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The meaningful experiences of being an Registered Nurse (RN) Buddy

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Summary This paper describes the previously unexplored Buddy RN experience. Critical interpretive theory underpinned this exploratory study set in a large metropolitan teaching hospital in South East Queensland. Participants were five RNs who had been Buddies to undergraduate nursing student(s) in the previous 12 months. They were interviewed using semi-structured techniques and their transcribed interviews summarised to identify relevant verbatim data for participant checking. Common themes were generated via critical interpretive analysis and points of tension extrapolated. Four main points of tension were uncovered: *Acknowledgement, Experience, Balance* and *Interruption*. These revealed a number of paradoxes: the Buddy RN role is not professionally recognised by bodies that manage nursing; nursing is still influenced by essentialist discourses which perpetuate outdated practices and attitudes to the detriment of the Buddy RN; RNs are compelled to follow direction without question or dissent even though they are mandated by nursing's regulating body to be independent and accountable critical thinkers. A clear articulation of the Buddy RN role in the form of policy is required from nursing's regulating bodies. From this, health service management and universities can initiate the process of creating a framework for preparing, supporting, assessing and educating the Buddy RN.

Introduction

Tertiary Schools of Nursing (SONs) in Australia currently utilise a system of clinical education where undergraduate students receive practical experience in a variety of health settings. This system is constrained by various issues and these have become more acute over the last five years. Current issues faced by those involved include a lack of resources for clinical education (National Nursing and Nursing Education Taskforce (N_3ET), 2005, p. 19); a shortage of suitable clinical placements (Queens-

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land Health, 2005a); an increase in undergraduate enrolments for nursing degree programs in an attempt to curtail the nursing shortage (Queensland Health, 2005b); competition between SONs to acquire quality clinical placements (Queensland Health, 2005a); confusion in the health industry about the variety of curriculum goals of competing SONs (Department of Education, Science and Training and Department of Health and Aging (DEST and DHA), 2002a,b; Queensland Health, 2005a); inflexible university semester timetables resulting in SONs seeking large numbers of clinical places at around the same time (Queensland Health, 2005a); and uncertain relationships between SONs and their significant health agency stakeholders (Clare et al., 2003; DEST and DHA, 2002a; Queensland Health, 2005a).

Working within this system of undergraduate clinical nursing education is the RN Buddy. The RN Buddy is a registered nurse, often previously unknown to students, assigned by nurse managers or shift coordinators to work with a student for a shift at a time. Registered nurses are usually chosen randomly from the staff working on the required shift, indicating that an RN Buddy can have a different student for each shift worked. The RN Buddy role is mandated by the Australian Nursing and Midwifery Council (ANMC, 2005) and although informal, carries important responsibilities and challenges. Unlike the role of the 'Mentor' in the UK context (or 'Preceptor' in the Republic of Ireland) and 'Preceptor' in the US context, the RN Buddy is not formally prepared or qualified to directly assess the student (Leners et al., 2006; Mallik and McGowan, 2007). Both preceptor and mentor roles exist in Queensland, as well as that of the 'Clinical Facilitator' who works with and assesses 6—8 students in a block placement (of 1—4 weeks). The Clinical Facilitator will often seek summative feedback from the RN Buddy; that is a succinct yet meaningful interpretation of the student's performance during the shift. Unfortunately the response from the RN Buddy is often incomplete, emotive and/or inarticulate which points to a lack of preparation for and understanding of the role.

Although the RN Buddy role in the Queensland context is not readily defined or discussed in academic texts and journals, anecdotal evidence suggests it is characterised by its poor preparation, short-term interaction and lack of recognition as a contributor in undergraduate nursing education. Feedback from health agencies and students suggests that RNs are student fatigued; having to carry unrealistically heavy clinical loads as well as work with and informally educate undergraduate nursing students (Edmond, 2001). As a result many RNs overtly resent having to teach students when they are already heavily burdened by a system profoundly impacted on by economic constraints (Jackson et al., 2002; Senate Community Affairs References Committee (SCARC), 2002; Turner, 2001). The outcome of this reliance on an already burdened RN population to work with undergraduate nursing students results in a stressful education system which, due to its inflexibility, is only able to react to its many inherent troublesome variables, making it frequently ineffective (DEST and DHA, 2002a,b,c).

Background/literature

A review of nursing and education literature reveals confusion about the various nursing education roles (Andrews and Chilton, 2000; Atkins and Williams, 1995; Cahill, 1996; Ehrich et al., 2002; Neary, 2000; Phillips et al., 1996), and little formal recognition or mention of the RN Buddy. The ANMC's National Competency Standards (2005, p. 4) direct RNs to contribute to the learning experiences and professional development of health-care students, however this mandate could be criticised by Registered Nurses for being vague. Adding to this confusion of role is the evidence of poor preparation and support of RNs involved in undergraduate nursing clinical education (Andrews and Roberts, 2003; Andrews and Chilton, 2000; Corlett, 2000; Spouse, 2001; Watson, 2000), from tertiary providers (Atkins and Williams, 1995; Neary, 2000; Rummel, 2004), hospital management and clinical staff (Cahill, 1996; Phillips et al., 1996; Spouse, 2001; Watson, 2000).

There are calls for change, most notably from the (Australian) National Review of Nursing and Nursing Education (DEST and DHA, 2002a) which highlighted clinical education as an integral and essential component of teaching nursing and suggested that successful clinical education could only occur where there were effective working partnerships between educational institutions and practice settings (DEST and DHA, 2002a). This examination of nursing and nursing education has been more recently reviewed and discussed within the Queensland context (Queensland Health, 2005a,b). These local reviews suggested that collaboration between educational and health stakeholders would have positive impact on the recruitment and retention of RNs (Henderson et al., 2006; Hutchings et al., 2005; Queensland Health, 2005a), as well as enabling approaches in nursing, nursing education and research which value democracy, community building, empowerment, caring and holism in health-care management and delivery (McAllister et al., 2006; Diekelmann, 2001; Hooks, 2003).