doctors. Even when they are doubtful of doctors' decisions, they are reluctant to question the decisions made by the doctors:

*... if the doctor is giving you an order and you don't agree with, don't just do it because the doctor say so, you need to erm...question it err...if you don't agree with what do doctor is suggesting for the patient, you must go and find a sister in charge or matron where you can address your concern...we as nurses, must be confidence in our nursing knowledge, practice and skill... [CSNS 7]*

One participant admitted that nurses are not even confident and assertive enough to defend their own research and let the doctor(s) know that the research is worthy. This is what one of the participants said:

*We [nurses] are not assertive enough to tell the doctor, no, no, no.... that [my] study... also is worthy [that] this is what it say[s]. [CE 3]*

A participant said nurses is feared being embarrassed by the doctors in front of their colleagues:

*...they [nurses] are afraid of been putting off by doctor or colleague. They [doctors] will look at them as lack of knowledge or they [nurses are] so concern about what other people will think about them [nurses]. They [nurses] are afraid of asking questions...not assertive enough to ask question..... [CSNS 8]*

#### 4.5.2.2.2 *Lack of team work and support*

Participants viewed a lack of team work as a challenge to scholarship. The participants felt there is a lack of support from management in the area of practice. This prevents staff as well as students from further contributing towards the development of clinical scholarship in the clinical arena. Participants offered the following comments:

*...if there can be a participative management, if they [management] can be able to hear from the staff at lower level what could they [staff] really want, not to do only things that they [management] think is good for the staff. If they can hear from the staff what are their concerns and how can the staff helps in developing and defending the nursing profession... are really wants. [CSNS 2]*

*...academic institution and practical area should work together and break the barriers...the student should get the management and other clinical staff support in the clinical area be it academically or practically... [CE 1]*

*They need to work together with the learner. Know their environment and work together with also the staff at the clinical area. Establish good communication among the learners and clinical staff also. [CSNS 5]*

### **4.5.3 Solutions for clinical scholarship as perceived by CSNSs and CEs**

Five categories of solutions emerged and 13 sub-categories.

#### 4.5.3.1 Resources

It emerged that adequate resources are needed to enable the development of scholarship. This category was sub-divided into three sub-categories: access to library, clinical facilitation, and funding.

##### *4.5.3.1.1 Access to library (information)*

The participants stated that hospitals should subscribe to peer-reviewed journals so that nurses could get access to the latest journal articles with the aim of learning and being up-to-date. Moreover, it may work out better for the hospital if it has its own library and own journal holdings. However, access to a library should not be a challenge, as claimed by the participants. Participants offered the following comments:

*I will also think a hospital could subscribe to certain journals, especially to journals that are more applicable to the particular hospital, or context or country from the local journals though maybe also international. Also like it is happening here in South Africa most hospital have library. [CE 3]*

*I think the best way is to make sure that the evidence practice that we are talking about, the research that we are talking about or the documents for all the research those evidence practice must be available to students specially in library. [CSNS 1]*

*...available resources like journal article should be easily accessed through the library. At time some of the journal or article is not freely accessible...[CSSN 8]*

#### 4.5.3.1.2 *Clinical facilitation*

The participants felt that there is a need to have clinical facilitation while they are in the clinical area. If something new is encountered in the clinical area, students should ask the clinical lecturer/facilitator about it so as to enhance their knowledge. Also, participants felt students need the clinical facilitator to provide motivation. CE and CSNS participants commented as follows:

*if I see anything interesting in the clinical area...such as new nursing procedure(s)...new drugs... I would bring it into class as soon as possible and try to discuss it as a group...[CE 2].*

*We as lecturers, we need to go out with the communities, not if possible, we are supposed to do that...identify the problem in the community or clinical arena, say what is the priority and do the intervention. This is what we [are] supposed to help the student to do...you look out what are the problems what are the challenges, how do the nurse develop this critical knowledge there... [CE 1]*

*Students need to be motivated, clinical facilitator need to go out and motivate the students to do things more than just sitting at schools...must instigate critical skills in students such as critical thinking, critical analysis...teaching them to ask questions...[CSNS 7]*

#### 4.5.3.1.3 Adequate funding

Funding was raised as a solution that can advance scholarship among the CSNSs. Participants viewed money as an important tool needed in the development of CS. The following comments were offered by participants:

*If maybe you want to do research on a particular thing, they can be certain things, like maybe funding, in order to use hmm...or maybe incentive say if you want to do research hmm [CSNS 2]*

*...the institution need to make sufficient fund available for individual who are interested in conducting small project that will benefit and contribute towards the development of clinical scholarship... [CSNS 4]*

*There is always money involves, that need to be foreseen or do it at your means....err...for example err..at time you need people to help you with the*

*work...err...and they ask you to pay them and it so happen at time that you as an individual or student you can't afford to pay. In that case individual or student need to know where funding can be available to assist in conducting small research project [CSNS 7]*

#### 4.5.3.2 Encouragement of scholarship activity

Under this second category, two sub-categories emerged, namely, promotion and guidelines:

##### *4.5.3.2.1 Promotion*

A way of ensuring high-quality work by CEs is to keep them happy by rewarding their efforts. According to one participant, clinical facilitators might leave the job if they are being neglected. Participants commented, accordingly, as follows:

*Other thing that can be done is to promote the clinical instructor when they are due for promotion because obviously if they are not happy in their work place, they don't get any reward such as increment in salary from what they are doing, they will be discouraged and they will not be producing good quality work [CSNS 6]*

*I think people involving in clinical scholarship development, should be supported by other colleagues and rewarded...I think this could encourage and gear up people more towards the development and sustain of clinical scholarship [CSNS 2]*

*I think the individual can be motivated if they can be promoted or reward for their hard work towards in helping the nursing students to achieve their goal [CSNS 3]*

##### *4.5.3.2.2 Need for guidelines*

The participants viewed guidelines as equally important for the development of scholarship. They felt without proper guidelines, CS will/may not go anywhere. Both the academic and clinical arena should provide support for scholarship. Participants commented as follows:

*University and clinical area should have policy or guideline that support clinical scholarship in if they want to students to be actively involves in scholarship. [CSNS 5]*

*The clinical area should be made available policies or guide lines, example evidence-based guidelines, so that nurses can perform according to what the*

*hospital is requires and in that way standard of practices can be maintained and clinical scholarship can be promoted [CSNS 6]*

*I think it will be better if the hospital has guidelines or policies errm...I am not sure if they have though...because that could help guide practice based on evidence and at the same time promote clinical scholarship and not to depend on journal article only [CSNS 1].*

#### 4.5.3.3 Culture of scholarship

Culture of scholarship emerged as a third category. This was further sub-divided in two sub-categories, namely, university and institution (clinical arena) should work together, and work between doctors and nurses.

##### *4.5.3.3.1 University and institution should work together*

The participants reported that despite the fact that CS is seen as important in the nursing profession, the university and the institution should work together. They should have mutual understanding and a shared vision of what is best for the profession and the patients. They should share a culture that embraces CS. The participants said that the university and the clinical arena should be jointly involved in planning, developing, supporting and getting to know what is happening in the clinical arena. They believed this could help in creating an environment that embraces CS. The participants also believed in sharing knowledge with other members of the health care profession. On enabling CS, participants commented as follows:

*If university or college can conduct training at different institutions, so that those [nurses from the training] that [when they] go back to the different institution [they] can promote the knowledge that acquires from the training to others [CSNS 3]*

*the clinical area and the university must be involved in planning and developing how to create an environment of clinical scholarship [CSNS 6]*

*[the clinical facilitator/expert should] take your students to the clinical area doing situational, [get to know] what is happening [in the clinical arena], why this is happening...then you work hand in hand with the clinical area of practice...the institution should allow the university student to conduct research at their institution [CSNS 5]*

*I think the division between education and clinical practice is one important thing that must be avoided. That distance between clinical and the theory of college or university, that distance must be narrow [CE 3]*

#### 4.5.3.3.2 *Doctors and nurses working together*

Another important element that can enable scholarship is the understanding between health care cadres. The participants felt there is a need for the two professions, doctors and nurses, to understand each other if they want to see scholarship progressing. The participants felt doctors and nurses should work side by side. They should try to narrow the gap between the two professions. Most of all, they should share their knowledge with each other and in that way knowledge can be enhanced and scholarship promoted: Participants offered the following comments:

*There must have mutual understanding between doctors, managers and other health care professional whilst in the clinical practice, they should work as a team [CSNS 1]*

*Here in South Africa we have the divide between the doctors and nurses, the doctors do not want to approach the nurses and vice versa, we need to close the gap and work together [CE 2]*

*Let say even between the discipline, nurses should also need to interact with doctors, physiotherapist, and other members in sharing of ideas, how to improve the patient care [CSNS 8]*

*I would say by involving the multidisciplinary team where there are doctors, where there are managers where there are nurses, so they need to come together and discuss problems if there are problems and then solves them together [CSNS 4]*

#### 4.5.3.4 Responsive teaching

The sub-categories that emerged from this fourth category of solutions were: integration of theory and practice and research, continuous professional development, and incorporating CS into the curriculum.

#### 4.5.3.4.1 *Integration of theory and practice*

The participants believed that the integration of theoretical knowledge with practice and research could help in promoting clinical scholarship. Additionally, participants stated that clinical scholarship could be promoted through the integration of practice and theory in the arena of clinical practice. This is highlighted by one participant:

*...put current practice with previous experience and literature then integrate the three, then that will assist them generate context driven knowledge, then that will promote clinical scholarship. That is how I feel we can promote clinical scholarship ... [CE 3]*

Other participants commented as follows:

*...nursing student can apply theory with practice, what they have been taught at the university, college, go to their community or go to clinical area, where they will integrate and apply the knowledge with practice in the real world... [CSNS 5]*

*Clinical student can demonstrate and promote clinical scholarship to their practice by looking at what their instructor are doing, paying attention to what the instructor is teaching them and then using available standard, using the available guideline, using available policies and research so that they can integrate evidence-based on research into their practice in the clinical area [CSNS 6]*

#### 4.5.3.4.2 *Continuous professional development*

It also emerged that continuous professional development through attending workshops would result in promoting CS. The participants believed that information from workshops could keep them abreast of the latest relevant research information needed to improve nursing practice in the clinical arena: Participants offered the following comments:

*I think clinical area can organise small in-service training for the staff and organise for workshop, so that they can go and expand their knowledge or refresh themselves, especially those nurses that has been long out from class...in that way they can be up-to-date with recent development pertaining to nursing practice [CSNS 7]*

*it can be done through small workshop, seminar, symposium where the people from the university come and explain what scholarship is all about, so that the clinical nurse and other professional can have a better idea what is clinical scholarship, and they can also use this opportunity for personal development in nursing [CNSN 1]*

*we can do a whole lot of workshop, conference and seminars that train the staff and teaches them about clinical scholarship [CSNS 3]*

*I think if each facilitator from their speciality has at least yearly workshop or update in the area. It is up to us as facilitator to actually have these workshops to promote clinical scholarship [CE 2]*

#### 4.5.3.4.3 *Incorporating CS in the curriculum*

Both groups of participants felt there is a need to align the curriculum with CS activity or development. According to the participants, CS should primarily start at the university or institution (College) where the students come from. Once a CS programme is established in the curriculum, learners will appreciate this development and ultimately CS would be promoted. Participants commented as follows:

*I think it could be promoted, first by been introduce while we are studying in our first year of nursing so it we could know about [clinical scholarship] before we go to our clinical area, so we could apply it. Not to learn it at the clinical area first when we go there, better to learn it while we are doing our theory in class. [CSNS 5]*

*I think it [clinical scholarship] can be promoted by incorporate it in the curriculum which I am not sure if it there at the moment [CSNS 4]*

*The students, administrators and the educators have to be part of the planning especially the curriculum how the students is going to carry along this scholarship. [CSNS 6]*

#### 4.5.3.5 Attributes in teaching clinical scholarship

The final category under “Solutions” was on the attributes required to teach CS. Three sub-categories emerged namely: knowledgeable in specialty, critical thinker, and positive role model.

#### 4.5.3.5.1 *Knowledgeable in specialty*

Most participants expressed that knowledge in the area of practice is crucial to enable the teaching of others. For teaching and learning to take place, one must have the necessary knowledge pertaining to what needs to be taught. This knowledge shared will not only teach students what CS is all about, but may empower them to actively engage in scholarly activity. Participants commented as follows:

*And again for this to happen the clinical nurse [expert] must be able think critically where they can apply and use practice with theory [laugh]...like I've just said we need [to be] knowledgeable...[CE 1]*

*I think [the] most important qualities [for the clinical facilitator] are they motivated, they know what they are talking about, they have the skills to teach, enthusiastic to come across the students... [CSNS 7]*

*...you [the clinical expert] must be grounded in your clinical knowledge, very grounded and that is the first thing to me, clinical content you must be grounded in the clinical area... providing the right information for the right qualification [CE 3]*

#### 4.5.3.5.2 *Critical thinker*

The participants felt that clinical instructors or clinical facilitators must also have the critical thinking skills to teach or share with others. They believed that students must develop an enquiring mind while engaging in clinical practice. This could help in delivering better health care to the patient. Participants offered the following comments:

*...clinical instructor must be critical thinker, so they need to make the students critical thinkers themselves so that we can help the patient to better cope and recover from their illnesses [CSNS 6]*

*You must be able to teach the students to become active thinkers, ask question and situation all the time [CSNS 7]*

*... this questioning mind, why things is this [way] why is it happening like this, can't we change the state core. You actually constructed a person who is inquiry*

*who has this inquiry mind because she was develop when he/she was taught. [CE 3]*

#### *4.5.3.5.3 Positive role model*

Participants found it equally important for the clinical expert or facilitator to have a good personality and be a positive role model for the students. According to the participants, all individuals are different, therefore the clinical expert should be patient with students in order to foster learning. She/he must possess the quality that they want to impart to the students, for example critical thinking. Participants explained that learning is enhanced when the clinical expert shows motivation and enthusiasm. This is what participants had to say:

*You [clinical facilitator] must be loving, caring and kind like everything a nurse should be. Be kind to the students if you want to develop good students [CSNS 8]*

*We [clinical facilitator] need to be patience with the students, need to be critical thinker, be a good observer, need to be a good role model, need to know how to motivate the students and the passion for the profession should be within you as clinical facilitator [CE 1]*

*I think for the clinical instructor, they really need the attributes like patience, caring and ready to accept different students because students are different characters different abilities You cannot produce good students if you are impatient, if you don't have the knowledge...then you will not have the knowledge to transfer [CSNS 6].*

*The teacher need also to be an inspiration to the students so that the student could have or may develop the drive to follow them [CNSN 2]*

*The facilitator or clinical instructor must be a role model for the students and others, they must have been able to learn something from me through my knowledge and skills to them. [CE 4]*

#### **4.6 Chapter summary**

This chapter presented and analysed the findings of the study, as broken down into categories and sub-categories for the qualitative phase. The findings of the quantitative phase, where the data were collected from questionnaires, were presented in the form of Tables. Chapter five discusses the results of the quantitative and qualitative data analysis in relation to relevant studies.

## **CHAPTER FIVE**

### **DISCUSSION OF FINDINGS**

#### **5.1 Introduction**

This chapter discusses the findings of the study in relation to the supporting literature. The discussion has been aligned to the analysis of the findings of the study. The discussion has been organised in line with the findings i.e.: Phase One – quantitative and Phase Two – qualitative

#### **5.2 Phase One: Discussion of quantitative findings**

This section discusses socio-demographics, barriers and solutions relating to clinical scholarship (CS).

##### **5.2.1 Socio-demographic characteristic**

A total of 81 clinical specialist nursing students (CSNSs) participated in the study. The socio-demographic of the CSNSs included gender, age, level of education, and length of experience in the nursing area at the time of the study. A 100% response rate was secured by the researcher, in contrast to other studies which had response rates of 77.0% (Nkwanyana, 2012) and 76.0% (Osborne, 2009). Although there is no specific justification for varying response rates, Geyer (2015) attributes variance to reluctance, low morale or non-cooperativeness of participants at the time of data collection.

The results indicated that the majority of the CSNSs were female (97.5%; n=79). Within the profession of nursing, male representativeness remains uneven despite efforts to encourage males to join the nursing profession (Rajacich, Kane, Williston et al., 2013). This may be due to the historical conception that nursing is more suited to women in view of the nurturing and domestic role of the female (Ozdemir, Akansel & Tunk, 2008) and to misperception or misconception and gender role stereotyping with regard to the work done within the profession (Rajacich et al., 2013). Interestingly, no studies have focused on statistical significance between gender and scholarship promotion, whether in academic or clinical scholarship.

Most of the CSNSs in the study (34.6 %; n=28) were older than 41 years, corresponding to a similar study conducted in Nigeria to determine nurses' self-reported utilisation of research

findings in clinical practice, where more than 50.0% of the participants were above the age of 41 years (Ofi, Sowunmi, Edet et al., 2008). This finding was consistent with those of Mannix et al. (2013) and Smith, Coyle, de Lacey et al. (2014), as opposed to a study in Iran (Farokhzadian, Nayeri & Borhani, 2015) in which the largest number of participants were in the age range 30 to 35 years.

In this study, with the largest population group being above the age of 40 years, there was, interestingly, statistical significance between CSNS age and CSNS perception towards CS, with a p-value of <0.02. This indicated that as CSNS grow older they become more aware of the outcomes expected of them in the profession. Additionally, growing older leads students to take more responsibility for their education and be more strongly committed to the profession (Sheard, 2009). According to Cassidy (2012) in a UK study, mature students are highly motivated and have more experience related to discipline, and will not just accept things the way they are. Broadly, it can be said that mature students see their education and profession as vehicles for personal growth and are less inclined to accept the status quo (Shanahan, 2000; Sheard, 2009). However, contrastingly, in a study investigating factors that influence learning in nursing, Hakimzadeh, Ghodrati, Karamdost et al. (2013) found no correlation between age and the need to pursue professional development.

The participants were predominantly undergraduate students (74.0%; n=60) as opposed to postgraduate students (9%; n=21). This finding echoes a study by Geyer (2015) where 67.5% of the participants were undergraduate students as compared to 4.9% postgraduate students. In contrast to this study, many authors found that most clinical nurse specialists were postgraduate nurses (Stark, 2006; Peters-Watral, Stenekes & Wowchuk, 2008; Affara, 2009). It has in fact been stipulated that when clinical nurses have a degree, they are in better position to help in advancing the nursing profession, as, for example, in developing standards, conducting research, developing theory and applying these factors to improve patient outcomes (Clinical Nurse Specialist, 2013). The effect is to make the clinical nurse specialist more enthusiastic about practising safely and ethically in the specialist area, thus influencing practice (Canadian Nurses Association, 2014). In this study, the CSNSs show their interest in pursuing their study and in specialising in area of interest with the aim of effecting changes in nursing practice, as previously noted in the literature.

Additionally, CS emphasises the need for nurses to be critical thinkers – to be creative and observant, and generate new knowledge for evidence-based nursing practice, thus improving patient outcomes.

In the present study, most of the CSNSs (44.4%; n=36) were registered in the first year of their degree, followed by 37.0% (n=30) who were in the second year of study programmes. Similarly, studies by Chernomas and Shapiro (2013) in a Canadian university and Milton-Wildey, Kenny, Parmenter et al. (2014) in Australia, found that more of their participants were first-year students. Interestingly, the present study indicated that there is a positive relation between year of study and student nurses' perception towards scholarship and no statistical significance (p-value =0.55). A possible explanation is that increased level of education puts them in a better position to analysis situation (Awad, 2015). Vigonte, Molina II and Fabella (2014) noted that students in the third year and fourth year pay attention to clinical instruction. There are also indications that, regardless of their level, students want to acquire maximum knowledge so that they can improve patient outcomes (Zamanzadeh, Valizadeh, Azimzadeh et al., 2014).

A majority (55.6%; n=45) of the participants had between 0 and 10 years of experience in nursing. Similarly Manias and Bullock (2002) found that 91.1% of their participants fell within the benchmark range of 1 to 10 years of experience in nursing. Studies have shown that clinical experience has an impact on clinical practice. Interestingly, the data revealed statistical significance (p-value =0.02) between the CSNSs' experience in nursing and their perception towards CS. Nurses with more experience are more enthusiastic about development of own career and improving patient care (Bjørk & Hamilton, 2011). For example, clinical experience helps nurses to build the knowledge, values and skills they need for professional practice (Mabuda, Potgieter & Alberts, 2008; Tiwaken, Caranto & David, 2015). This helps in developing CS and advancing clinical practice and has a positive impact on service delivery to the patient (Barrie, 2014). Tymkow (2010) makes the point that the integration of knowledge, skills and research for advancing the profession and practice are all part of nursing experience.

In this study, findings in regard to experience in a clinical speciality showed 60.5% (n=49) with clinical specialty experience in the range 0 to 10 years and 8.6% (n=7) with clinical specialty

experience between 11 and 20 years. Similarly, in a study conducted at the University of Tasmania, 50.0% of the participants had between 0 to 10 years of experience in a nursing clinical specialty (Courtney-Pratt, FitzGerald, Ford et al., 2012). The present study indicated there is a positive relationship between clinical specialty and the nurse's perception towards scholarship. In line with CS expectations, these clinical nurses are the trend setters of quality nursing practice. It is their responsibility to ensure that they are current with research, knowledge and skills, regardless of unforeseen constraints such as workload or having a degree together with experience (Smith, 1998; Köse & Öztunç, 2016). Clinical specialists need to keep abreast with recent and best available resources, above all to help improvement of patient care (Malik, McKenna & Plummer, 2015; Canadian Nurses Association, 2017).

### **5.3.1 Barriers to clinical scholarship**

The barriers to clinical scholarship are explained in turn from the top three most commonly identified to the three least commonly identified.

#### **5.3.1.1 Inadequate funding to support all forms of scholarship in organisation**

A significant 83.9% (n=63) CSNSs indicated lack of funding for supporting the different forms of scholarship within the faculty, college or clinical area as the most common barrier to CS. Funding for scholarship was also identified as a barrier by other authors (Kennedy et al., 2003; Crookes, Smith, Else et al., 2016).

The lack of funding in the clinical arena impedes hospital management from investing in staff development. Lack of funds also impede CS activities, including the conducting of small clinical projects that can advance practice. In a study conducted in Egypt, (El-Badawy & Kassam, 2008) analysing nurses' perception of barriers faced by nurses' in the clinical area, nurses agreed specifically that lack of funding for research activities was the most challenging barrier in the clinical area. This impeded their opportunities to gain research knowledge, which escalated the gap between research and practice in the clinical area. Additionally, lack of funding has an impact on conducting research, promotion and development of projects, and staff development (Chalmers, 2011). On the other hand, when sufficient funds are made available for scholarship within specific areas, scholarly activities are promoted (Crookes, Smith, Else & Crookes, 2016). Chalmers (2011)

notes that inadequate funding limits research and development of projects and all other activities integral to furthering CS in the clinical arena.

#### 5.3.1.2 Clinicians need assistance in writing publications

The second most common barrier, identified by 82.7% (n=67) of CSNSs, agreed that clinicians need assistance in writing articles for publication and in other activities related to scholarship. With the surge in researching for publication, the clinician or researcher needs to have good skills in academic writing. This is supported by Smith et al. (2012) in Australia, who make the point that, individuals in the clinical area often find it difficult to publish their work due to the lack of writing skills. Furthermore, despite the research being peer reviewed and identified as significant in the area of practice, due to high ranking of the journal system, the research was not published.

Similarly, in California, Brown et al. (2009a) noted that nurses lack knowledge about research and need expert guidance on the process of research. The challenges identified were uncertainty in work presentation and difficulty in navigating the process of getting published. Sometimes nurses felt that the data was inadequate for production of a publication. However, within the principle scholarship field of teaching, Jacelon et al. (2010) encourage learners to take control of their intellectual growth as future scholars. For this reason Smith et al. (2009) argue that if researchers lack knowledge and yet want to be successful in publishing their work, there should be assistance for the scholarly activity. Difficulty in choosing the research topic, lack of academic writing skills, inability to meet the journal's stipulations/criteria, and time constraints are among the reasons why it is appropriate to provide support to clinicians for publication (Moos, 2009). In aiding publication, Ay et al. (2014), in Turkey, suggest that hospital administrators should organise an in-hospital research centre that facilitates CS and provides support for clinical scholars

#### 5.3.1.3 Lack of mechanisms to reward scholarship

In relation to professional development and academic achievement, research and publications have been a key focus for many clinical nurse specialists, and their enthusiasm for research has been a credit to the nursing profession (Affara, 2009; Barrie, 2014). Yet the professional commitment, energy and dedication that nurses invest in research activities is given scant recognition by management in clinical practice (Boyer, 1990; Peterson & Stevens, 2013). This was highlighted

as the third most common barrier in this present study by 79.1% (n=64) of CSNSs, who said that scholarship activities in teaching or scholarship application are barely rewarded within the departments of health, either at local level or at national level. All too often, certain components of scholarship have been overlooked, and the scholarship of teaching has in particular suffered neglect. In agreement with the current study, Boyer (1990) and Smith et al. (2012) noted that evaluation, assessment and reward of all scholarship activities was ignored due to an exclusive emphasis on research activities. Disappointingly, this has disadvantaged clinical staff, as they are unable to cope with the expectations of research and publication. Smith et al. (2012) argue that this limits the dissemination of knowledge among clinical staff.

Lending support to the current study, Smith and Crookes (2011) in Australia conclude that a thorough consideration of the reward system for scholarship should create opportunities for individual members who are interested in all forms of scholarship and enable recognition of the specific needs of scholarship. This may ultimately develop scholarship even further (Smith & Crookes, 2011). Peterson and Stevens (2013) in the United States concur, stating that the services and practices of clinical nurses are important CS activities, and that recognising all form of scholarship encourages nurses to continuously maintain competencies and legal responsibilities for safe practice.

#### 5.3.1.4 Need for team work

Team work is important for the development and progression of scholarship. Among the three least common barriers identified in this study, more than half (65.4 % n=53) of CSNSs identified lack of interdisciplinary cooperation among health care professionals as barrier to the development of scholarship. Working as a team is crucial for the clinical specialist nurse. Agreeing with the current study, nurses in the United Kingdom reported that when working in cooperation with one another, clinical specialist nurses find themselves in a better position to apply their knowledge and skills in practice, which further helps to improve patient outcome (Edwards, 2011). Literature sees clinical specialist nurses as the innovators of best care practice in the health care environment, and their knowledge needs to be shared with other colleagues (Wickham, 2013). This can be done by assessment of clinical needs, counselling and providing the most relevant and up-to-date

information (Baker, Kearins, O'Connell & Sullivan et al., 2013). These skills are necessary to support CS and it is important to ensure that the CNS has these skills (Tymkow, 2010).

Barrie (2014) state that the clinical nurses specialist needs to undertake personal development and further academic participation that is consistent with clinical practice. The clinical nurse specialist needs to work alongside the researcher and interdisciplinary team so that they can be aware of research and appropriately equipped to contribute in the development of the clinical arena (Edwards, 2011). This could be a crucial development for the clinical nurse specialist in helping to promote clinical scholarship. Moreover, involvement in research by the clinical nurse specialist enhances clinically based knowledge that ultimately integrates theory and practice (McNamara, Lepage & Boileau, 2011; Ryan & Doody, 2014).

#### 5.3.1.5 Time frames for promotion related to all forms of scholarship

It has been established that development and demonstration of scholarship often takes longer than expected before promotion is finalised (Smesny et al., 2007). In the present study, 61.8% (n=50) of CSNSs stated that time frames for promotion related to development were too lengthy, causing stagnation in promotion based on scholarship. Research has confirmed that career path promotion can be challenging (Clark, Alcalá-Van Houten & Perea-Ryan, 2010), and an individual often has to wait for quite some time before getting promoted (O'Meara, 2010). Although Clark et al. (2010) agree with the participants in the present study that promotion can take a long time, individuals nevertheless need to be continuous and consistent in publication and show commitment and professional aptitude in their practice.

On the issue of promotion, Boshier (2009) stated that some individuals misunderstand the criteria for scholarship of teaching and this may delay promotion. For example, an individual may be promoted, only once the knowledge is disseminated to the public. The teaching activity should include peer-reviewed works, and knowledge should be shared with the public (Fincher et al., 2000). Additionally, for promotion, the expectation in regard to scholarship of teaching is that individuals must be able to help and facilitate learning, publish articles and make presentations, thus influencing and fostering an environment of scholarship (Vardi & Quin, 2011). However, in

support of Boyer's (1990) recommendations for promotion of scholarship, Anderson et al. (2013) insist that all forms of scholarship should be equally recognised.

#### 5.3.1.6 The effects of clinical service and teaching

In this study, teaching and the amount of time spent in clinical service was reported as the least common barrier to scholarship. Forty-seven CSNS participants (58.0%) reported that workload in clinical teaching and other clinical services limited involvement in scholarship activities. Lending support to the participants in the study, Robles, Youmans, Byrd et al. (2009) note that when little support is received from team members it often makes it almost impossible to cope with scholarly activities. Furthermore, such imbalance of time in the working environment puts pressure on allocation of time between scholarship activities and routine work (Kehrer & Svensson, 2012).

In the UK, Segrott, McIvor and Green (2006) noted that workloads for clinical practice and teaching are extremely high in the clinical area, preventing nurses from participating in scholarship activities. To overcome this barrier, Staun, Bergström and Wadensten (2010) argue that clinical teaching and clinical work should be well organised, enabling the CE expert to assist students nurses to integrate their clinical knowledge with theoretical and literature. In the course of clinical practice, integration of practice and theory has in fact been a core factor for the student nurse. Similarly, Goldszmidt, Zibrowski and Weston (2008) agree with Cryder, Schmidt, Arif et al. (2014) that enhancement of scholarship endeavours requires that imbalance between scholarship activities and teaching time be resolved. Coupled with this, Carlson, Pilhammar and Wann-Hansson (2010) note that teaching in the clinical area becomes impossible when a unit is busy and clinical nurses are occupied with routine practice.

Though it has been postulated that clinical nurse specialists need time away from bedside responsibilities to embrace scholarship activity (Malik et al., 2015), despite busy schedules and complexity in the clinical arena, the knowledge-practice gap can nonetheless be bridged in nursing practice (Clark et al., 2010). Chaboyer, McMurray and Wallis (2010) point out that teaching can occur at the patient's bedside, where nurses not only recall key information but are in a more inquiring state of mind and search for answers. The CSN should make this their priority in on-

going management of patients, treatment and diagnosis, as often they are the first in line to provide such (Ray, 2016). This can be an important contribution to dissemination of CS.

### **5.3.2 Solutions for clinical scholarship**

This section discusses the three most common and least common solutions for clinical scholarship

#### 5.3.2.1 Re-examine criteria for promotion for all forms of scholarship

One of the common solutions for CS identified in this study, supported by an overwhelming 92.6% (n=75) of CSNSs, was that universities, colleges and institutions should create a structural framework and re-examine criteria for promotion in order to assess, foster and reward all forms of clinical scholarship. This is supported by Boyer's (1990) argument that all forms of scholarship engagement should be acknowledged and rewarded. Concurring, O'Meara (2006) asserts that the reward systems for all forms of scholarship should be addressed in the mission statement of the institution.

To avoid disparity between kinds of scholarship, Braxton, Luckey and Helland (2006) argue that although universities and colleges are being proactive in rewarding all forms of scholarship, scholarship of discovery has been regarded as superior to scholarship of integration, application, and teaching. Boyer (1990) has argued likewise that not all forms of scholarship have been treated fairly (1990). Similarly, Anderson et al. (2013) state that promoting all forms of scholarship would encourage individual responsibility in publicising the significance of one's work. Indeed, individuals are often influenced by knowing that there is a good reward system in place that motivates them to be productive in the workplace (O'Meara, 2010). Although Chalmers (2011) notes that, progressively, universities and colleges are acknowledging of all forms of scholarship, he also points out that without proper criteria to reward all forms of scholarship some individuals will be left behind, regardless of their commitment at work.

#### 5.3.2.2 Provide sufficient time for all forms of scholarship

The second most commonly supported solution for CS is that time should be made available for all forms of scholarship. Scholarship activities in scholarship of discovery, integration, application and teaching are very demanding and time allocation can make it impossible to complete the work

(publication) on schedule (Peterson & Stevens, 2013). For this reason, the majority of CSNSs (91.4%; n=74) recommended that more protected time should be allocated to enable individuals to perform any form of scholarship as needed within the profession or career and as requested by the college, university or institution. Performing scholarship activities is not easy, nor can everyone cope with the combination of activities that it calls for. Clinical management need to assess and adjust time allocation so that individual staff members can participate effectively and sufficiently in all forms of scholarship and can organise and plan the time that they need to undertake their CS activities (Kennedy et al., 2003). For effective teaching and learning to take place it is equally important for clinical educators to identify coping mechanisms or ways to reduce workload and stress in order to facilitate the students' learning (Karabulut & Aktaş, 2015).

When uninterrupted time to engage in CS is allowed, opportunities are created to produce quality scholarship outcomes and meaningful research (Hinchey, McDonald & Beasley, 2009). Further supporting participants in the current study, in a study by Whittaker, Kernohan and McLaughlin (2014) on learning, development, and support need of community palliative care clinical nurse specialists, although research was reported as useful in advancing nursing practice, the clinical nurse specialists stated that, although they were not opposed to conducting research, too often it was just extra work for them as they did not have time for research (Whittaker et al., 2014). Mindful of this constraint, the unit manager along with the clinical nurse specialist should manage time so that time is set aside for activities such as research and publication (Ryan & Doody, 2014).

#### 5.3.2.3 Using senior role models, create a collaborative mentoring programme

Students need role models or mentors to follow and to guide them in achieving or developing their research skills. Mentors can also assist the students to integrate research and practice. Mentors play an important role in helping the students to publish their work, thus helping with the development of scholarship (Blanchard, Visintainer & La Rochelle, 2015). In the present study, the majority of CSNSs (91.4%, n=74) agreed that role models are vital in creating mentoring programmes and training in academic writing skills. This was identified as the third most common solutions for CS. Smesny et al. (2007) support this in their study on barriers and solutions to scholarship in dentistry, medicine, nursing and pharmacy practice. Similarly, Brown, Daly and

Leong (2009b) agree that mentors encourage students to get involved in research and other scholarly activities.

Learning can also be enhanced when a formal and well organised curriculum is in place to guide and to improve areas in CS where there is a deficit in learning (Pfund, House, Spencer et al., 2013). In agreement with the present study, the study by Brown et al. (2009b) on mentoring in research notes that good guidance in research creates opportunities and offers exposure to different areas of research, especially the clinical area. Such guidance also leads to opportunities to attend conferences and meetings and, most especially, to present and discuss papers before publication. Senior professionals should guide students not only in teaching them about patient's ailments and illnesses and procedures but also in shaping them to become scholars. It is crucial to inculcate clinical decision making in the training of clinical nursing students. Moreover, the students should be supported in the clinical arena in order to narrow the gap between practice and theory (Papastavrou, Lambrinou, Tsangari et al., 2010; Salminen, Stolt, Saarikoski et al., 2010). Clinical role models would assist the nurses to work autonomously, furthermore, empowering nurses to narrow the gap between practice and theory (LaSala, Connors, Pedro et al., 2007; Ryan & Doody, 2014).

#### 5.3.2.4 Create a model of scholarship that requires a high level of discipline-related expertise

In this study, 83.9% (n=68) of CSNSs agreed that scholarship requires a high level of discipline-related expertise to have significant impact on the nursing profession in the form of new developments and innovations. Waldrop (2016) argues that nurses should collaborate with other colleagues and other professionals for systematic evaluation of work, significant to the field of interest that impacts on the profession, and then document the scholarship activities. In agreement with this current study, Register and King (2017) note, in relation to scholarship of teaching and learning, that working together and linking ideas helps to generate new knowledge and making it have a significant impact across the profession. Importantly, Roets et al. (2016) noted that there is a need for nurse specialists in the clinical arena and that research should not be a reason to take them elsewhere. Rather these specialists should be used as catalysts for scholarship to help in generating new knowledge for the clinical arena. This is supported by Grigsby and Thorndyke (2011) in their study on recognising and rewarding clinical scholarship. The researchers highlight

that the scholarship of discovery helps the nurse to generate new knowledge which is subjected to peer review and critique and can ultimately be disseminated. Additionally, the knowledge is not only disseminated but also creates opportunities for further discoveries. Yet even though scholarship is seen as vehicle for generating new knowledge, absence of proper expertise and knowledge to guide research and other scholarly activity may slow the process of research and impede quality care and patient outcomes (Schwab, Greenwood & Dustin, 2014; Roets et al., 2016).

As nursing continues to develop, education, research, policy development and leadership have become important factors in scholarship development for enhancing the profession. Tahan, (2006) notes that objectives need to be identified that are researchable using scientific knowledge, and that knowledge should be disseminated and documented. There is similar agreement that the activities of scholarship need to be peer reviewed, creative and significant to enable development of the nursing profession (Stockhausen & Turale, 2011).

#### 5.3.2.5 Design postgraduate programme to be geared more towards research

In this study, 82.7% (n=67) of CSNSs spoke of designing postgraduate programmes geared more towards research rather than education, and establishing more research training fellowships. In this way, nurses can increase their knowledge of research in order to give nursing care on best evidence available (Smith et al., 2012). However, nurses often seem to find research difficult to master and stressful to use in their daily practice. Nurses stated that research findings should be made easier for all nurses to use and apply in practice, as research is an on-going activity that helps in identifying problems and solutions in the entourage of health care (Mattila & Eriksson, 2007; Ofi et al., 2008).

Peters-Watral et al. (2008) concur with the current study that clinical nurses must hold a postgraduate degree, and that research is one of the CS activities that the clinical nurse must be accomplished in. This is consistent with a study conducted in South Africa by Roets et al. (2016) that identifies the need for postgraduate training to prepare clinical nurses to function in clinical practice where they can disseminate, apply and generate knowledge through research. Moreover, it was noted that scholarship is recognised through original research and publication (Braxton &

Del Favero, 2002; Coulton, 2011). This may further create a research culture which ultimately encourages curiosity and new ways of thinking in practice through knowledge of discovery (Jamerson & Vermeersch, 2012). In this present study, the CSNSs support previous literature on the need for them to be involved in research. In that way, they will not only integrate research into practice but also engage in research activity that will or may make them more research oriented.

Although nurses find it difficult to interpret and use research findings, Robb (2005) and Wilkes and Mohan (2008) state that it is nonetheless essential to acquaint practitioners with research so that they may appreciate research and may in turn perform on best available evidence. Ofi et al. (2008), stated that research is an important component in the nursing profession as it develops an evidence base for practice that ultimately may bring changes in practice.

#### 5.3.2.6 Using Boyer's model of scholarship to work in four areas of scholarship

Using Boyer's (1990) model of scholarship was the least commonly identified solution for CS. Numerous authors concur with the present study and have been working, solving and developing clarification on what scholarship entails based on Boyer's initial framework (Diamond, 2002; Steinert, Nasmith, McLeod et al., 2003; De Golia & Katznelson, 2015), and on finding ways to assess the different components and improve the framework whilst maintaining the fundamental principles (Braxton et al., 2006, Wilkes et al., 2013). In agreement with literature findings, the CSNSs (81.5%: n=66) stated that the faculty, institution and clinical arena should work within the four domains of scholarship established by Boyer (1990). Many significant resources have been made available in an attempt to promote scholarship; they include dissemination of knowledge, research articles, scholars, club journals, scholarly activity, discipline and institutional initiatives, seminars, and conferences (Chalmers, 2011).

Importantly, in the framework established by Boyer (1990), all forms of scholarship; integration, discovery, teaching and application need to be assessed and developed as standards to guide the engagement of scholarship. For this reason, according to Glassick et al. (1997), six standards were introduced that can be used to assess all forms of scholarship: clear goals, adequate preparation, appropriate methods, significant results, effective presentation and reflective critique. This agreement between Boyer (1990) and Glassick et al. (1997) provided a guide for more

understanding and standardised assessment for scholarship rather than modifying the explanation of scholarship (Kennedy et al., 2003; Grigsby & Thorndyke, 2011).

Lending support to the current study, a study by Wilkes et al. (2013) on practising nurses' perspectives of clinical scholarship found that when scholarship was considered in the context of nursing profession, Boyer's (1990) framework was used as a guide. Along with findings of this study indicating that Boyer's framework is an instrumental guide for scholarship, literature showed that other frameworks have been created based on Boyer's seminal work. For instance, Storch and Gamroth (2002) sought to evaluate and simplify Boyer's four domains of scholarship in nursing. Thoun (2009) asserted that values, interest and belief should remain at the scholar's choice and that scholars should let them develop according to what they want within the scholarship. Jacelon et al. (2010) wanted to create a climate which is more comprehensively inclusive of the academic and the community. Sadly, according to Grigsby and Thorndyke (2011), two components that have been overlooked in Boyer's seminal work are scholarship of integration and scholarship of application.

#### **5.4 Phase Two: Discussion of qualitative findings**

From the data collected, nine categories emerged. These categories were divided into 24 sub-categories.

##### **5.4.1 Clinical specialist nursing students and clinical expert knowledge about clinical scholarship**

Two categories emerged from the data: academic excellence and scientific knowledge, and need for research in practice.

###### 5.4.1.1 Academic excellence

The category of academic excellence was divided into two sub-categories: scientific knowledge and improved patient outcome, and critical thinking.

#### *5.4.1.1.1 Scientific knowledge and improved patient outcome*

Participants saw CS as a way in which nurses can improve patient outcomes through the use of scientific knowledge. Participants were in agreement with Olf and Clark-Wadkins (2012) that nurses must be mindful that nursing care/management should be grounded in scientific knowledge and that nurses must keep abreast with research findings in order to maintain and improve standards of care. Nurses are key players in restoring and improving the lives of patients based on scientific knowledge and research (El-Badawy & Kassam, 2008; Lusk, 2014).

It has been established that any programmes of nursing that prepare professional nurses to develop new knowledge and apply scientific knowledge (scholarship of discovery and integration) in their daily practice can be seen as integrating and teaching research. Having this strategy in place helps to prepare students to value the importance of research, which they may apply appropriately in their daily practice as they acquire new scientific knowledge (American Association of Colleges of Nursing, 2004). In addition, according to Gray and Pratt (1995), nurses who are able keep abreast with nursing development and improve nursing practice, are seen as true scholars in the development of nursing. However, despite emphasis on using best available evidence to guide practice, the process of EBP and CS slow (Wallin, 2009; Rudman, Gustavsson, Ehrenberg et al., 2012).

Limited acknowledgment of evidence-based practice and scientific knowledge may hinder development of policies and guidelines and increase health care costs to the detriment of patient outcomes (Melnyk, Gallagher-Ford, Long et al., 2014a; Williams, Perillo & Brown, 2015). Participants agreed that through scholarship new knowledge can be generated and applied in daily practice in the clinical arena thus improving practice and patient care.

#### *5.4.1.1.2 Critical thinking*

Participants saw clinical scholarship as a vehicle that could help them to develop their critical thinking skills and apply them to specific situations in the clinical arena. Through clinical scholarship, participants stated, they can acquire the skills needed to provide better care for patients. Participants commented on the escalating trend of epidemiology, changes in nursing management and patient care and other health-related issues. Supporting this present study, a study

by Andreou, Papastavrou and Merkouris (2014) on the “relationship between learning styles and critical thinking” among nursing students noted that critical thinking develops higher mental abilities and competence for effective clinical and logical reasoning and judgement in decision making and in discussing areas for improvement and problem solving in clinical practice. Ability to think critically enables nurses to integrate skills, knowledge and evidence-based nursing practice (National Council of State Boards of Nursing, 2013).

Continued updating with current literature enhances nurses’ tendency and ability to develop critical thinking skills. This effectively helps the nurses to deliver improved nursing care to the patient or client and ensures that their practice is supported by the most recent and best current evidence (Spiers, Williams, Gibson et al., 2014). In a US study on integrating the scholarship of practice in the nurse’s portfolio, Peterson et al. (2013) emphasise the need for clinical nurse to know how to apply and use critical thinking for decision making. Developing critical thinking gives nurses greater self-confidence in their decision making, and makes them mindful that nursing is a profession that needs depth and breadth of knowledge (ISNA Bulletin, 2014). On the other hand, it was noted that nurses who lack critical thinking ability are more prone to poor judgement and defective practice in delivering nursing care (Suliman, 2006; Wangenstein, Johansson, Björkström et al., 2011). Inability to think critically also hampers professional engagement with the multidisciplinary team (Banfield, Fagan & Janes, 2012).

#### 5.4.1.2 Importance of research in practice

Three sub-headings emerged in this category: context-driven evidence-base practice, practice that informs education, and better way of doing things.

##### *5.4.1.2.1 Context-driven evidence-based practice*

Participants explained that CS involves evidence-based practice. They acknowledged that CS assists nurses to acquire knowledge based on evidence which can be applied (scholarship of integration) in daily nursing practice. They agreed that current nursing practice is evidence-based. Moreover, evidence cannot exist in the absence of research. This is also noted in a previous study conducted in Arizona on implementing evidence-based nursing practice, where it was identified that one integral ways of closing the gap between research and practice is to integrate evidence-

based practice in daily practice (Pipe, Wellik, Buchda et al., 2005). Another supporting study, done in Egypt, which analysed nurses' perception of barriers and facilitators in their use of research in the clinical setting (El-Badawy & Kassam, 2008), indicated that it is the nurse's responsibility to ensure that he/she is continuously searching for new skills and research evidence that would help to improve patient care and evidence-based nursing care.

Evidence-based nursing practice enables the nurse to make decisions whilst simultaneously allowing the patient to make their choices: for example, through scholarship of integration and by giving explanation to the patient about their condition and what is expected, which may help the patient to show more understanding and cooperation in his/her management (Friesen-Storms, Bours, Van der Weijden et al., 2015). Consequently, it helps the organisation to develop new guidelines and policies in the management of care and it also shows cost effectiveness in patient care, such as reduced duration of hospital stay and increased patient satisfaction (Long & Brewer, 2011). Practice, research and theory are vitally important in quality of nursing care and in knowledge development across the discipline, and it can be helpful for the researcher to construct the new knowledge (scholarship of discovery) which is required as a basis for practice in the health care profession (Chinn & Kramer, 2011).

Using best evidence in daily practice is strongly advised, but it also presents challenges. Studies have noted that evidence-based practice is not always a norm (Grol & Grimshaw, 2003; Jette, 2016). Causal factors are insufficient skills or confidence, too long in-service, lack of time, absence of policies, guidelines or organisational support, lack of authority or autonomy to change practice, and research findings not available (Uysal, Temel, Ardahan et al., 2010; Bussièrès, Al Zoubi, Stuber et al., 2016; der Zijpp, Niessen, Eldh et al., 2016). To overcome these challenges, nurses need to know how to reflect on current clinical practice, evaluate and understand research, and integrate knowledge, research and evidence in practice (Florin, Ehrenberg, Wallin et al., 2012; Schaffer, Sandau & Diedrick, 2013). In the present study, participants supported previous findings in South Africa by Almaze and Emmamally (2015) that research must be recognised and applied in day-to-day practice. In so doing, opportunities are created for the clinical nurse to utilise his/her evidence-based knowledge widely, and simultaneously develop and demonstrate their skills through evidence-based practice and scholarship activities.

#### 5.4.1.2.2 *Practice informs education*

Participants defined CS as an activity that systematically aids research and teaching. Additionally, CS integrates theory with practice and helps nurses to find solutions for improving patient care. Kitson (2006) stresses the need for combining academics and practice, and Squires, Estabrooks, Gustavsson et al. (2011) state that nurses involved in continuing education have a positive attitude to using the best research available to guide their practice. According to Melnyk, Fineout-Overholt, Feinstein et al. (2008), nursing education, especially at postgraduate level, prepares and motivates nurses to efficiently integrate the evidence with practice in provision of care. However, Burke, Schlenk, Sereika et al. (2005) discovered in their study that research was often taught separately from other subjects, which made it difficult for the students to understand how to translate theory and research (scholarship of integration) in the clinical area.

Newton, Billett, Jolly et al. (2009) argue that the theory gap in nursing is one of the main causes preventing the nursing student from integrating practice with theory. Our participants indicated that it is equally important for practice to inform education. In corroboration, Smith et al. (2007) concluded that academic are often isolated and disconnected from what is happening in clinical arena. Furthermore, participants in this study agreed with Mohide et al. (2005), investigating promotion of evidence-based practice in the clinical setting, that practice should inform education and that a united front may promote CS. This can be achieved where the clinician works in collaboration with the researcher to identify health-related problems, ultimately improving patient outcome and escalating the translation of research (Gordan, 2013).

#### 5.4.1.2.3 *Better way of doing things*

Participants of the study supported studies showing that nurses must compare old evidence with current emerging evidence and ultimately identify the best practice going forward in the clinical arena. Clinical scholarship encourages nurses to scrutinise nursing practice in order to find new and better ways for nursing practice, rather than just continuing accept practices, procedures and theories (Dreher, 1999). Rosswurm and Larrabee (1999) and Thompson and Stapley (2011) argue that health care professionals need to have an inquiring mind to challenge their own practice and identify alternatives to improve practice. Supporting the literature (Rosswurm & Larrabee, 1999; Melnyk, Gallagher-Ford, Long et al., 2014b; Almaze & Emmamally, 2015), participants agreed

that clinical nurses should not rely solely on opinion, traditional nursing or their clinical experience for patient's preference.

According to Kitson (2006), nurses should be able; to understand what has been done before and (through literature) compare it with current practice; they should be able to communicate ideas freely, must think logically and not forget about the reference point. In this way, nurses can find alternate ways to extend their knowledge, offer deeper and richer understanding of practice, and most importantly, even possible be able to change theory in response to own practice (Bell, 2003), thus promoting CS and improve practice. This may in turn lead to knowledge translation and may simultaneously initiate innovation in the practice area, as well as providing solutions to health-related issues (World Health Organization, 2014a). Ting, Shojania, Montori et al. (2009) and Gordan (2013) argue that engagement in scholarship results in better cost effectiveness and innovative treatment. Importantly, participants also felt that support from nurse managers and other colleagues is essential for CS to flourish; supporting this point, Booyens (1998) stresses the need for nurse managers to assist and encourage autonomy.

#### **5.4.2 Barriers to clinical scholarship as perceived by CSNs and clinical experts**

From the data collected, two categories emerged in relation to barriers to CS: scholarship overlooked, and poor communication.

##### 5.4.2.1 Scholarship overlooked

This category was further divided into four sub-categories: limited resources, research not important, resistance to change, and increased workload and limited time.

###### *5.4.2.1.1 Limited resources*

Participants indicated that limited resources is a major problem for nurses as it impedes their scholarship development. Resource constraints mentioned by participants included lack of clinical experts, and lack of funding. Participants explained that the clinical instructors should be more available in the health facilities. As one of the participants noted, clinical experts should be readily available to coach nurses and help them acquire skills for clinical scholarship. Another noted that it was sometimes hard to find clinical instructors in the clinical area of one's interest. This creates

an extra load for nurses seeking to acquire certain skills. Literature confirms that in seeking to produce good quality health care professionals it is important to have clinical experts to help students develop their skills and knowledge whilst training for their lifelong profession (Pololi & Knight, 2005; Crites, Gaines, Cottrell et al., 2014; Kelsey, 2016). In another study, Smedley et al. (2010) said that clinical experts should make themselves available for students, as they are among the primary resources that students rely on to learn. Students need them for orientation of their learning style, which may help to motivate them to learn and at the same time assess their learning progress.

More recently, it was reported that clinical supervision for nursing students in the clinical arena is a major problem. This has impeded students from integrating practice with theory during clinical placement (Papastavrou et al., 2010) in which theory, practice and research is grounded in CS (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). As a point of concern, participants stated that regardless of the circumstance, clinical experts must find ways and means to support students in the clinical area. Among other skills such as critical thinking and decision making, Kitson (2006), commenting on the relevance of scholarship in nursing, states that nurses need to be equipped and well trained in problem-solving skills as this is crucial in the development of scholarship, and especially so in the development of nursing practice to improve patient outcome. Similarly, in a study conducted in Australia on CS among preceptors supervising longitudinal integrated clerkship medical students, Weston and Hudson (2014) supported participants' suggestion that clinical supervision is needed to help the student enhance learning in development of professional CS.

Participants identified lack of funding as barrier to engaging with CS activities. Thomas, Diener-West, Canto et al. (2004) state that funding constraints not only affect research but also hamper intellectual development of nurses. This is supported by Coulton (2011) and Kennedy et al. (2003), who make the case that limited funding can cause constraints on scholarship. El-Badawy and Kassam (2008) concur that funding for research is needed to improve practice or help with knowledge translation.

Mtawa et al. (2016) note that poor funding demotivates individuals that wish to be engaged in scholarship. Lack of funds results in poor teaching and diminishes research activity, which eventually results in low publication output. Similarly, participants in this study agreed with studies showing that lack or absence of funding not only affected teaching and learning, but also limited the development of projects, policies and guidelines to improve clinical practice (Gosling, 2004; Eccles, Armstrong, Baker et al., 2009). Additionally, Coulton (2011) notes that funding issues could also lead to lack of support for staff development programmes in area of practice.

#### *5.4.2.1.2 Research is not important and is difficult*

Another sub-category that emerged was that some nurses do not see the importance of research. The reason for disinterest was that research is difficult to interpret and at times impossible to implement. Other limitations to research involvement are lack of support from the organisation and administration, research having limited value in practice, lack of funding, and a feeling of powerlessness when it comes to bring about changes (Adib-Hajbaghery, 2007; Uysal et al., 2010; Chen, Shao, Hsiao et al., 2013). Other significant hindrances which researchers have noted include inability to interpret the statistical language of research, research resources not being easily available and accessible, and workload issues that ignore the importance of research (Funk, Champagne, Tomquist et al., 1995; El-Badawy & Kassam, 2008). According to Burke et al. (2005), postgraduate and undergraduate students both complain that research brings no value to their daily practice in the clinical area. Nonetheless, healthcare professionals need to know and understand the importance of research (Bonner & Sando, 2008), in the clinical arena.

In a study conducted in Finland on nursing students learning to utilise nursing research in clinical practice, Mattila and Eriksson (2007) reported that nurses found it difficult to interpret the meaning of research, which, according to Long and Brewer (2011), causes negative attitudes, fear, lack of interest and misconceptions about research among nurses. Despite this negativity nurses need to be able to apply research, need to know about research (Mattila & Eriksson, 2007) and ultimately need to be able to base their daily practice on the best available evidence. In addition, when students are motivated to do research (for example, given assignments to search for articles that are relevant to own practice and thus integrate it into practice), it enhances the students' knowledge on research participation. This was evident in CS programmes to improve patient care in Australia,

in which O'Connor and Peters (2014) found that research provided up-to-date information which improved patient care and practice. Supporting this study, it has also been noted that if nurses do not attach importance to research this can slow the generation of new nursing knowledge and limit nursing development, ultimately putting patient care at risk (Uysal et al., 2010; Benea, 2014; Ryan & Doody, 2014).

#### *5.4.2.1.3 Resistance to change*

Participants viewed resistance to change as a barrier to scholarship. One participant said that it is sometimes difficult to interact with senior nurses who have been in the field for long time and consequently find no problem with what they are doing. This makes them complacent, questioning the need for changes if nursing practice is doing well, since they feel comfortable with the way they are managing the patients and the institution. Consistently, in a study conducted in Australia on behavioural intention and user acceptance of research evidence among clinicians, Moloney (2013) found that healthcare professional are often unwilling to use evidence based in their clinical practice despite strong emphasis on its importance. Coupled with this Hussein and Hussein (2013) noted that in Egypt, nurses are unwilling to change when they see little benefit of the change. They not only want to see the benefit or advantage of the change at organisational level but also how they can personally benefit from the change. Additionally, some nurses argued that new changes are just another burden as they involve extra work for them. Nurses complained that new change often came with new protocols and too much bureaucracy and creates extra paperwork (Silow-Carroll, Alteras & Meyer, 2007).

However, Fowler, Howarth and Hardy (2006) argued that individuals have reasons for accepting or resisting change. They misunderstanding or failure to understand, mistrust, stress, and self-interest as contributing factors in the process of change. Additionally, Kerridge (2011) notes other aspects that might contribute and prevent individual accepting or implementing change. Individuals may reject change when they are living and working with uncertainty – for instance, when they do not feel confident and competent in doing what is expected of them or when they feel insecure and threatened due to the forthcoming change. Similarly, Offei, Bannerman and Kyeremeh (2004) agree that individuals are more resistant to change when the forthcoming change

is not well explained in terms of benefits, disadvantages, privileges, and knowledge and skills required to implement the change.

Participants noted that the clinical practice was becoming monotonous with the repetitive practices and ways of doing things. Simarlaly, Olf and Clark-Wadkins (2012) noted that satisfaction with monotony was a barrier to acceptance and implementation of change in the nursing practice. For instance, despite scientific proof that it is ineffective and harmful to instil sodium chloride (NaCl) into the endotracheal tube before suctioning, many nurses in clinical practice still practice it. In a study on translating evidence into nursing practice, (Makic et al., 2013) revealed that although clinical nurses were discouraged from continuing to give scientifically unproven care, especially in the event that it could be harmful, hazardous and bring no benefit to patients, at times clinical nurses were not consistent in practising and sustaining evidence-based practice in their daily routine.

#### *5.4.2.1.4 Increase workload and limited time*

Clinical experts indicated that increased workload did not allow them to engage in scholarship activity. Often, they found themselves doing multiple tasks: teaching, and setting exams along with other tasks. One participant said that the workload made it difficult for them to cope with scholarship activities. Similarly, in Japan, researchers noted that with the explosion of clinical supervision and academic work, it was difficult for them to extend to scholarship activities such as publication, though it was crucial to bridge the gap between practice and theory (Turale et al., 2009). In China due to the nature of nursing working hours, it was impossible for nurses to participate in scholarship activities such as publication (Turale et al., 2010).

Confirming the pressure encountered by clinical experts, Beattie (2000) and Howell and Karimbux, (2004) noted that academic staff (teachers), and health care professionals in particular, dedicated most of their time to fulfilling visions and goals of their institutions, which limited them from getting involved in scholarly activity. It was further explained that research activity consumes lots of time and often the institution or area of practice does not allocate special time for the individual to conduct research (Bland, Center, Finstad et al., 2005; Uysal et al., 2010; Beeckman, Defloor, Schoonhoven et al., 2011; Pfund et al., 2013). Similarly, Toews and Yazedjian (2007)

reported that individual felt overwhelmed by the amount of responsibility and work that had to cope with – in particular, keeping up to date with current research in one's speciality and simultaneously teaching students. Participants suggested that the combination of clinical supervision and academic scholarship was too much to for an individual to cope with.

Furthermore, participants felt there should be more time allocated for practical practice, claiming a need to spend more time in the clinical setting where they could integrate practice with theory. Additionally, one participant said there was a detrimental imbalance of time between theory and practice, with more time allocated to learning theoretical aspects and limited time given for practical application of theory and integrating it with practical skills. It has been argued that students' exposure to clinical area is as important as having theoretical formation in the classroom (Tiwaken et al., 2015), and that even though the clinical area is stressful, clinical practice is a crucial component of nursing. In fact, clinical exposure creates opportunities for student nurses to develop their professional skills, thus integrating theory with practice (Newton, Jolly, Ockerby et al., 2010) and thereby promoting scholarship of integration. Furthermore, Tiwaken et al. (2015) reveal that most often, nursing students gain educational experience through clinical practice.

In a study conducted in Australia to understand the attitude of undergraduate nursing students towards mental health nursing, Happell and Gaskin (2013) found that student nurses develop more positive attitude towards the profession when they have been well exposed to the clinical area. Most of all, it was found that the student nurses showed more responsibility in caring for the patient once they had been introduce to the clinical area (Tiwaken et al., 2015). Against this background, the CSNSs felt that it was crucial to give more time for their practical skills and simultaneously give them a chance to demonstrate the integration of theory with practice, ultimately helping to promote CS.

#### 5.4.2.2 Poor communication

In this category, two sub-categories emerged: lack of confidence, and lack of team work.

#### 5.4.2.2.1 *Lack of confidence*

Assertiveness is an important communication skill that enables all cadres of health care professional to communicate and build team relationships. It gives the ability to be open and honest with others, while at the same time expressing interests, needs, perceptions, thoughts and feelings without being aggressive (Shrivastava & Mishra, 2015). However, care should be taken to avoid violating or interfering with interest of others (Okuyama, Wagner and Bijnen, 2014). Participants revealed lack of confidence leading to unassertiveness among colleagues and other health team members such as doctors and/or senior colleagues. They stressed that enquiry with other health care professionals is important when one is uncertain about the management or regime of the patient. For example, when doctors prescribe a regime for the patient and uncertainty arises, nurses should be able to approach the prescribing doctor for clarification, so long as they only enquire, and don't try to show authority. In this way, the nurse can show concern and offer suggestion, knowing his/her rights and responsibilities in decision making for problem solving (scholarship of integration) that may bring benefit for the patient (Miller, 2015).

Lack of confidence, and being unsure of the decisions that a nurse needs to take, can lead to medical errors that jeopardise the well-being of the patient. In situations where clinical specialist nursing students are concerned and uncertain about the medical or nursing care or the pathological change in patient condition, assertiveness means stepping forward to avoid mismanagement of the patient and to help restore and maintain the well-being of the patient (Okuyama et al., 2014). This is in line with what Dreher (1999) established: that nurses should not accept anything as it is without making enquiry. Additionally, this improves the quality of patient care as the nurses show confidence and assertiveness in their practice; they become more confident in applying and integrating knowledge with practice in order to deliver appropriate patient care or management (McVanel & Morris, 2010).

In situations where nurses lack confidence or are reluctant to show assertiveness, this creates a greater chance of putting the life of a patients at risk or compromising patient care (Deltsidou, 2009). Arslan, Akça and Baser (2013) suggest that peer pressure, poor self-esteem, lack of confidence and lack of knowledge limit nurses' assertiveness. Similarly in a study by Mc Cabe and Timmins (2003) exploring possible approaches to the teaching of assertiveness to nursing

students, it was established that nurses are anxious due to low self-esteem, underestimating their own ability and fear of what their teammates will say about their performance at work. Nurses often live in fear of upsetting their colleagues (most probably the doctors), causing them a setback in their nursing care. Weston and Hudson (2014) emphasise that CS offers potential for nurses to develop knowledge and skills which would eventually enable them to transfer that knowledge to others and ultimately improve clinical practice. Additionally, in a study to compare the assertiveness level of nursing students, Miller (2015) noted that patients may find it difficult to confide in nurses who lack assertiveness and confidence when coming to attend to their care. Most recently, in rethinking scholarship for nursing, Kelsey (2016) and Tiwaken, Caranto and David (2015) state that nursing needs nurses with abilities, skills and knowledge working within the profession to demonstrate rationale behind responsibility, safeguard the patient, and promote CS.

#### 5.4.2.2.2 *Lack of team work*

Participants saw lack of team work as a problem for scholarship. One participant stated that due to lack of teamwork, management in health facilities sometimes prevent them from meeting their CS objectives in the clinical area. One participant commented that there was a gap between academia and practice which needed to be closed. Participants also said there was a barrier between students and clinical staff that should be narrowed. This is supported by Smedley and Morey (2010) who indicate that a good relationship between the students and clinical staff is needed to enhance students' learning. The CSNSs further expressed that for CS to flourish, management in the clinical arena should take into consideration students' learning needs. Especially regarding scholarship outcomes. When there is good team work, effective communication and support for student, learning is facilitated and knowledge is enhanced.

Furthermore, the CSNSs stated that they felt unwelcome at times in the clinical arena. They said expressed the need for management to be more attentive to staffing needs and work together with staff to improve work and practice. Participants revealed that they felt that nurses were frustrated at work and projected this on students affecting their clinical placement. Twigg and McCullough (2014) and Calarco (2011) note that team work can help to create a good learning environment for clinical practice. In an establishment that encourages team work and shows interest in their staff (allowing nurses to be participants in decision making and supporting their ideas) good clinical

practice and knowledge can be enhanced (Twigg & McCullough, 2014). Additionally this may create opportunities for the clinical expert and students to work in a more conducive clinical arena where learning can take place, enhancing their professional knowledge development (Tiwaken et al., 2015) and helping to develop CS. Where team work does not exist among colleagues, this create tension in the working environment and ultimately makes it difficult for learning to take place and for innovations to be proposed (Schein, 2010).

This is in line with the finding in this study where students stated that the clinical nurses and students should establish good communication that facilitates learning and integration of theory and practice, further gearing them towards scholarship.

### **5.4.3 Solutions for clinical scholarship as perceived by CSNSs and clinical experts**

Five categories and 14 sub-categories emerged from the data.

#### 5.4.3.1 Resources

In this category, three sub-categories emerged: access to library, clinical facilitation, and funding.

##### *5.4.3.1.1 Access to library (information)*

The first sub-category that emerged from what the participants expressed was that hospitals should subscribe to peer-reviewed journals so that nurses can get access to the latest journal articles with the aim of learning and being up to date. This coincides with the emphasis on nurses using the best available resources to improve their practice (Houser & Oman, 2010; Makic et al., 2013; Melnyk et al., 2014b). However, despite the emphasis on nurses using the best available resources of information to guide practice, numerous challenges exist and one was the need for library resources (Long & Brewer, 2011).

Nwagwu and Oshiname (2009) in a study on the “information needs and information seeking behaviour of nurses” in Nigeria state that nurses had difficulties accessing information due to clashes between their patient care shifts in clinical arena and the opening hours of the library. Others claimed they did not have identification for accessing the library (Honey, North & Gunn,

2006). In another study, hospital administration blocked access to the internet as they believe it was a contributed to waste of time by personnel (Estabrooks, O'leary, Ricker et al., 2003). A study which found the library was within reach for nurses to use, nurses argued that the information made available was mostly for doctors (Dee & Stanley, 2005).

Nwagwu and Oshiname (2009) noted that among other facilities such as nursing and medical journals, conferences and workshops, libraries were identified as more important and appropriate to use in daily practice than being informed by colleagues. In support of the previous studies, Younger (2010) argued that access to libraries gives nurses access to recent and best available information to base practice on. Interestingly in South Africa, the health facilities have taken a step forward with introduction of an online library for health professionals (Puckree, Maharaj & Mshunquane, 2015), giving nurses easy access to recent scientific knowledge. Marshall, (1992) and Ajayi (2005) comment, on the other hand, that existence of a library in the clinical arena does not guarantee that this will help to improve patient outcomes if other resources for clinicians to use in support of practice and research are inadequate or unavailable.

#### *5.4.3.1.2 Clinical facilitation*

Participants felt that there is need to have clinical facilitation while the students are in the clinical area. They also felt that there is a need to have more nurses trained in clinical scholarship. According to the participants, the more nurses there are with training in clinical scholarship, the greater the improvement in nursing practice. Clinical facilitation/supervision was seen as a process of professional support that enables nurses to develop their practice, acquire responsibility for own action, interact in discussion, and develop their knowledge for competence in clinical practice (Fowler, 1996). This is becoming significant in the development of nurse practice and scholarship activity (Tony, Louise, Christine et al., 2008; Crites et al., 2014). In support of previous studies, a study conducted in South Africa by Letswalo and Peu (2015) to explore the perceptions of student nurses during accompaniment in the clinical environment stated that it is mandatory for nursing students to be supervised and supported for them to become competent professional nurses. For this reason, the participants felt there is a need for clinical facilitators to engage more with the nursing students when they are in clinical practice. It was also noted that clinical facilitation helps the clinical nurses to inquire when in doubt during patient care, which ultimately creates

opportunity for clinical nurses to improve patient care, as established in CS principles. Furthermore, it provides the clinical nurses with reassurance that people are there to help them in developing their competency (Brunero & Stein-Parbury, 2008).

According to Kristofferzon, Mårtensson, Mamhidir et al. (2012), during clinical supervision/facilitation, students are able to discuss their learning objectives so that they can fulfil their learning outcomes. Without proper supervision, guidance and support, on the other hand, the clinical nurse student may be slow or fail to acquire the necessary skills, knowledge and attitude for their professional development in the clinical arena (Gilmour, Kopeikin & Douché, 2007). It was consistently noted that without proper supervision, the application of knowledge and the development of critical thinking can be impeded (Joubert & De Villiers, 2015). Importantly, clinical facilitators need to encourage students to become a scholars, as well as simply educating them (Jacelon et al., 2010).

#### *5.4.3.1.3 Adequate funding*

In regard to resources, participants felt there is need to have a budget to facilitate CS. Funding, as previously stated in this study, was also identified as a barrier for scholarship by many authors. Against this background, participants pointed out that scholarship mostly involves research and until they get financial support, it is not easy for them to conduct research. A comment from one respondent was “maybe you want to do research on a particular idea, there should be funding to support us.” This corresponds with findings in a study by El-Badawy and Kassam (2008) in Egypt, where the participants rated funding among the top ten facilities needed to use research in the clinical arena. Likewise in a study conducted in China by Turale et al. (2010), participants said that funding should be allocated to researchers who show great interest in research or interdisciplinary scholarship.

In clinical scholarship, research also needs to be disseminated, for example in scholarship of teaching and discovery, so that the knowledge can be used by others. For this reason, the World Health Organization (2014a) has stressed the importance of funding and resources being made available for conducting research, as research requires significant resources. Funding for research and scholarship has long been a concern (Boyer, 1990), as noted recently in a clinical scholarship

programme in Australia (O'Connor & Peters, 2014). Participants in the current study agreed that a well-planned source of funding for research could help the students engage more with research activities and other scholarship activities involved in publication of articles. Nevertheless, in the absence of funding, scholarly activity such as research, and hence knowledge production, may be slow (Eccles et al., 2009; Gordan, 2013). Participants agreed that if funding is made available to them, they will be more than willing to take part in scholarship activity such as research in order to enhance knowledge and develop the profession.

#### 5.4.3.2 Encouragement for scholarship activity

Two sub-categories emerged under this category.

##### *5.4.3.2.1 Promotion*

It emerged from the study that one way of keeping the clinical experts satisfied is by rewarding them or promoting them for the good work done. According to the participant, clinical facilitators might leave the job if they are being neglected. Therefore, one participant suggested that promoting clinical instructors may help in retaining the individual in the system of scholarship. They felt that when an individual does not get job satisfaction, they look for better options. One participant further stated that opportunities should be created so that people (nurses) can be interested in scholarship. Booyens (1998) argued that the management should demonstrate how important the staff are and acknowledge the hard work done by nurses, giving reward and recognition for excellence work separate from salary increases.

In line with the participant's suggestion in this study, Crawford, Burns and McNamara (2012) note that increase in salary and changing of status to a higher level can be a driving force for better results at work. Even though it was argued that scholars should be promoted, there is a cost attached to promotion; individuals must be involved in scholarship activities such as scholarship of teaching, scholarship of discovery, scholarship of integration and scholarship of application in order to generate and disseminate new knowledge (Boyer 1990). Mabrouk (2007) and Green (2008) similarly argue that promotion is based on scholarly activities. These criteria can be used to promote nursing, as the knowledge generated can be utilised in other discipline as well as signalling the value of nurses work (Gray & Pratt, 1995). This idea also supported by Short, Keefer

and Stone (2009), who note that reward or promotion is a good incentive for those who show particular devotion to their work, especially in a profession where research and practice depend on each other to strengthen the profession. Clemente (2008) and Kosteas (2011) note that promotion can encourage nurses or clinical instructors to be more devoted and fruitful in their work when recognition is given for important professional achievement. The Sigma Theta Tau International Clinical Task Force (1999) confirms that CS is likely to flourish in a context of encouragement and reward. The participants in this study claimed that individuals will give of their best, if they know that promotion or reward will follow. It has also been noted that individuals are often discouraged from giving good service and being enthusiastic about scholarship activity when they are doubtful whether it will benefit their careers (Gosling, 2004; Crites et al., 2014).

#### 5.4.3.2.2 *Need for guidelines*

The participants viewed guidelines as equally important in the development of scholarship. They said that without proper guidelines CS will not or may not go anywhere. Support for scholarship should come from both arenas: the academic and the clinical. University and clinical area should have policies or guidelines that support clinical scholarship if they want students to be actively involved in scholarship. The participants argued that the hospital should change their policy in order to facilitate the progress of scholarship. For example, hospitals should support the idea of clinical scholarship.

In support of this, a qualitative descriptive study by Botma, Hurter and Kotze (2013) investigating nursing student's perceptions on how immersive simulation promotes theory and practice integration argued that formal supporting structures should be put in place for monitoring the activities of scholarship. The structure should be incorporated in policies and guidelines that individuals can understand. Without proper policies or guidelines, individuals often forget about their role and responsibilities. Similarly, Kristofferzon et al. (2012) state that a supported structure/policy helps students' learning development, serving as a guide on what to expect from a specific institution. It is further suggested by Gidman, McIntosh, Melling et al. (2011) that individuals need to sit down together and plan the objectives and outcomes that students are supposed to achieve.

An important element of scholarship is research, and nurses need to know and understand the importance of the linkage between research and scholarship. For this reason, Lode, Sørensen, Salmela et al. (2015) stress the importance of having guidelines, policies, standards and norms in place that could guide practice and strengthen the nursing profession, as well as providing solutions to nursing practice derived from evidence. Similarly, Jamerson and Vermeersch (2012) make the point that the potential outcome for implementation of knowledge would depend on available policies, guidelines or standards being in place. When these principles are in place and documented, it leads nurses to adhere to the documentation (Adamsen, Larsen, Bjerregaard et al., 2003; Lode et al., 2015).

#### 5.4.3.3 Culture of scholarship

This third category is further divided into two sub-categories; university and institutions working together, and doctors and nurses work together.

##### *5.4.3.3.1 University and institution should work together*

Participants said that universities and the clinical arena should work together. There should be mutual understanding and similar vision on what is best for the profession and the patients. The participants said that they should be involved in planning, developing and supporting, and should get to know what is happening in the clinical arena. They believed this could help to create an environment that embraces CS. In line with this study, Gray and Pratt (1995) and O'Neil Mundinger et al. (2009) postulate that if nursing wants to defend the profession and make it recognised, then it is widely recommended that nursing should embrace a culture of scholarship. In this way, new generations of nurses can be moulded and prepared to replace those scholars already performing in this position. Coupled with this, O'Neil Mundinger et al. (2009) and Mohide et al., 2005 agree that unity between academic and clinical arena promotes CS, thus building a culture of scholarship. This will shape the clinical area of practice and encourage nurses to challenge their practice and make the necessary changes if and when require (Mannix et al., 2013).

Additionally, the input of different perspectives and values will create broader vision and goals for the achievement of clinical scholarship. According to Heinemann and Zeiss (2002), shared goals and vision and good leadership helps individuals to be more productive and innovative. Likewise,

Kitson (2006) notes that academic institutions have the power to shape clinical nurses with the knowledge and skills for problem solving and decision making and for generating evidence-based practice. These components are important for a scholarship culture in safeguarding patient care and defending the profession (Kitson, 2006).

The International Council for Nurses (2015) argues that it is important for the academic institution to provide learning opportunities to enhance practice. On this point, participants said that theory is vitally important in nursing, and that clinical practice plays an important role in developing the students to become competent nurses. In the clinical arena, the students are exposed to developing their skills in practice, which cannot be done in the classroom. Students' success will depend on the academic institution and the clinical arena regardless of their differences and students should not be victims of their differences (Levett-Jones & Lathlean, 2008). Indeed, according to the participants, the university needs the clinical area to facilitate learning for the students and likewise the clinical area needs the university or college to provide the theory part to the students. In so doing, the scholarly activity for the student will be able to meet the academic standard and the standard of practice in the clinical area (Henderson, 2010).

Broadly, the participants in this study agreed that when clinical institutions allow them to practice the competency skills and objectives they have been taught and value, this creates opportunities for their professional development and motivates them to learn and be focused. This is in line with the point made by Levette-Jones (2008) on the relationship between belongingness and placement experience of nursing students from Australia and the United Kingdom. Conversely, when students feel unwelcome, have poor understanding, are unsupported and don't get cooperation, this may impede learning (Duddle & Boughton, 2007) which may result in lack of confidence in their nursing development (Levette-Jones, 2009).

#### 5.4.3.3.2 *Doctors and nurses working together*

It emerged that doctors and nurses should have a mutual understanding and work together as one. The participants felt that understanding each other was if there was to be further development of scholarship in nursing practice. According to Turale et al. (2010), opportunities, skills and knowledge can be enhanced when the multidisciplinary teams of scholars and clinical nurses work

hand in hand. This is supported by participants in this study who appealed for doctors and nurses to narrow the gap between them. Participants said there was an obvious divide between doctors and nurses, echoing findings by Weller (2011) on the nature of interprofessional collaboration among doctors and nurses in New Zealand.

When clinical nurses are equipped with evidence from research they are better positioned to question practice and doctors in regard to patients management, and ultimately to make critical clinical decision (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). However, in a study conducted in Sweden to understand attitude to teamwork by general practitioners, Hansson, (2008) discovered that doctors most often are unwilling to cooperate as a team. This is because often doctors' attitude is that they take the lead and are more task-oriented. Additionally, Hansson, Arvemo, Marklund et al. (2010) noted that doctors often did not show appreciation for contributions by nurses, which is in the interest of developing the profession. This often happens, as nurses and doctors have different levels of education and skills (El Sayed & Sleem, 2011).

Hansson et al. (2010) postulate that in general, the more highly educated people are the less likely it is that they will be cooperative with others who have a lower education level, and doctors have been identified among the group having such behaviour. However, contrastingly, it has been pointed out that some nurses are highly trained and know quite as much as the doctor (Qolohle, Conradie, Ogunbanjo et al., 2006). When both professionals in the team mutually share knowledge this further helps to improve clinical practice. This study also revealed that without the support from doctors, nurses' work is less likely to be highlighted, will remain under cover and will not be respected among the multidisciplinary team. Importantly, no single disciplinary can develop the profession alone (Carryer, 2011). In support of the participants' views, a study by McInnes (2015) in Australia identifying facilitators and barrier influencing collaboration and teamwork between doctors and nurses confirmed that it is important for doctors and nurses to work together in other for students to achieve their learning objective.

#### 5.4.3.4 Responsive teaching

This fourth category is divided into three sub-categories: integration of evidence in practice, continuous professional development, and incorporating CS in curriculum.

##### *5.4.3.4.1 Integration of theory in practice*

Participants made the point that the qualities of a clinical scholar need to be reflected in their daily practice. Nursing education has a role to play in helping nursing students to achieve their professional goal. Participants said that practice, theory and research should be integrated in day-to-day practice in the clinical arena.

This corroborates the finding by Karabulut et al. (2015) that in the nursing process, observation, case presentation and group teaching in clinical arena are first priorities in teaching clinical students, as they help the student integrate practice with theory. Integrating practice, theory and research develops nursing knowledge, creating expert and effective nursing practice (Chinn & Kramer, 2011). Further, the knowledge produced provides nursing with an identity. This knowledge can be transferred across health care disciplines, increasing the credibility of nurses as clinical scholars (Copnell, 2008; Jackson, Clements, Averill et al., 2009). In addition, when practice is integrated with research and theory, this leads to better nursing care, safer care, and ultimately to improved cost effectiveness (El-Badawy & Kassam, 2008; Melnyk, 2012). Other studies note that when nurses integrate theory and research with practice they are demonstrating EBP in their day-to-day practice, which ultimately helps to improve patient care (Sackett et al., 1996; Bussièrès et al., 2016) and also contributes to development of CS.

##### *5.4.3.4.2 Continuous professional development*

Participants regarded it as important to continuously develop as a clinical scholar. They suggested that a small workshop could be organised to help them achieve this. They believed that information from workshops updated them with the latest necessary information. With continuous education, nurses will be able to gain new knowledge thus using the best available evidence in practice, and it may also contribute to the development of healthcare practice (Dee & Reynolds, 2013).

Participants argued that people from the university should come and explain what scholarship is all about, so that clinical nurses and other professionals can have a better idea of what clinical scholarship is. In this regard it can be said that “educational activities intended to build upon the educational and experiential bases of the professional nurse for the enhancement of practice, education, administration, research or theory to the end of improving the health” (Ferguson, 1994 p:641). Murphy (2006), in an Irish study reviewing the importance of CPD among nurses to discover the factors that motivate and prevent their participation in CPD, concluded that CPD is a core element for nursing growth, as nursing care and unsafe practice is of concern and nurses need to be competent and up to date with their practice. This will not only improve nurses’ knowledge, skills and performance but will also strengthen their professional values and reinforce their committed to the profession. Nalle (2010) notes that nurses will be increasingly challenged to improve nursing practice, and CPD will become increasingly important in helping nurses to keep up to date with nursing developments.

Andrew (2005) noted, on the other hand, that in an organisation where CPD was not encouraging, this had an impact on nurses such as causing them to leave their profession. Additionally, it was noted that nursing became stagnant and monotonous when there was no further continuous education (Pool, 2012). In this regard, previous studies support the participants’ concern that it is important for organisations to recognise, encourage and mandate both younger and older nurses to continuously participate in CPD and acknowledge the benefit it bring to the nurses’ practice. Continuous professional development strengthens the nursing profession, and nurses should embrace the idea throughout their career (Dee et al 2013, Pool, 2012); generating knowledge does not stop at graduation.

#### *5.4.3.4.3 Incorporating CS in the curriculum*

In the present study both groups of participants felt there was a need to align the curriculum with CS activity or development. According to the participants, CS should be part of the curriculum taught at the academic institution. Thus learners would come to appreciate it, engage with it and ultimately CS would be promoted. Burke et al. (2005) suggest that literature search should start in the first year of training so that students can develop their searching skills, enabling them to use relevant research. Thereafter, the students should be able to demonstrate that they can identify

health-related issues in the clinical area. Having completed these phases, including an understanding of statistical analysis, the students should be in a better position to analyse research finding and ultimately apply research in practice. Furthermore, the American Association of Colleges of Nursing (2004) has stated that baccalaureate programmes for graduates can help in shaping the graduates with a fundamental understanding of research, such as how to apply evidence base in area of practice.

It is believed that incorporating CS in the curriculum may contribute to further research and could create and foster a culture of CS that promotes the development of clinical doctoral programmes for the profession. Nursing needs to develop programmes that produce highly knowledgeable nurses able to provide high-quality care that improves patient outcomes (O'Neil Munding, 2009). Supporting the study participants, Tymkow (2010) emphasises that research is the core element in CS and that nurses need to be prepared with research skills in order to generate new knowledge. Similarly, the AACN (2006) notes that having such a curriculum in place may help in teaching the nurse about research, thus translating new knowledge into practice.

#### 5.4.3.5 Attributes in teaching clinical scholarship

This final category in enablers for CS is further divided into three sub-categories: knowledgeable in specialty, critical thinkers, and positive role model.

##### *5.4.3.5.1 Knowledgeable in specialty*

Participants stated that knowledge in one's speciality is crucial in facilitating others, but it needs to be relevant knowledge pertaining to what needs to be taught. The knowledge shared should not only discuss what CS is but must empower individuals to actively engage in scholarly activity. Participants agreed that a good clinical expert, was one with updated knowledge and skill. Nelson (2011) encourages clinical experts to be experienced and knowledgeable in clinical arena of practice and specialisation, so that they have the necessary confidence and ability to teach learners effectively.

The participants in this study agreed with literature that in order to be a good scholar and be knowledgeable and enthusiastic in teaching, one must be involved in the clinical arena in which

one's skills can be updated with recent developments and research (Henderson, Alexander, Haywood et al., 2010) in line with the principles of CS. There is also agreement that if clinical experts are not knowledgeable in an area of interest it will be a barrier to delivering the knowledge needed by students (Henderson, 2010), such as teaching students about research and publication and nursing scholarship (Löfmark, Thorkildsen, Råholm et al., 2011). Additionally, according to Löfmark et al., (2011) this may lead to misguidance of students' learning in the clinical area and slow the process of nursing development and scholarship.

CEs must promote creativity and foster critical thinking in the students (Sigma Theta Tau International Clinical Scholarship Task Force, 1999). However, Grigsby and Thorndyke (2011) argue that knowledgeability and excellence in teaching does not stop at delivering good lectures or instruction to students. It extends to incorporation of inquiry and reflection about teaching and learning. In this study the participants felt that they need clinical experts who are knowledgeable in CS and able to drive them to acquire the skills and knowledge needed to further develop their scholarship and become scholars themselves.

#### 5.4.3.5.2 *Critical thinkers*

Participants felt that clinical experts must also have critical thinking skills to teach or share with others. According to the ISNA Bulletin (2014), critical thinking makes nurses self-confident in their practice as they develop their knowledge and practical skills. Furthermore, Suliman (2006) states that critical thinking, together with problem based learning style, is a priority for and inculcating in students the aptitude for CS (Dickerson, 2005).

According to Wangensteen et al. (2011), critical thinkers are open to challenges and new ideas, grounded with knowledge, have an inquiring mind and are willing to face situations. Nurses with these attribute are more likely to handle situations with quality reasoning and remain focused on what happening in practice (Profetto-McGrath, Hesketh, Lang et al., 2003). Additionally, critical thinker are more likely to reconsider decisions, search for essential information and retrieve accurate information pertaining to enquiry (Wangensteen et al, 2011).

#### 5.4.3.5.3 *Positive role model*

Participants felt that a clinical expert should show patience and caring when facilitating student nurses. The participants further added that the clinical expert needs to know how to motivate students, as students often tend to be neglectful in their learning. In particular, they asserted that because students all behave differently the clinical expert needs to be patient and serve as a role model for students in the clinical arena. Nelson, (2011) and Levy, Sexton, Willeford et al. (2009) concur that clinical experts need to be good role models – that they need to be enthusiastic, well organised, competent and have good instructional communication skills for proper engagement with learners in the clinical arena.

Participants in this study said that clinical experts who provide a role model for students help them to gain competence and confidence in their practice, thus creating a welcoming environment shared with the learner. The clinical expert must be willing to help, approachable, caring and friendly. When clinical experts are committed to their job, students find it easier to interact with them (Croxon & Maginnis, 2009); students feel more secure, confident and competent when the clinical expert makes them feel that they belong. Ennis, Happell and Reid-Searl (2015) state that clinical experts who are patient and caring are seen as effective and enthusiastic in identifying and creating learning opportunities for the learners. However, in circumstances where the clinical expert is not patient and caring students feel rejected or worthless, which may further discourage them from getting involve in scholarship activity such as research (Kilcullen, 2007).

For scholarship to flourish, participants said that role models are needed with good personalities who can continuously influence others to maintain nursing standards despite the challenges encountered. Such challenges may lead to loss of interest in nursing care, negative attitudes, and failing to maintain aseptic technique (Oosthuizen, 2012). For this reason, the CSNS participants felt the need for someone who can inspire them develop positive attitudes in their learning for a lifelong profession. When clinical experts are enthusiastic about changes and innovations and provide a positive role model for the clinical nurse, this become motivates students and has a positive influence on their learning (Shakespeare & Webb, 2008; Ó Lúanaigh, 2015).

## **5.5 Chapter summary**

This chapter discussed significant findings from both the quantitative and qualitative investigation, in line with current literature and the purpose of the study.

The chapter that follows focuses on developing recommendations to promote CS in the clinical arenas.

## CHAPTER SIX

### DEVELOPMENT OF RECOMMENDATIONS

#### 6.1 Introduction

This chapter details *Phase Three* of the study which was the development of recommendations to promote clinical scholarship in the clinical arena.

#### 6.2 Process of developing recommendations

It was noted that recommendations have become an important tool for influencing practice. Many institutions have tried to identify relevant areas that need to be improved and to formulate recommendations for clinicians or individuals to use and apply (Brown, Brunnhuber, Chalkidou et al., 2006; Jaeschke, Guyatt, Dellinger et al., 2008). The researcher reviewed both quantitative and qualitative findings to develop recommendations. From the interpretation in *Phase One*, the researcher identified the most common barriers and solutions for CS in the clinical arena as summarised by the CSNSs. In *Phase Two* the responses from the CSNSs and CEs regarding categories and sub-categories were considered. Recommendations were aligned with Boyer's Framework of Scholarship: scholarship discovery, scholarship integration, scholarship application and scholarship of teaching. There is also supporting literature from a number of authors (Coulton, 2011; Grigsby & Thorndyke, 2011; O'Connor & Peters, 2014; Roets et al., 2016; Carter et al., 2017).

Furthermore, if recommendations are to be developed there should be no harm to clinical staff nor jeopardy to health care practice that could ultimately cause harm to patients (World Health Organization, 2014b). For these reasons, the researcher organised two workshops to discuss, interrogate, critique and finalise the recommendations made by the participants. To remain true to the paradigm of pragmatism and methodology of mixed methods, multiple views of participants were elicited. This was aimed at bringing their opinions and understanding to bear on development of recommendations suitable to promoting CS in the clinical arena, hence influencing and developing practice (Fretheim, Schünemann & Oxman, 2006).

In order to develop the recommendations, the study was conducted in three phases, as previously mentioned. In *Phase One*, a set of data was collected from the CSNSs using a questionnaire. In *Phase Two*, qualitative data was collected from the CSNSs and clinical experts using semi-structured interviews. In *Phase Three*, the researcher *mixed* the two sets of data to formulate the tentative recommendations for promoting CS in the clinical arena.

Arrangements were made for a workshop to meet with the clinical experts and CSNSs for interrogating and refining the recommendations compiled by the researcher. All participants involved in Phase Three were contacted via email. A total of eight participants (four CSNSs and four clinical experts) responded positively to attending the workshop.

The supervisors were informed and assisted the researcher in securing a suitable venue for the workshop on campus at the university. Once the date, time and venue were confirmed, the researcher were able to meet with the participants. The participants were reminded of the purpose of the workshop and the researcher explained to them that this was the final phase of the study, mentioned during the process of data collection. An explanation was provided on how the initial recommendations had been compiled by the researcher and the participants were given assurance that all contributions to refinement of the recommendations would be treated with confidentiality. Reassurance were given that no names would be revealed to anyone and all participants would remain anonymous. They were reminded that this workshop was a discussion and that all participants' opinions should be respected, since they were there to adjust and refine the recommendations made by the participants. Importantly, before the discussion started, the researcher ensured that the purpose of the study was made clear and understood. Thereafter, the participants were allowed to sign to acknowledge their informed consent.

The presentation was done on PowerPoint and a hard copy was given to participants so that they could review what was being presented and so that any suggestions or comments could be made directly on the copy, which was later given back to the researcher. This was followed by open discussion to finalise details.

### 6.3 CONCLUDING THE WORKSHOP

The workshop was concluded with thanking the participants for their participations in the study.

The researcher reassured the participants that feedback would be given (Annexure 13).

Table 6.1 shows the suggestions made as rough notes by the participants during the workshop.

**Table 6.1: Development of recommendation aligned to Boyer’s framework**

Tentative recommendation by CSNS, CEs and support from literature	Changes
<b>Scholarship of Discovery</b>	<p><b>Scholarship of Discovery</b></p> <ul style="list-style-type: none"> <li>• Staff (nurses) from clinical area should be encouraged to utilise the facilities at their exposures. For example, information in the library related to health development and nursing practice. Placement of the library could be more appropriate if it is place at the hospital rather at the college.</li> <li>• Allocate someone who is good at research to do searches for current evidence and that way could help sharing the information.</li> <li>• Encouragement for a journal club</li> </ul>
<b>Scholarship of teaching</b>	<p><b>Scholarship of Teaching (systematic study of teaching)</b></p> <ul style="list-style-type: none"> <li>• Teaching the clinical skills, research skills, to avoid replicate of clinical studies thereby innovate practice. Involves people to actively engage into research so they can also be the ownership of the research</li> </ul>
<b>Scholarship of Application</b>	<p><b>Scholarship of Application</b></p> <ul style="list-style-type: none"> <li>• To organise workshops that to engage nurses in CS activities such as dissemination of research findings, publication and application of technical skills. (As per example, scholarship day)</li> <li>• If possible to allocate someone specific to do searches for current evidence, at least two hours per, then share the information towards application.</li> </ul>
<b>Scholarship of Integration</b>	<p><b>Scholarship of Integration</b></p> <ul style="list-style-type: none"> <li>• Collaborative work – work with clinical staff on research activities to enhance ownership of the scholarship. For example, involve clinical staff as protectors; protect the participants under any circumstance of abusiveness, subject; help filling the questionnaire, field worker; helping with administrating the drugs if there is a</li> </ul>

	<p>control, implementer; present the findings, investigator; do the investigations.</p> <ul style="list-style-type: none"> <li>• Encourage teaching rounds in the clinical arena. For instance, nursing students and clinical expert can carry out field based patients management where they can ask questions on drugs, therapy infusion, why the management is like this? Why are the patients on such medications?, Is there any alternative in regard to this management?.</li> </ul>
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#### 6.4 Recommendation to promote CS in the clinical arena

The final recommendations to promote CS in the clinical arena is as follows:

##### **Scholarship of Discovery (original research that advances knowledge)**

Reward for scholarship (forms of encouragement):

- Clinical facilitators need to be acknowledged and rewarded for their contributions to clinical scholarship. The reward can be in the form of paying for conferences, seminars or continuous professional development. In this way, they will be more enthusiastic towards CS and bring current knowledge to the clinical area.
- Management should support innovation in the clinical arena, encouraging individuals to participate in research and present their work at conferences, forums, workshops or seminar.
- Sufficient funding for interested staff to conduct research projects or small project should be made available by management of the institutions.
- Results of clinical studies must be disseminated in the clinical arena. In this way, the management will know what the findings are and the recommendations of the research, so that these findings can be translated into practice. Giving feedback is crucial for further development and promotion of CS, as feedback is needed for changes.
- Hospital management can promote scholarship by investing in CS facilities. For example, access to knowledge/information could be made available within the hospital in the form of a library (to be equipped with up-to-date journals, computers and other necessary material) enabling retrieval of evidence for practice (through subscription to journal databases). If at all possible, there should be a librarian to assist staff who are not well versed in searching for information.

- Staff (nurses) from clinical area should be encouraged to utilise the facilities at their disposal, such as information in the library related to health development and nursing practice. Location of the library would be more appropriate if it is positioned in the hospital rather than at the college.
- Employ a research assistant (librarian) to do searches for current evidence and in this way help to share the information.

### **Scholarship of teaching (systematic study of teaching)**

Need for research-grounded clinical experts who will

- Be clinical facilitators who serve as good role models, in that they are well grounded in clinical speciality skills and knowledge as well as research skills which will foster clinical thinking and innovation in clinical staff.
- Foster debate on current practice using journal articles and best practice guidelines. Debates must address the contextual appropriateness of clinical guidelines as well as discussing how to refine them.
- Invest clinical time with students so as to create and foster a culture of clinical scholarship. When supervising the student in the clinical arena, supervision should not be only on teaching about procedures and conditions of the patients; there should also be emphasis on problem identification and acquiring evidence-based solutions to problems.
- Teach clinical skills and research skills to avoid replication of clinical studies, thereby innovating practice. Involves people actively engaging in research so they can also have ownership of the research.

### **Scholarship of application (disciplinary expertise)**

Issues in promoting application of scholarship:

- Requires leaders in the clinical arena who can be creative, innovative and visionary. Individuals who can reflect on clinical practice and identify and put together ideas on the best way to improve clinical practice. Need to identify and showcase such people so other nurses are aware of them.

- Staff in the clinical arena should be educated on the research process. They need to know how to conduct research and the importance of research in nursing practice. This could be done through workshops facilitated by academic staff in clinical specialities, along with monthly journal clubs for the different clinical specialities in the hospital.
- Management must invest in registering nurses in continuing clinical speciality programmes. Bursaries can be awarded to staff who excel academically and then utilise their research in practice.
- Organize workshops that engage nurses in CS activities such as the dissemination of research findings, publication, and application of technical skills (for example, a scholarship day).
- If possible, allocate someone specific to do searches (at least two hours) for current evidence, then share the information for possible application.

**Scholarship of Integration (synthesis of information across disciplines, across topics within a discipline or across time)**

Issues in supporting a culture of clinical scholarship:

- Collaborative sharing of expert knowledge between academic and the clinical arena rather than each shareholder working in silos. Possibilities include workshops, research newsletters, or a journal club. The Department of Health should also be involved and contribute towards the development and promotion of CS, thereby helping to sustain and improve nursing practice.
- Nurse managers should engage with students and consider how the clinical area can improve practice. For example, discuss with students what they would like to contribute in the development of clinical areas, as they are the new generation of nursing.
- When supervising the student (research supervision), choose problems that are within the institutional context, focusing on something that has happened locally and involves the unit manager in participating in the small project.
- Collaborative work with clinical staff on research activities to enhance ownership of the scholarship. For example, involve clinical staff as protectors shielding participants from possibilities of abuse, as subjects filling in questionnaires, as fieldworkers helping

with administration of drugs if there is a control, as implementers presenting the findings, or as investigators doing the investigations.

- Encourage teaching rounds, as opposed to doctor's rounds. This entails a discussion and critique of the patient's management (drugs, therapy infusion, etc.) Why is the management taking this form? Why is the patient taking this medication? Is there any alternative to this management? This will require academic/clinical collaboration.

## **6.5 Chapter summary**

This chapter has explained how the researcher developed the recommendations to promote clinical scholarship in the clinical arena, and presented the final recommendations. The next chapter will discuss limitations, give recommendations for further research and offer a conclusion to the study.

## CHAPTER SEVEN

### LIMITATIONS, RECOMMENDATIONS AND CONCLUSION TO THE STUDY

#### 7.1 Introduction

This chapter provides a summary of results, indicates limitations of the study, presents recommendations as identified by the researcher for further research and concludes the study. Also included are the researcher's reflections on the process of the research.

#### 7.2 Quantitative summary *Phase One*:

In this phase, the researcher identified barriers and solutions for CS among the CSNSs at a university in KwaZulu-Natal. A questionnaire was used to gather information from the participants. Regarding the barriers and solutions to CS in the clinical arena, the questionnaire was adopted from (Smesny et al., 2007). A total of 81 CSNSs participated in this phase. The participants were either pursuing a Bachelor Degree in nursing (Advanced Practice) or a Master's degree in a clinical speciality at the university.

#### 7.3 Qualitative Summary *Phase Two*

An interview guide was used to guide the researcher in data collection. The participants involved were eight CSNSs, doing a Bachelor's degree in Nursing (Advanced Practice) or a Master's degree in a clinical speciality, and four clinical experts working at a university in KwaZulu-Natal. The number of participants in this phase was determined by data saturation. Responses expressed by the participants were condensed into nine categories; academic excellence, importance of research to practice, scholarship overlooked, poor communication, resource, encouragement of scholarship activity, culture of scholarship, responsive teaching and attribute in teaching clinical scholarship.

#### 7.4 Summary Phase Three

The aim of the study was to develop recommendations for promoting CS in the clinical arena. To achieve this, the researcher compiled recommendations from the data from *Phase One* and *Phase Two*. In *Phase Three*, the researcher received participation from four CSNSs and four CSs who had been contacted via email by the researcher. Thereafter, a workshop was organised to present

tentative recommendations with discussion, critique and suggestions being invited to refine the final recommendations.

## **7.5 Recommendations**

In line with the findings of the study, the following recommendations are made for nursing research, nursing education and nursing practice.

### **7.5.1 Areas for further research**

- A quantitative study with a larger sample size could be carried out to enable generalisation of the findings.
- Further research can be done to identify ways in which nurses can translate the nursing knowledge to other colleagues and disciplines.
- The researcher proposes further development to the quantitative tool used in order to address its current limitations.

### **7.5.2 Nursing education**

- The nursing curriculum should include CS activities pertaining to specific issues so that nursing students become more aware of CS, thus creating a culture of scholarship (e.g. in relation to problem-based and case-based learning).
- There should be more emphasis on the integration of research with practice and research utilisation in the clinical arena. Nurses should be able to identify researchable problems and solutions in the clinical arena.
- Provision should be made by clinical educators to facilitate learning experiences that involve all of the CS activities (eg: research, publication).

### **7.5.3 Nursing practice**

- The clinical arena should encourage and create a conducive environment for CS development through policies and visions that incorporate the philosophy of CS.
- The clinical arena should welcome innovation through recognition by rewarding the professionals, in order to develop the nursing profession further.

- Clinical staff should be assisted in choosing a career path to further pursue their professional development in order to keep up with up-to-date and best research available.

## **7.6 Limitations to the study**

One of the major limitations identified by the researcher was that the sample size of the participants in the quantitative arm of the study was small, which means that the findings could not be generalised. However, the researcher tried to overcome the small sample size challenge by using a mixed methods approach to explore the phenomenon of clinical scholarship. The researcher envisaged that the qualitative aspect of the study would provide a more in-depth understanding of the phenomenon under study.

The second limitation identified was that the study included one setting, that of the university, in eThekweni district. Clinical scholarship promotion might face different challenges in other areas of KwaZulu-Natal, especially in regard to resource constraints.

## **7.7 Reflections of the researcher**

These reflections share my experiences in undertaking this study of Master's by full research at the university, on exploring and describing clinical scholarship in order to develop recommendations to promote clinical scholarship in clinical arenas. My enthusiasm for being enrolled in this course was not only to generate new knowledge but to share in the development of nursing practice and improve patient care, and most of all, to be a good and positive role model to others. This study, and my supervisors, have become instrumental in inspiring my endeavours in the profession in a number of ways:

- I developed an appreciation for qualitative research and the value such data can have in researching and investigating a particular area or topic.
- Conducting a mixed method study served to illustrate the value in researching a topic from different angles and show how they together contribute to providing a rich and comprehensive view.
- I have been on my own journey of scholarship, starting as a nurse researcher and following through with this research journey has been quite difficult because of **insufficient** research

experience, transcribing sets of raw data and analysing data which has been a very tedious process.

## **7.8 Conclusion**

As with many other professions, the nursing profession is continually undergoing changes and development. Nurses are the most dominant cadres in the system. They are also key players in the patient's care. Their decisions need to be precise and based on the best available evidence pertaining to patient care. For this to happen, nurses need to embrace a culture of clinical scholarship which can help them to enhance knowledge on how best to manage patients.

In this study, CSNSs showed great interest in incorporating clinical scholarship in their daily practice. The study has shown the importance of developing clinical scholarship for the future nursing profession. The study also revealed perceived barriers and enablers to clinical scholarship. Most of all, CS was viewed as an integral part of development in nursing knowledge.

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## **Annexures**

### **Annexure 1: Interview guide: Clinical specialist nursing students**

#### **Welcome**

Do you think that clinical scholarship is necessary?

Probe: Why do you say that?

How do you think clinical scholarship could be promoted in the clinical arena?

Probe: Why do you say that?

#### ***Scholarship of Discovery***

How can a clinical nursing student generate new knowledge to guide practice?

Probe: What types of knowledge should be generated and how?

Probe: How can the students generate new knowledge?

Do you think that research plays an important role in clinical scholarship?

#### ***Scholarship of Integration***

How can the knowledge/research be translated into clinical scholarship?

How does a clinical nursing student demonstrate the integration of evidence into their practice?

Probe: What are some of the methods that can be used to achieve this link?

How can clinical scholarship promote EBP within nursing and across disciplines?

#### ***Scholarship of Teaching***

What does scholarship of teaching mean to you?

What do you think are the required attributes of an expert (lecturer) to teach clinical scholarship?

Probe: How can the expert (lecturer) do this?

How can clinical scholarship promote dissemination of nursing knowledge?

Probe: What strategies can be used to do this?

#### ***Scholarship of Application***

How does a clinical nursing student apply theory in practice?

What do we need to change in nursing education and in nursing administration to promote clinical scholarship?

Probe: How can nursing educators, administrators and clinicians work together to promote clinical scholarship?

Is there any additional information that would you like to tell me?

**Thanks for your participation**

## **Annexure 2: Interview guide: Clinical Expert**

### **Welcome**

What do you understand by the term clinical scholarship?

Do you think that clinical scholarship is necessary?

Probe: Why do you say that?

Do you think there are any barriers to clinical scholarship?

Probe: Can you explain these for me please?

Do you think there are any enablers (things that help or promote) to clinical scholarship?

Probe: Can you explain these for me please?

### ***Scholarship of Discovery***

How can clinical nursing student generate new knowledge to guide practice?

Probe: What types of knowledge should be generated and how

Probe: How do clinical nursing students participate in the generation of new knowledge?

Do you think that research plays an important role in clinical scholarship?

### ***Scholarship of Integration***

How can the knowledge/research be translated into clinical scholarship?

How does a clinical nursing student demonstrate the integration of evidence into their practice?

How does clinical scholarship achieve a link between academic research and practice?

Probe: What are some of the methods that can be used to achieve this link?

How can clinical scholarship promote EBP within nursing and across disciplines?

### ***Scholarship of Teaching***

What does scholarship of teaching mean to you?

What do you think are the attributes of an expert (lecturer) to teach clinical scholarship?

Probe: How can the expert (lecturer) do this?

How do you think experts can help the student understand and put into practice what s/he has been taught?

How can clinical scholarship promote dissemination of nursing knowledge?

Probe: What strategies can be used to do this?

***Scholarship of Application***

How does a clinical nursing student apply theory in practice?

What do we need to change in nursing education and in nursing administration to promote clinical scholarship?

Probe: How can nursing educators, administrators and clinicians work together to promote clinical scholarship?

Is there any additional information that would you like to tell me?

**Thanks for your participation**

### **Annexure 3: Information Sheet and Consent to Participate in Research (quantitative)**

Dear Students of Bachelor in Nursing Advanced Practice and Degree in Masters in a clinical speciality

My name is Mr. Jean-Paul Almaze from the Nursing Department, University of KwaZulu-Natal. My contact number is 0723541241 and email address [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com)

You are being invited to consider participating in this research: **Promoting Clinical Scholarship in the clinical arena**. The study is expected to involve all the Bachelor in Nursing Advanced Practice and Degree in Masters in a clinical specialty programmes at the university. You are requested to take part in this study by accepting and signing the informed consent form after you have finished reading the information related to the study. Questionnaires will be given to you upon your voluntary agreement to participate in this study. Completing this form will take approximately 30-45 minutes of your time and additional time will be given if needed.

Please be aware that participation is voluntary, you are not compelled to participate in this research and you may discontinue your participation at any time you may so wish. However, in the event of handing in the complete questionnaire, you will not be able to withdraw it. The study data will be coded and your responses will be anonymous. Anonymity will be maintained by not writing your name anywhere on any form of documentation and by using a coding system on the documentation in such a way that participants' responses cannot be linked or connected to any name. Data will be kept safe under lock and key in a safe place for 5 years which will be shredded, burn and permanently deleted from the computer after that.

There are no foreseen possible risks associated with participation in this study and there is no direct benefit linked to the participation in this study. If you experience any discomfort during the process of the interview you may discontinue. In the event of refusal/withdrawal of participation will not incur penalty or loss of benefits to which you entitled.

Potential benefits associated with the study include better understanding of how clinical scholarship may improve clinical practice to better patient outcomes and your contribution may assist in developing the nursing practice in this area.

This is a minimal risk study involving no vulnerable groups, restricted to health care professionals (Clinical Nurse). The materials collected will not be personal or sensitive in nature. This study will provide a better understanding of the perceptions of BNAP's students towards clinical scholarship.

In the event of any problems or concerns/questions you may contact the researcher from the above mentioned contact details or the university Humanities & Social Sciences Research Ethics Administration or the study supervisor, contacts details as follows;

This study has been ethically reviewed and approved by the university Humanities & Social Sciences Research Ethics Committee (HSSREC) (approval number **HSS/1550/016M**).

#### HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, XXXX Campus

XXXX Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

**Supervisor**

Ms. Waheedha Emmamally  
Co-ordinator Bridging Programme  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031)2601437  
Fax: 0864000382  
Email: emmamally@ukzn.ac.za

**Co-Supervisor**

Professor. Petra Brysiewicz  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031)2601281  
Email: brysiewicz@ukzn.ac.za

## CONSENT

I ..... have been informed about the study entitled **Promoting Clinical Scholarship in the clinical arena** by Mr. Jean-Paul Almaze in nursing.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0723541241 or [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

---

**Signature of Participant**

---

**Date**

#### **Annexure 4: Information Sheet and Consent to Participate in Research (qualitative)**

Dear Students of Bachelor in Nursing Advanced Practice, Degree in Masters in a clinical speciality or clinical experts

My name is Mr. Jean-Paul Almaze from the Nursing Department, XXXX, University of KwaZulu-Natal. My contact number is 0723541241 and email address [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com)

You are being invited to consider participating in this research: **Promoting Clinical Scholarship in the clinical arena**. The study is expected to involve all the Bachelor in Nursing Advanced Practice and Degree in Masters in a clinical speciality and the clinical expert within the clinical specialty programmes at UKZN. You are requested to take part in this study by accepting and signing the informed consent form after you have finished reading the information related to the study. Please note that the interview will be recorded. The interview might be approximately one hour of your time.

Please be aware that participation is voluntary, you are not compelled to participate in this research and you may discontinue your participation at any time you may so wish. No real name of the participant will be used when conducting the interview. The study data will be coded and your responses will be anonymous. Anonymity will be maintained by not writing your name anywhere on any form of documentation and by using a coding system on the documentation in such a way that participants' responses cannot be linked or connected to any name. Data will be kept safe under lock and key in a safe place for 5 years which will be shredded, burn and permanently deleted from the computer after that. The audio recording will also be deleted from the computer.

There are no foreseen possible risks associated with participation in this study and there is no direct benefit linked to the participation in this study. If you experience any discomfort during the process of the interview you may discontinue. In the event of refusal/withdrawal of participation will not incur penalty or loss of benefits to which you entitled.

Potential benefits associated with the study include better understanding of how clinical scholarship may improve clinical practice to better patient outcomes and your contribution may assist in developing the nursing practice in this area.

This is a minimal risk study involving no vulnerable groups, restricted to health care professionals (Clinical Nurse). The materials collected will not be personal or sensitive in nature. This study will provide a better understanding of the perceptions of BNAP's students towards clinical scholarship.

In the event of any problems or concerns/questions you may contact the researcher from the above-mentioned contact details or the university Humanities & Social Sciences Research Ethics Administration or the study supervisor, contacts details as follows;

This study has been ethically reviewed and approved by the university Humanities & Social Sciences Research Ethics Committee (approval number **HSS/1550/016M**).

**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, XXXX Campus

XXXX Building

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Durban

4000

XXXX, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

**Supervisor**

Ms. Waheedha Emmamally  
Co-ordinator Bridging Programme  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031) 2601437  
Fax:0864000382  
Email:emmamally@ukzn.ac.za

**Co-Supervisor**

Professor. Petra Brysiewicz  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031)2601281  
Email: brysiewicz@ukzn.ac.za

## CONSENT

I ..... have been informed about the study entitled **Promoting Clinical Scholarship in the clinical arena** by Mr. Jean-Paul Almaze in nursing.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0723541241 or [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

I hereby provide consent to audio-record my interview

---

**Signature of Participant**

---

**Date**

### **Annexure 5: Information Sheet and Consent to Participate in Research (Focus groups)**

Dear Students of Bachelor in Nursing Advanced Practice and Degree in Masters in a clinical speciality or clinical expert

My name is Mr.Jean-Paul Almaze from the Nursing Department, XXXX, University of KwaZulu-Natal. My contact number is 0723541241 and email address [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com)

You are being invited to consider participating in this research: **Promoting Clinical Scholarship in the clinical arena**. The study is expected to involve all the Bachelor in Nursing Advanced Practice and Degree in Masters in a clinical speciality and the clinical expert within the clinical specialty programmes at the university. You are requested to take part in this study by accepting and signing the informed consent form after you have finished reading the information related to the study. Please note that the interview will be recorded. The interview might be approximately one hour of your time.

Please be aware that participation is voluntary, you are not compelled to participate in this research and you may discontinue your participation at any time you may so wish. No real name of the participant will be used when conducting the interview. The study data will be coded and your responses will be anonymous. Anonymity will be maintained by not writing your name anywhere on any form of documentation and by using a coding system on the documentation in such a way that participants' responses cannot be linked or connected to any name. Data will be kept safe under lock and key in a safe place for 5 years which will be shredded, burn and permanently deleted from the computer after that. The audio recording will also be deleted from the computer.

There are no foreseen possible risks associated with participation in this study and there is no direct benefit linked to the participation in this study. If you experience any discomfort during the process of the interview you may discontinue. In the event of refusal/withdrawal of participation will not incur penalty or loss of benefits to which you entitled.

Potential benefits associated with the study include better understanding of how clinical scholarship may improve clinical practice to better patient outcomes and your contribution may assist in developing the nursing practice in this area.

This is a minimal risk study involving no vulnerable groups, restricted to health care professionals (Clinical Nurse). The materials collected will not be personal or sensitive in nature. This study will provide a better understanding of the perceptions of BNAP's students towards clinical scholarship.

In the event of any problems or concerns/questions you may contact the researcher from the above-mentioned contact details or the university Humanities & Social Sciences Research Ethics Administration or the study supervisor, contacts details as follows;

This study has been ethically reviewed and approved by the university Humanities & Social Sciences Research Ethics Committee (approval number **HSS/1550/016M**).

**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, XXXX Campus

XXXX Building

Private Bag X 54001

Durban

4000

XXXX, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@the.university.ac.za](mailto:HSSREC@the.university.ac.za)

**Supervisor**

Ms. Waheedha Emmamally  
Co-ordinator Bridging Programme  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031) 2601437  
Fax:0864000382  
Email: emmamally@ukzn.ac.za

**Co-Supervisor**

Professor. Petra Brysiewicz  
School of Nursing and Public Health  
Discipline of Nursing  
University  
4041 Durban, South Africa  
Tel: +27(031)2601281  
Email: brysiewicz@ukzn.ac.za

## CONSENT

I ..... have been informed about the study entitled **Promoting Clinical Scholarship in the clinical arena** by Mr. Jean-Paul Almaze in nursing.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0723541241 or [jpbalmaze@yahoo.com](mailto:jpbalmaze@yahoo.com).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

I hereby give my permission to focus group discussion      YES / NO

---

**Signature of Participant**

---

**Date**

**Annexure 6: Questionnaire Barriers and Solutions to clinical scholarship**

In this study, clinical scholarship means an approach where clinical nurses use their clinical skills to observe and identify health related issues. It involves the application of scientific knowledge to rectify the problems, enhance clinical standards and ultimately improve patients care and outcomes. Based on this definition may you kindly participate in answering the questionnaire. For each item, cross the response that best represents your view.

**Participant Number: .....**

**Section A: Demographic information data**

1. Gender:

Male  Female

2. Age: \_\_\_\_\_ years

3. Undergraduate  Postgraduate

3. Years of Studying: First Year

Second Year

Third Year

Fourth Year

6. Years of experience in nursing \_\_\_\_\_

7. Years of experience in nursing clinical specialty \_\_\_\_\_

8. Area currently working \_\_\_\_\_

## Section B: Barriers to Scholarship

1 = Strongly Disagree

2 = Disagree

3 = Agree

4 = Strongly Agree

6	Clinical services requirements and teaching reduce opportunities for scholarship.	1	2	3	4
7	Promotion and tenure guidelines are not consistent with clinical practice job specification	1	2	3	4
8	Discipline members are unaware of other forms of scholarship as it relates to promotion and tenure.	1	2	3	4
9	Few role models/mentors for scholarship and clinical activities.	1	2	3	4
10	Institutional culture does not foster or promote scholarship.	1	2	3	4
11	Health student debt load or salary is too low leading to a lack of interest in positions requiring scholarly activities.	1	2	3	4
12	Lack of support or funding mechanisms to support scholarship of application or teaching in funding agencies or organisations.	1	2	3	4
13	No mechanisms to reward or recognise scholarship of teaching or scholarship of application locally or nationally	1	2	3	4
14	Time frame for tenure and promotion related to development and demonstration of scholarship of application, teaching, etc may be longer than current time frames.	1	2	3	4
15	Lack of interdisciplinary cooperation between clinicians and academics lack of collegiality	1	2	3	4
16	Clinicians need assistance or mentoring in writing publications or other mentoring activities related to scholarship	1	2	3	4
17	Difficulty in becoming a competent clinician who can keep up with complexity of sciences	1	2	3	4
18	Work of Clinician educator is less amenable to publication or to presenting their scholarship or activities.	1	2	3	4

<b>Solutions to Scholarship Barriers</b>					
19	Re-examine criteria for promotion of clinical faculty and create a structural framework within the School/College as well as the Institution to foster, assess, and reward all types of scholarship.	1	2	3	4
20	Provide more protected time and/or uninterrupted time and resources to perform scholarship of all types	1	2	3	4
21	Encourage interdisciplinary cooperation and create cross disciplinary initiatives to link the physician scientist and/or basic researcher to the clinician.	1	2	3	4
22	Include a similar reward system for all forms of scholarship and educate clinicians and administrators on the different forms of scholarship.	1	2	3	4
23	Develop new faculty positions to foster various types of scholarship and clinical practice (i.e. "clinician-educator researcher").	1	2	3	4
24	Create a clinician-educator researcher by providing training in master's levels or PhD in the area of education and 75% protected time for research endeavours.	1	2	3	4
25	Using Boyer's model of scholarship to work in four areas of scholarship	1	2	3	4
26	Develop criteria for recognising and rewarding faculty scholarship related to service including clinical activities, community service, public health service practice, and professional organisation activities.	1	2	3	4
27	Using senior faculty role models, create a collaborative mentoring programme which may include training on how to approach writing papers	1	2	3	4
28	Create a model of scholarship that requires a high level of discipline-related expertise, breaks new ground or is innovative, can be replicated, documented, peer-reviewed, and has a significant impact.	1	2	3	4
29	Assign more importance to the special contributions of clinician educators and use a variety of methods to assess their abilities (i.e. teaching skills, clinical skills, mentoring, academic administration, developing clinical educational programmes)	1	2	3	4
30	Develop a thematic based faculty development curriculum to catalyse clinician faculty to become involved in scholarly projects that increase enthusiasm for research.	1	2	3	4
31	Develop and implement a two track system (clinical track and research track)	1	2	3	4
32	Regularly review balance of activities in academic posts, particularly between service work, teaching and research.	1	2	3	4
33	Create synergy between research and practice	1	2	3	4
34	Design postgraduate residencies to be geared more towards research rather than education and establish more research training fellowships.	1	2	3	4

Upon completing the questionnaire, if you are willing to participate in the second phase for interview, kindly please provide the following details

Cells No: \_\_\_\_\_ Email: \_\_\_\_\_

**Thank you for the participation and contributions**

**Annexure 7: Letter to the academic leader seeking permission to conduct the study**

JP Almaze  
University of KwaZulu-Natal  
Durban  
South Africa  
9 September 2016

THE ACADEMIC LEADER  
DISCIPLINE OF NURSING  
UNIVERSITY OF KWAZULU-NATAL  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF NURSING AND PUBLIC HEALTH  
HOWARD COLLEGE, DURBAN, 4001

**RE: Permission to undertake a research project at School of Nursing, Howard College,  
University of KwaZulu-Natal**

I Jean-Paul Bryan Almaze currently a Master's by research student at the University of KwaZulu-Natal humbly request your permission to conduct a research project as mentioned from the above as part of the requirements for the ward of the Master Degree. The title of my research project: *Promote clinical scholarship among clinical specialist nursing students at University in South Africa.*

Please find enclosed herewith a copy of the proposal for the project.

Thanking you

Almaze JP (Mr)

**Annexure 8: Letter to the registrar seeking permission to conduct the study**

JP Almaze  
School of Nursing  
University of KwaZulu-Natal  
Durban  
South Africa  
9<sup>th</sup> September 2016

THE REGISTRAR  
UNIVERSITY OF KWAZULU-NATAL  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF NURSING AND PUBLIC HEALTH  
HOWARD COLLEGE, DURBAN, 4001

Dear Madam/Sir

**RE: Permission to undertake a research project at School of Nursing, Howard College,  
University of KwaZulu-Natal**

I Jean- Paul Bryan Almaze (208519646) currently a Master's student at the University of KwaZulu-Natal humbly request your permission to conduct a research project as mentioned from the above as part of the requirements for the ward of the Master Degree. The title of my research project is *Promoting clinical scholarship among clinical specialist nursing students at a University in South Africa.*

Please find enclosed herewith a copy of the proposal for the project.

Thanking you

Almaze JP (Mr.)

## Annexure 9: Approval letter from the academic leader of the university



Date: 13 September 2016

**Re: GATE KEEPER LETTER FOR MASTERS BY RESEARCH FOR MR JEAN-PAUL ALMAZE**

We are pleased to provide this letter of support for the research study for Mr. Jean-Paul Almaze Masters by research student at the University of Kwazulu Natal, School of Nursing and Public Health:

Our understanding is that the research project titled "**Promote clinical scholarship among clinical specialist nursing students at University in South Africa**" will involve interviewing and collection of data from BNAP and Masters Students and also interviewing of lecturers who are teaching clinical modules as well as clinical facilitators

This letter serves as a gatekeeper permission letter to grant provisional support for these planned activities and to support the students' application to the relevant ethics Committee.

Yours sincerely

 DR. J. P. NAIDOO

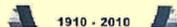
PP Professor GG Mchunu

**Academic Leader: Nursing**

School of Nursing and Public Health

Postal Address: University of Kwazulu-Natal, School of Nursing and Public Health, Howard Campus, Private Bag X 54001, Durban, 4000

Telephone: +27 (0) 31 2602499 Facsimile: +27 (0) 31 2601543 Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



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## Annexure 10: Approval letter from the registra of the university



27 September 2016

Mr Jean-Paul Bryan Almaze (SN 208519646)  
School of Nursing and Public Health  
College of Health Sciences  
Howard College Campus  
UKZN  
Email: [jpalmaze@yahoo.com](mailto:jpalmaze@yahoo.com)

Dear Mr Almaze

### RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

*"Promoting clinical scholarship among clinical specialist nursing students at a University in South Africa".*

It is noted that you will be constituting your sample by handing out questionnaires and/or conducting interviews and/or workshops with students undertaking the Degree in Advanced Nursing Practice (BNAP) as well as with Masters students from the College of Health Sciences on the Howard College Campus.

Please ensure that the following appears on your questionnaire/attached to your notice:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

  
**MR SS MOKOENA**  
**REGISTRAR**

---

#### Office of the Registrar

Postal Address: Private Bag X54001, Durban, South Africa

Telephone: +27 (0) 31 260 8005/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: [registrar@ukzn.ac.za](mailto:registrar@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



## Annexure 11: Approval letter from the Humanities & Social Science Research Ethics Committee of the university



27 September 2016

Mr Jean-Paul Almaze 208519646  
School of Nursing and Public Health  
Howard College Campus

Dear Mr Almaze

Protocol reference number: HSS/1550/016M  
Project Title Promoting clinical scholarship among clinical specialist nursing students at University in South Africa

### Full Approval – Expedited Application

In response to your application received 20 September 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

  
.....  
Dr Shenuka Singh (Chair)  
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Petra Brysiewicz & Ms Waheeda Emmamally  
Cc Academic Leader Research: Professor B Sartorius  
Cc School Administrator: Ms Caroline Dhanraj

---

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4608 Email: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) / [snymann@ukzn.ac.za](mailto:snymann@ukzn.ac.za) / [mohunp@ukzn.ac.za](mailto:mohunp@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

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## Annexure 12: Amended ethical approval from the Humanities & Social Science Research Ethics Committee of the university



22 September 2017

Mr Jean-Paul Almaze 208519646  
School of Nursing and Public Health  
Howard College Campus

Dear Mr Almaze

Protocol reference number: HSS/1550/016M  
New Project Title: "Promoting clinical scholarship in the clinical arena".

### Approval notification – Amendment Application

This letter serves to notify you that your application for an amendment dated 20 September 2017 has now been granted Full Approval as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shenuka Singh (Chair)  
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Petra Brysiewicz & Ms Waheeda Emmamally  
Cc Academic Leader Research: Professor B Sartorius  
Cc School Administrator: Ms Caroline Dhanraj

---

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za) / [snymam@ukzn.ac.za](mailto:snymam@ukzn.ac.za) / [mohunp@ukzn.ac.za](mailto:mohunp@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



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Westville

## **Annexure 13: Developing recommendations**

### **Exploring and describing clinical scholarship in order to develop recommendations to promote clinical scholarship in clinical areas.**

#### **Focus group instructions:**

Welcome by the researcher;

Good day to you all. Once again, a warm welcome to you all for accepting and taking part in the third phases of my research.

#### **Explanation of the purpose of the focus group:**

This phase is the last phase of the study mentioned during the process of collecting the data. I am going to present the data that I collected from participants of the study with regards to how clinical scholarship in nursing be promoted/developed in the clinical arena. Again, these are the recommendations of participants promoting clinical scholarship in the clinical arena.

The purpose of the focus group today is for you to review and critique these recommendations. I will discuss this with a power point presentation however you also have hardcopies where you can review what is being presented and make suggestions or comments directly on the copy, which you can please return to me.

The question addressed is: How can clinical scholarship in nursing be promoted /developed in the clinical arena?

#### **Focus group rules:**

You are all most welcome to contribute in refining the recommendations. All the information contributed towards the research will be treated with confidentiality. No names will be revealed to anyone and all participants will remain anonymous. Please keep in mind, that all participant's opinions should be respected as we are here to adjust/refine the recommendations made by the participants.

Before we begin, the researcher would like you to please sign the consent form agreeing to participate in this discussion.

In this study, clinical scholarship is defined as an approach where clinical nurses use their clinical skills to observe and identify health related issues involving the application of scientific knowledge

to rectify these problems. This enhances clinical standards and ultimately improve patient care and outcomes.

### **Concluding the focus group**

Thank you all for your participation and contribution towards the final phases of my research. It was a great pleasure having your expert knowledge throughout the process of my research. The information given will be used in the final document of the research thesis as recommendation for promoting clinical scholarship in the clinical arena. The researcher will ensure that feedback will be communicated back to you all.

Thank you all for the positive responses through the process of data collection and focus group discussions

**Annexure 14: Letter from editor**



29 November 2017

To whom it may concern

This is to certify that the thesis by Jean-Paul Almaze entitled 'Promoting Clinical Scholarship in the Clinical Arena' has been edited for English grammar, idiom, orthography and sentence structure.

I will be happy to furnish additional information if requested.

A handwritten signature in blue ink that reads "David Newmarch".

David Newmarch BA (Hons)(Natal), M Phil (York)



197 Queen Elizabeth Ave, Durban 4001, South Africa  
082 554 9090 (c) • 031 261 2197 (h) • [grammarline@gmail.com](mailto:grammarline@gmail.com)