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Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Care Programs as it Pertains to Faculty Development

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Amanda Lea Doneski

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A Dissertation submitted to the Education Faculty of Lindenwood University in partial fulfillment of the requirements for the degree of

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Dr. Rhonda Bishop, Dissertation Chair — Date

Sherry L. DeVore — 6-8-17

Dr. Sherry DeVore, Committee Member — Date

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Dr. Doug Hayter, Committee Member — Date

Declaration of Originality

I do hereby declare and attest to the fact that this is an original study based solely upon my own scholarly work at Lindenwood University and that I have not submitted it for any other college or university course or degree

Full Legal Name: Amanda Lea Doneski

Signature: Amanda Lea Doneski Date: 6/8/17

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This journey would not have been possible without the many blessings from God. Starting this program was a "God thing." My favorite verse, Jeremiah 29:11, "For I know the plans I have for you," declares the Lord, "plans to prosper you and not to harm you, plans to give you hope and a future," is the motto I live by.

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Abstract

The purpose of this quantitative study was to evaluate the self-efficacy of novice nursing and allied health educators as it pertains to their overall desire to enhance their knowledge of educational instruction. Many nursing and allied health faculty transition from clinical practice to teaching with little to no formalized knowledge in education (Cangelosi, 2014; Gresham-Anderson, 2015). Bandura's (1977a) theory of social learning and self-efficacy was utilized as the theoretical framework for the study. This study was guided by four research questions used to investigate how the self-efficacy of nursing and allied health professionals changed as participants became more experienced educators, the types of learning opportunities the contributors participated in, and the supports and barriers novice educators faced when making the transition from being a practitioner to becoming a teacher. A survey was utilized to gain the data needed. A total of 202 surveys were sent to allied health personnel in higher education institutions in a Midwest state. The results were analyzed using descriptive statistics. In the findings, most of the survey respondents noted their self-efficacy was lower when entering the teaching field as compared to working in their designated allied health field. However, by participating in self-directed learning, professional development, and mentoring, the survey respondents noted self-efficacy increased as they became more skilled as instructors. Implications for practice included providing a formalized orientation process, investment in faculty development, as well as mentoring for novice teachers. Future research studies could gain a more comprehensive understanding of the barriers novice educators face when transitioning from clinical practice to academia and the steps taken to improve self-efficacy.

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Chapter One: Introduction

In today's job market it is predicted individuals will have 11.7 jobs in their lifetime (Bureau of Labor and Statistics, 2015a). Many factors play a role in changing jobs (Huysse-Gaytandjieva, Groot, & Pavlova, 2013). Overall job dissatisfaction is one major element, change of work schedule to a more family friendly one, an advancement, and promotion through continued education, or being presented a different opportunity are all reasons why a person changes careers (Huysse-Gaytandjieva et al., 2013; Loftus, Gerzina, Higgs, Smith, & Duffy, 2013). What one chooses as an initial career path will change and deviate as opportunities are presented (Loftus et al., 2013). According to Greenwood (2015), "career paths are not linear, they are often serendipitous or circuitous routes that bring exciting challenges our way" (p. 87). This illustration emulates the career journey for many healthcare professionals.

When an individual chooses health care as a career choice, the first step is to enroll in courses to obtain proper education and certification needed to pursue the chosen occupation (Torpey, 2015). Career options include but are not limited to nursing, radiologic technology, dental hygiene, and respiratory therapy (Bureau of Labor Statistics, 2015b). Once courses are completed and all requirements are met by certifying organizations, healthcare professionals enter the workforce in their designated area of expertise (American Registry of Radiologic Technologists, 2016).

Advancement opportunities in management, sales, and education are attainable for many healthcare professionals (Adler & Carlton, 2016). To advance in their chosen field, most opportunities require individuals to obtain additional education beyond initial health care education and certification (Loftus et al., 2013). Persons who desire to

pursue a career path to become health care educators will require an augmenting of skill sets so there will be successful performance in this arena (van den Bos & Brouwer, 2014).

Individuals who transition from the role of a health care provider to educator often do so when openings occur and bring to the classroom limited or no formalized instruction specific to education (Loftus et al., 2013). As a result, health care providers who become teachers feel thrown into their new roles with little to no guidance (Steketee & Bate, 2013). Feelings of inadequacy in teaching abilities not only affect the novice educator but also the students in their classrooms (Loftus et al., 2013).

In this chapter, an introduction to the study is provided. The background for research on the topic of professionals transitioning to becoming educators is discussed. A theoretical framework is identified, statement of the problem and the purpose of the study. In addition, research questions, definitions of key terms, and limitations and assumptions are provided.

Background of the Study

The world has changed greatly over the years; advancement in technology has altered the way people live (Reig, Valverde, & Reig, 2015). Health care education is one area which has transformed over time (Loftus et al., 2013; Reig et al., 2015). Historically nursing and allied educational programs were offered in conjunction with a hospital as a certificate program (Accreditation Commission for Education in Nursing, 2016; Adler & Carlton, 2016). Once the program was complete, the health care professional would take a national test to gain certification, registration, or licensure in the chosen allied health care field (Alder & Carlton, 2016). Requirements for exams and certification vary based

on the profession (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016). Individuals must meet educational requirements of their certifying agency, which include graduating from an approved educational program, complying with professional ethical standards, and passing a certifying exam (Adler & Carlton, 2016). Once certification has been achieved, healthcare professionals must keep up with continuing education mandated by their field of study (American Registry of Radiologic Technologists, 2016).

The majority of educational programs are accredited (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016). Accreditation is a "mechanism where the educational program of an agency or educational institution is assessed by an external panel against established criteria" (McDavid & Huse, 2015, p. 59). Accreditation agencies have brought forth many changes and advancement in educational programs (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016; Higher Learning Commission, 2016).

Many fields in nursing and allied health have transitioned from earned certificates to degree seeking programs (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016). In January 2013, The American Registry of Radiologic Technologists (2016) mandated all candidates sitting for the national registry must have an associate's degree or higher. Changes in the degree requirement mandated certificate programs to become affiliated with a college or university or to impose an associate's degree as a prerequisite for a radiologic technology program (American Registry of Radiologic Technologist, 2016). Dental hygienists and

respiratory therapist are also required to have a minimum of an associate's degree to be eligible to sit for their examination (American Association for Respiratory Care, 2016; American Dental Association, 2016).

While requirements of health care professionals are strict and based on accrediting or licensing body, nursing and allied health care educators are not as regulated and vary from those of other disciplines (Higher Learning Commission, 2016). Typically, a nursing and allied health care educator has obtained an advanced degree, yet those degrees are not always required and there are no requirements as to the area the degree has to be in (Murray, Stanley, & Wright, 2014). Many professionals enter into the world of academia without any formalized educational training (Paul, 2015). As instructional openings occur, health care professionals find themselves transitioning from the role of a provider to an educator with little to no formal training (Loftus et al., 2013).

Upon entering into this new role, experienced health care professionals became novice educators (Anderson, 2019; Loftus et al., 2013; Paul, 2015). An example given by Anderson (2009) was a mermaid entering a "sea of academia" (p. 204) to describe how a clinician feels when becoming a full-time teacher. Using this metaphor, novice educators find themselves "sitting on the shore, splashing in the shallows, drowning, treading water, beginning strokes throughout the waters" (Anderson, 2009, pp. 205-206). Essentially, these health care professionals struggle to become competent health care educators (Anderson, 2009; Loftus et al., 2013; Paul, 2015).

Novice educators have to navigate how to become instructors often on their own (Anderson, 2009; Paul, 2015). These individuals need to be subject matter experts who are able to impart knowledge to students (Loftus et al., 2013). While this may seem like

an easy task, a lot of time and preparation are involved in the process (Paul, 2015). There are many other responsibilities of an educator than lecturing or facilitating a class (Whitfield & Hickerson, 2013). Those duties often include academic advisement, committee work, as well as collaboration with colleagues in research (Whitfield & Hickerson, 2013). Understanding objectives and curriculum are additional struggles novice educators face (Loftus et al., 2013). To aid the transition from professional to educator, some organizations will provide professional development to provide these educators with additional instruction in areas such as curriculum, objectives, and learning theories associated with academia (Meyer & Murrell, 2014). Loftus et al. (2013) stated entering the world of academia can be a rewarding experience, yet many are not aware of all duties required. Preparation for the role of an educator includes these three parts: research, teaching, and service/administration (Loftus et al., 2013).

Theoretical Framework

One of the major underpinnings for this body of work was the theory of social learning coined by Albert Bandura (1977a). According to Bandura (1977a), social learning is the concept people learn by observing behavior. Bandura's theory worked well with this current study as Loftus et al. (2013) indicated health care professionals enter into academia using only personal experience with learning, which can transfer into the instruction in the classroom. The importance of social learning theory is it is "ultimately judged by the power of the procedures it generates to effect psychological changes" (Bandura, 1977a, p. 4). Concerning social learning theory, the premise that just because something is learned does not mean it is acted upon (Bandura, 1977a). Most individuals will adopt a behavior if the behavior has the desired outcome (Bandura,

1977a). According to Davis, Palladino, and Christopherson (2013), a key to observational learning is participants identify with the person being observed.

Bandura (1977a) stated one of the underlying tenets of social learning theory is an individual's behavior is guided by continuous, reciprocal exchanges of both personal and environmental factors. Essentially, Bandura (1977a) recognized people are not motivated by internal influences nor guided by environmental prompts. The interplay between symbolic, vicarious, and self-regulatory interactions undertake a significant role (Bandura, 1977a; Petrovich, 2004). With traditional psychological theories, in order to learn, individuals must practice and experience the effects (Bandura, 1977a). Bandura (1977a) indicated all learning occurs on a vicarious basis by observing other actions and the consequences of their behavior. Essentially, based on Bandura's theory (1977a), observing allows individuals to obtain knowledge by observation as opposed to gaining knowledge based on trial and error.

Bandura (1986) developed four requirements for learning; observation (environmental), retention (cognitive), reproduction (cognitive), and motivation (both). For learning to occur through observation, several conditions must be met (Bandura, 1986). Situations Bandura (1986) described included the learner observing the action a person was doing, memories being stored of the action observed, creating situations where the behavior must be repeated or replicated, knowing the learner's motivational state must be the same as the behavior observed, and attention must be paid to the discriminative stimuli.

In the theoretical framework, the structure from which the novice educator's desire to improve his or her instructional skills is examined and more fully understood

(Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). In social learning theory, Bandura (1977a) recognized there appeared to be a direct correlation between a person's perceived self-efficacy and behavioral change. Self-efficacy is the belief an individual can be successful at a given task (Bandura, 1977b). Bandura (1997) stated, "People guide their lives by their beliefs of perceived efficacy" (p. 3). When self-efficacy is low, risks are not taken (Bandura, 1977b). Yet when self-efficacy is high, action is taken and will continue after traditional behavior approach suggests extinction should occur (Bandura, 1977b). A person's belief in his/her self-efficacy influences the decision making process in regards to life decisions, how adversity is handled, the amount of stress tolerated, and the level of accomplishments realized (Bandura, 1997). One way to develop self-efficacy is to pay attention to previous successes and failures (Feldman, 2013).

According to Bandura (1977b), there are four factors which affect self-efficacy; performance accomplishment, vicarious experiences, verbal persuasion, and emotional psychological states. Performance accomplishment is the first factor and is based on individual mastery experiences (Arslan, 2013; Bandura, 1977b). When an individual is successful in an experience, a person's expectations of the experience also increases (Bandura, 1977b; Skaalvik & Skaalvik, 2014).

Likewise, Bandura (1977b) indicated, as there are repeated failures, expectations are lowered. When repeated success occurs, occasional occurrences of failure have a reduced negative impact (Bandura, 1977b; Bliss & Dressner, 2015). Bandura (1977b) observed, when a person is able to overcome obstacles through perseverance, realizations emerge difficult obstacles can be overcome with continuous effort.

Vicarious experiences are the second factor, which affects self-efficacy (Bandura, 1977b). According to Bandura (1977b), when individuals are viewed performing frightening activities without any negative consequences, this awareness produces expectations the same outcome can be achieved. Observation can provide a power mean of increasing self-efficacy (Bliss & Dressner, 2015). Verbal persuasion, the third factor identified by Bandura (1977b) can be a very powerful tool when used in different ways. Bandura (1977b) indicated four factors assist in understanding human behavior where success can be achieved even during unsurmountable odds. The final factor is emotional arousal (Bandura, 1977b). Stressful and challenging situations affect self-efficacy (Bandura, 1977b; Skaalvik & Skaalvik, 2014). According to Bandura (1977b), individuals who are highly aroused are not expected to be successful because anxiety and stress can affect performance.

Statement of the Problem

The field of academia employs a myriad of individuals with varying ranges of professional and educational backgrounds (Cangelosi, 2014; Gresham-Anderson, 2015). While a diverse population of educators with different skills sets can be highly beneficial for those they educate, it can also be problematic in nature (Cangelosi, 2014; Gresham-Anderson, 2015). Individuals entering into an educator role in nursing and allied health care often do so when an opening is present not as a planned career advancement (Loftus et al., 2013).

Many new health care educators are thrust into the role of an educator without any additional training or orientation in education or educational theory (Cangelosi, 2014; Gresham-Anderson, 2015). In specifically examining the field of allied health, there is

currently no formalized preparatory procedure(s) for novice educators who enter a teaching environment except for initial minimum level of education required (Accreditation Commission for Education in Nursing, 2016; Joint Review Committee on Education in Radiologic Technology, 2016). The only preparation for this new role is personal experience or the manner in which they were taught (Loftus et al., 2013).

Educators are expected to prepare students to enter multifaceted health care settings as competent providers with skills and knowledge needed for patient care (Costello et al., 2014). Based on the readings of Branscum, Haider, Brown, and Sharma (2016), the "primary role of health educators is to conceptualize and implement interventions that improve the health and overall quality of life for society" (p. 310). Educators are expected to teach students the ins and outs of the profession which include but are not limited to anatomy, physiology, law and ethics, and procedural requirements of the profession (Adler & Carlton, 2016). Expectations for teachers also include instructing students on pertinent subject matter to allow for successful test scores on students' certifying or licensing exams (American Registry of Radiologic Technologists, 2016).

All of these expectations require a skill set novice educators often do not possess (Loftus et al., 2013). The importance of terms such as curriculum, objectives, and outcomes are lost on novice educators (Loftus et al., 2013; Wiseman, 2016). Words such as pedagogy and andragogy have no significant meaning yet mastery of these concepts are expected (Loftus et al., 2013). Switching from professional practice to academia can cause a change in professional identity (Loftus et al., 2013). While serving as a professional in the medical field, these individuals were considered experts (Loftus et al.,

2013). However, the journey to become both an expert professional and educator in the field of education has yet to intersect (Schoening, 2013).

Purpose of the Study

The purpose of this study was to evaluate the self-efficacy of novice nursing and allied health educators as it pertains to the overall desire to enhance knowledge of educational practice and subsequently augment their instructional development in academics. Novice educators are often health professionals who choose to enter the world of academia with little to no formalized schooling in the field of education (Cangelosi, 2014; Gresham-Anderson, 2015). Studies show feelings of inadequacy and low self-efficacy with regards to these novice educators' role as teachers (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). According to Bandura (1997), "Teachers' beliefs in their efficacy affect their general orientation towards the education process as well as their specific instructional activities" (p. 241). Minimal research has been done on what motivates educators to improve teaching skills, and whether it is intrinsic motivation, such as reading books or seeking out new instruction methods, or extrinsic motivation including faculty development opportunities provided by their institution (Lancaster et al., 2014; Loftus et al., 2013).

Research questions: The following research questions were developed to guide this study:

1. How has the self-efficacy level of health care professionals changed from the time they entered the higher education teaching field to the present?

2. What types of opportunities do novice health care educators report improved their knowledge and execution of andragogy?

3. What barriers do health care educators report having to overcome in an effort towards becoming a teacher in higher education?

4. What personal actions, or opportunities, do health care educators with no prior experience or training in educational practices seek in an effort to improve their implementation of andragogy?

Definition of Key Terms

For the purposes of this study, the following terms are defined:

Allied Health. Part of the health workforce generally distinct from physicians, dentists, nurses, or pharmacists (Elwood, 2013).

Andragogy. The art and science of helping adults learn (Knowles, 1970).

Faculty development. The enhancement of skills in three areas; personal, professional, and instructional development (Anwar, & Humayun, 2015).

Novice educators. Educators who have been in teaching positions for five years or less (Wiesman, 2016).

Pedagogy. The art of teaching children (Knowles, 1970).

Professional development. The improvement of professional knowledge, competence, skill, and effectiveness (Alder & Carlton, 2016).

Social learning. A behavioral worldview that emphasized people learn by observation (Bandura, 1977a).

Self-efficacy. The belief in one's capabilities to organize and execute the courses of action required to produce given attainment (Bandura, 1977b).

Limitations and Assumptions

It is necessary to identify limitations and assumptions which may affect the research process. First, the researcher acknowledges personal bias in this study as she is representative of the population being surveyed and ultimately studied. The sample was limited to nursing and allied health educators in a specified geographic location in Southwest Missouri. Due to a limited location, results may reflect only a Southwest Missouri experience and may not be widely applicable (Fraenkel, Wallen, & Hyun, 2016). The instrument in this study was constructed by the researcher and utilized for data collection for this specific research project.

The following assumptions were accepted:

1. The responses of the participants were offered honestly and without bias.
2. Full anonymity of respondents will be insured.
3. Historically speaking, surveys yield low return percentage rates for research studies (Fraenkel et al., 2016).

Summary

In this chapter, issues of health professionals transitioning from clinical practice to academia was discussed. Literature shows lack of knowledge in formalized education is a significant problem (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Wiseman, 2016). The utilization of Bandura's (1977b) social learning theory as the theoretical framework identified learning occurs through observation. Four parts are required in Bandura's (1977b) theory of social learning: observation, retention, reproduction, and motivation. As stated prior, many individuals who pursue education as a new career have little to no experience in teaching (Cangelosi, 2014; Gresham-

Anderson, 2015). Novice educators often teach modeling their own experiences in education (Loftus et al., 2013). An educators' desire to improve instruction is intrinsic and often is self-reported to determine if a change of the individual's self-efficacy has occurred (Loftus et al., 2013). Changes in self-efficacy can be accomplished through four specific factors which include master experiences, vicarious experiences, verbal persuasion, and emotional psychological state (Bandura, 1977b). Health care professionals who transition into the role of an educator often feel overwhelmed and not prepared for this new role (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Wiseman, 2016).

In this chapter, an introduction, background of the study was given. Statement of problem and theoretical framework was given. The self-efficacy of novice nursing and allied health educators as it pertains to the overall desire to become better educators was discussed. The purpose of the study was provided. Lastly research questions were developed as well as key terms given.

In Chapter Two, a review of literature with topics associated with this study is presented. Literature on the framework of social learning theory and self-efficacy is discussed. Other areas related to the study including transitioning from clinical practice to education, andragogy, and faculty development are explored.

Chapter Two: Review of Literature

Educators in nursing and allied health care programs are often experts in the clinical capacity of their chosen field (Loftus et al., 2013; Schoening, 2013). Career changes can occur when opportunities for allied health professionals arise in educational programs (Huysse-Gaytandjieva et al., 2013; Loftus et al., 2013). Individuals who choose to transition from clinical practice in health care to being an educator are typically schooled in their health care specialty rather than in education (Cangelosi, 2014; Gresham-Anderson, 2015).

Due to lack of training in education, novice educators often lack knowledge in curriculum, teaching, and learning theories (Loftus et al., 2013). Frequently novice educators find themselves learning to be an educator as they go, utilizing resources available (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). Studies have shown novice educators find mentoring and professional development or faculty development instrumental in advancing their skillset (Anderson, 2009; Cangelosi, 2014; Loftus et al., 2013). The majority of students in nursing and allied health programs are known as adult learners (Loftus et al., 2013). This distinction, the theory of andragogy, requires educators to know there are differences in how adults learn (Knowles, 1970).

In this study, social learning theory and self-efficacy theory, coined by Albert Bandura (1977a, 1977b, & 1997) were used for the theoretical framework and are discussed further. The transformation from being a health care worker to becoming an academic instructor is addressed. In addition, faculty development and the importance of andragogy and how both of these areas relate to self-efficacy are reviewed.

Theoretical Framework

In this study, the theoretical framework revolves around the concepts of social learning theory and self-efficacy and provides both the structure and the central theme throughout the research (Bandura, 1977a, 1977b; Bandura, Adams, & Beyer, 1977). Bandura et al. (1977) stated social learning theory is a lens to view human behavior in constant common interaction with cognitive, behavior, and environmental determinants. Essentially these three factors interplay with each other and influence each other in a reciprocal manner (Bandura, 1997; Bandura et al., 1977; Davis et al., 2013). Social learning occurs where individuals learn behaviors, attitudes, as well as the outcomes of those behaviors by merely observing (Bandura, 1977a, 1997). New patterns of behaviors can develop by direct experiences or by observing the behaviors of others (Bandura, 1997; Bandura et al., 1977; Bandura & Walters, 1977; Davis et al., 2013).

Bandura (1986) posited there are three modes for motivating the observation and modeling process; live modeling, verbal instruction, and the symbolic model. Utilizing Bandura's theory from an educator's perspective; live modeling would occur when an educator observes another educator teaching in a classroom (Mintzes, Marcum, Messerschmidt-Yates, & Mark, 2013). Verbal instruction, according to Mintzes et al. (2013) would require an educator to orally describe the instructional process and to articulate the steps a novice teacher would need to take. In the symbolic model, novice educators would observe teaching through other avenues such as TV, books, and internet (Mintzes et al., 2013).

Four necessary conditions must be met for effective modeling to occur: attention, retention, production, and motivation (Bandura, 1977a, 1986; Bandura, et al., 1977).

Bandura (1977a; 1986) posited attention is essentially the deliberate focus of effort towards a specific endeavor. Essentially learning requires paying attention, which includes the elimination of distractions (Bandura, 1977a; 1986; Petrovich, 2004). The more interesting the model, the more attention will be given (Bandura, 1977a, 1986; Bandura et al., 1977). Retention is necessary because without it, learning will not be established (Bandura, 1977a, 1986). Retention allows an individual's observations to be converted into parameters, which provides for functional usage (Bandura, 1977a, 1986). In the production process, the learner engages in the behavior utilizing learned rules and concepts and is able to create new, more complex behaviors (Bandura, 1977a; Bandura et al, 1977). Motivational processes, the final condition, prompts the learner to select the desired behavior to learn (Bandura, 1997; Petrovich, 2004).

Self-efficacy. Self-efficacy theory originated from social learning theory and the premise is there is ultimate control over outcomes based upon perceived competence (Bandura, 1977a, 1997). Self-efficacy is a byproduct of social cognitive-learning theory (Davis et al., 2013). Social cognitive-learning theory holds portions of an individual's knowledge can be directly related to observing (Davis et al., 2013). Through social cognition, individuals learn from each other through modeling, observation, and imitation, witnessing people's behavior, and personalities (Davis et al., 2013).

Bandura's findings indicated self-efficacy relates to a person's perception of one's own ability to reach a goal and being capable of performing in a certain manner to attain certain targets (Bandura, 1977a, 1997; Karabacak, Serbest, Kan Öntürk, Eti Aslan & Olgun, 2013). Sezgin and Erdogan (2015) posited self-efficacy is not about belief in ability, but the determination to achieve. Self-efficacy of novice educators can help

predict retention, performance, and effectiveness (Hand, 2014). According to Bandura (1997), individuals with low self-efficacy will give up when faced with challenges, whereas educators with higher efficacy are believed to be more committed and sets higher goals. Bandura (1977a; 1997) suggested there are four contributors to self-efficacy: mastery experiences, vicarious experiences, physiological states, and verbal persuasion.

Mastery experiences can be knowledge in areas of pedagogical and instruction (Hand, 2014). Defined by Bandura (1977a), mastery is "experience of overcoming obstacles through perseverant effort" (p. 80). Mastery experiences are considered the most dominant basis of efficacy information and are known as the performance accomplishment (Petrovich, 2004).

While subjective in nature, the mastery experience comes from the learner's own interpretation of a successful performance, whereas if the individual interprets too many failed presentations, this can be damaging to self-efficacy (Petrovich, 2004). It is the expectation different situations can be mastered and produce a positive outcome (Bandura, 1977a, 1997). The mastery experience for health care educators consists of being able to successfully teach specialty content to students (Bandura, 1977a, 1997). By doing so, educators should expect to feel a higher feeling of self-efficacy (Petrovich, 2004).

Vicarious experience is defined by Bandura (1977) as learning "mediated through modeled attainments" (p. 86). Modeling is most commonly known vicarious experience (Petrovich, 2004). People tend to seek proficient models who emulate strengths they desire (Bandura, 1977a, 1997).

Based on readings from Mintzes et al. (2013), observing a lesson skillfully taught would provide a vicarious experience, while being able to participate and receive feedback in a group with health professional educators with similar experiences would offer emotional support. By observing the successful implementation of lessons, the novice educator can build a capacity of skills and this can lead positive outcomes (Mintzes et al., 2013). Modeling is more likely to occur when the learner values the outcome or perceives it to be personally satisfying as well as enhancing the learners' sense of self-worth (Petrovich, 2004; Skaalvik & Skaalvik, 2014). Health care educators often model previous teachers (Loftus et al., 2013).

The physiological state affects a learner's competency (Bandura, 1977b; Hand, 2014). People's emotions, moods, and stress levels can influence feelings about abilities thus affecting perceived self-efficacy (Bandura, 1977b). Health care educators who are apprehensive about teaching will be looking for cues in the classroom that may be perceived as threatening (Petrovich, 2004). The final contributor to self-efficacy is verbal persuasion (Bandura, 1977b; Skaalvik & Skaalvik, 2014). Verbal persuasion is commonly used due to its ease and ready availability (Bandura, 1977b). Petrovich (2004) suggested verbal persuasion can be considered encouraging feedback, a lesser source of self-efficacy. Bandura (1997b) indicated people could be led through suggestion; handling situations previously thought to be too overwhelming in the past using verbal persuasion.

A person's perception of one's self-efficacy has a direct correlation to personal goals set as well as how difficulties are faced (Zimmerman, Bandura, & Martinez-Pons, 1992). Self-efficacy can influence feelings, choices, and motivations (Woolfolk & Hoy,

1990). The term self-efficacy is often referred to "as mastery expectations and is one dimension of self-perceived competence" (Skaalvik & Skaalvik, 2014, p. 69). Since self-efficacy is usually domain and context specific, it can vary in levels in different situations (Skaalvik & Skaalvik, 2014). In the instance of teaching, it is possible an educator may have high self-efficacy in one area such as lab simulations and a lower self-efficacy in lecture (Velthuis, Fisser, & Pieters, 2014).

Studies conducted by Goroshit and Hen (2014) and Kasler, Hen, and Nov (2013) used self-efficacy as a model in other forms of efficacy such as teacher self-efficacy. Both of these studies use definitions similar in nature and support Bandura's claim if self-efficacy is low, risks will not be taken, yet when self-efficacy is high, action is not only taken but continues even when it should stop based on results of said action (Goroshit & Hen, 2014; Kasler et al., 2013). Bandura (1997) theorized individuals who have low mastery expectations dwell personal weakness and enlarge possible threats. Self-efficacy is thought to impact teacher performance, types of tasks teachers choose to implement in the classroom, and the total amount of effort put forth to accomplish those tasks (Rowbotham, 2015).

Self-efficacy can change over time and with career changes (Bandura, 1977a; Loftus et al., 2013). Health care professionals' self-efficacy changes when transitioning from clinical practice to education (Goroshit & Hen, 2014; Rowbotham, 2015). Literature shows when job satisfaction is high, self-efficacy is high (Bandura, 1977b; Petrovich, 2004; Skaalvik & Skaalvik, 2014). However, when burn out and job satisfaction are low, self-efficacy is low (Petrovich, 2004; Skaalvik & Skaalvik, 2014). Klassen, Tze, Betts, and Gordon (2011) suggested significant sources of teacher efficacy

beliefs takes in account previous mastery experience, vicarious experience, and verbal persuasion. Low self-efficacy is relevant for individuals who have little to no teaching experience (Bandura (1977a; 1997; Loftus et al., 2013). Successful teachers are more likely to have a strong sense of self-efficacy thus affecting their success in helping students learn and develop (Klassen, Tze, Betts, & Gordon, 2011).

A teacher's level of self-efficacy is relevant to how successful a person's career in teaching can be (Sezgin & Erdogan, 2015). Bandura (1997) posited the learning environment teachers establish is very dependent on their instructional capability and self-efficacy. Casanova and Azzi (2015) and Goroshit and Hen (2014) agreed self-efficacy of teachers and greater learning outcomes for students are related. The higher a teacher's self-efficacy, the greater the students' learning potential (Bandura (1977a; 1997). If a teacher is confident in his or her abilities as an educator, this will show in the way he or she interacts with students as well as in classroom instruction (Loftus et al., 2013; Petrovich, 2004; Skaalvik & Skaalvik, 2014). Bandura (1997) and Casanova and Azzi (2015) both suggested self-efficacy has a significant impact on achievement of an individual.

Efficacy beliefs influence how a person thinks whether in a positive or negative manner, which can also affect goals and aspiration (Bandura, 2006). Loftus et al. (2013) discussed when self-efficacy is low, student learning and achievement is also found to be low. Properly prepared educators are important in ensuring success of students (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013).

Hand (2014) looked at sources which influenced teaching efficacy. Participants of the study were clinical educators and student teachers (Hand, 2014). There were

varying differences in how participants reported efficacy (Hand, 2014). Findings showed when given new course work or a change in expectations there was a negative impact on the perception of educators' abilities (Hand, 2014). Supporting teacher development is important for ensuring teachers stay committed and enthusiastic (Hand, 2014; Loftus et al., 2013). A study conducted by Sezgin and Erdogan (2015) looked at the predictive influence of educators' academic optimism, hope, and zest for work based on perceptions of self-efficacy and success. Results of the study showed a relationship between teachers self-efficacy and their perceived success was positive and important (Sezgin & Erdogan, 2015). Outcomes of the study also supported other exploration of relationship between self-efficacy and job satisfaction (Hand, 2014; Sezgin & Erdogan, 2015).

Studies conducted by Phillippo and Stone (2013), Mintzes et al. (2012), and Sezgin and Erdogan (2015) suggested self-efficacy is an important factor in an educator's effectiveness. Research findings by Bulus (2015) showed a connection between self-efficacy and student academic satisfaction, the higher the teacher self-efficacy the higher the student's academic satisfaction. Educators with a higher self-efficacy will provide a better learning environment to students (Mintzes et al., 2012; Phillippo & Stone, 2013; Sezgin & Erdogan, 2015). Factors such as being prepared, mentoring, and support from the educator's leaders all affect self-efficacy of educators (Hand, 2014; Loftus et al., 2013).

Moving from the Professional Field to Education

The road to academia does not always begin as a direct career pathway (Hallmark, 2015). For most, it occurs when there is a job opening (Loftus et al., 2013). Many individuals, especially in the nursing and allied health care field, begin careers as

professionals in a clinical setting with the only educational experiences being in their chosen health care specialty and not in teaching and instruction (Hallmark, 2015). Others may decide to use their clinical expertise to help educate future health professionals (Cangelosi, 2014; Frantz & Smith, 2013; Gresham-Anderson, 2015). Regardless of how and when the choice is made to join the world of academia, many challenges are identified with the journey (Frantz & Smith, 2013; Loftus et al., 2013). Gresham-Anderson (2015), Cangelosi (2014), and Goodrich (2014) are all in agreement and found novice educators face difficulties adjusting to their new role in education.

Establishing a new identity as an educator can be challenging for a novice teacher (Izadinia, 2014; Loftus et al., 2013; Woolfolk & Hoy, 1990). Especially for those who have had a successful career practicing their health specialty (Loftus et al., 2013). Izadinia (2014) reviewed 52 research papers where challenges and tensions educators experienced during the beginning of their career as an educator were presented. Findings of the study concluded, educators face difficulties in teacher identity due to a lack of knowledge of how to teach (Izadinia, 2014). Other trials and stressful situations novice educators experienced, along with factors influencing development of professional identity as an educator, were also identified throughout the literature review of the study (Izadinia, 2014).

A nursing and/or allied health care professional's role is to take care of patients in a manner fitting to his or her specialty (Adler & Carlton, 2016). Nursing and allied health students are educated in areas such as taking vital signs, taking x-rays, or cleaning teeth (Accreditation Commission for Education in Nursing, 2016; American Dental Association, 2016; American Registry of Radiologic Technologists, 2016). Following

graduation and successful entry into the workforce, these individuals continue to practice and hone these specialty skills in an effort to become highly trained nurses, radiologic technologists, or dental hygienists (Accreditation Commission for Education in Nursing, 2016; American Dental Association, 2016; American Registry of Radiologic Technologists, 2016). When individuals transition from practicing in the health care profession to novice educators, confidence levels in regards to the new role and their abilities to be effective in the position change (Anderson, 2009; Izadinia, 2014). Job duties changed from caring for individuals to lesson planning, lecturing, advising, and serving on committees (Izadinia, 2014; Loftus et al., 2013). In a study from Izadinia (2014), a few key features were identified regarding information novice educators should be provided at the beginning or induction of the teaching career. Included was an orientation process where new instructors collaborated to learn and to build supportive and professional relationships (Izadinia, 2014). Results from Izadinia (2014) supports the findings of Cangelosi (2014), Goodrich (2014), Gresham-Anderson (2015), and Loftus et al. (2013).

Challenges. In a study from Whitfield and Hickerson (2013), the difficult transition into teaching shows the need for educators to be prepared for their new role. Beginning at the graduate level, preparation is done by providing seminars and courses to help these students gain the knowledge to be successful educators (Whitfield & Hickerson, 2013). Graduate programs for educators can give individuals many opportunities to gain knowledge in instruction, including hands-on experience, and seminars on teaching (Whitfield & Hickerson, 2013).

In the same study, findings reported on confidence levels, educator students who did not receive training in advising or research had lower confidence levels in this aspect of teaching (Whitfield & Hickerson, 2013). These conclusions support the need for all educators to be provided with formal training on becoming an educator (Loftus et al., 2013; Whitfield & Hickerson, 2013). Suggested components of development programs for health care professional educators, included the need to have an orientation to the role of faculty (Whitfield & Hickerson, 2013). Knowledge of educational theories, especially adult learning principles should be provided (Caruth, 2014; Knowles, 1970; Loftus et al., 2013). Novice educators should be given educational improvement opportunities and provided mentoring along with some leadership development (Loftus et al., 2013). Understanding of policies and procedures as well as research and governance is also needed for novice educators to be successful in their positions (Loftus et al., 2013).

Individuals who want to become educators should enroll in courses in teaching practicum (Loftus et al., 2013; Takkac Tulgar, 2015). These courses will help expose individuals to the educational environment (Takkac Tulgar, 2015). Formalized courses will allow educators to feel more confident as an educator (Loftus et al., 2013; Takkac Tulgar, 2015). Without formal training, novice educators can face challenges and feelings of low confidence in their teaching abilities (Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015; Izadinia, 2014; Loftus et al., 2013). If novice educators are not able to deal with the duties of their new work environment, feelings of discontent and despair may occur causing novice educates to feel the need to quit the job (Takkac Tulgar, 2015).

Some of the other trials facing novice educators include lack of time to prepare for the role of a teacher and a deficiency of knowledge on specific areas of education (Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015). Anxiety often occurs when the role of a faculty member is not properly defined (Gresham-Anderson, 2015). Another obstacle identified as a hurdle is knowing and/or understanding the curriculum as prescribed by accreditation agencies (DaRosa et al., 2011; Loftus et al., 2013). Academia involves knowing objectives and outcomes needed to satisfactorily complete coursework, which ultimately helps students pass licensure or certifying exams (Frantz & Smith, 2013; Loftus et al., 2013). According to DaRosa et al. (2011), an instrumental component of teaching is to ensure students are meeting prescribed outcomes for courses in an effort to satisfy accreditation guidelines. Understanding the importance of outcomes and ensuring curriculum garners evidence those outcomes are being met can be challenging for the novice educator (Booth, Emerson, Hackney, & Souter, 2016).

While classroom instruction is a main component, additional duties are also included in the role of the educator (Loftus et al., 2013; Whitfield & Hickerson, 2013). Novice educators find themselves immersed in academic advising, serving on committees, as well as collaborating with colleagues on research studies; all new areas to navigate and acclimate to in an educational setting (Whitfield & Hickerson, 2013). Without formalized training, novice educators often find themselves overwhelmed with feelings of self-doubt in their abilities, as well as being held to unrealistic expectations of the new position as an educator (Cangelosi, 2014; Gresham-Anderson, 2015; Murray et al., 2014; Schoening, 2013). Phrases such as “sink or swim,” “winging it,” or “flying by the seat of my pants,” are commonly noted among educators changing from the

professional world to education (Gresham-Anderson, 2015, p. 206; Schoening, 2013, p. 169). Many novice educators have little to no experience in areas such as writing exam questions, handling difficult students, or even creating a course syllabus (Gresham-Anderson, 2015).

As novice educators prepare to teach the first class, they frequently have to review the subject matter to allow them to present the material in a way students can learn (Loftus et al., 2013). Often times, what is done in clinical practice may not reflect what students need to learn to pass their certifying exam (Adler & Carlton, 2016). Subsequently, these additional steps require educators to spend time relearning some of the material; time not available in their schedule which requires them to work outside of normal work hours (Adler & Carton, 2016; Cangelosi, 2014).

Even though novice educators may be considered experts in the clinical setting, according to Schoening (2013), they are fearful of not being able to answer a student's question. Therefore, instructors feel the need to be over prepared for classes (Cangelosi, 2014; Loftus et al, 2013). Time restraints are problematic as educators often find there is not sufficient time to prepare for classes (Cangelosi, 2014; Loftus et al., 2013; Schoening, 2013). Between student advisement, committee meetings, and various disruptions throughout the day, Gresham-Anderson (2015), stated many participants of her study reported taking work home on weekends and struggling with work-life balance. Another area reported to create anxiety was a lack of feedback provided on the novice's teaching performance (Cangelosi, 2014; Gresham-Anderson, 2015). Clinicians are able to recognize when treatment is making a difference in a patient because in many cases they see almost immediate reaction (Adler & Carlton, 2016). However, in education, rarely

does an instructor receive instant feedback on his or her teaching abilities (Gresham-Anderson, 2015).

Suggestions for support. A qualitative study conducted by Gardner (2014) looked at educators' experiences from learning to teach to instructional effectiveness. Participants of the study were nursing educators who taught in various degree programs for a minimum of five years and held a minimum of a master's degree in nursing (Gardner, 2014). Findings of the study identified several themes consistent with other studies; finding support, gaining confidence and competence, as well as being a part of the bigger picture (Gardner, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Whitfield & Hickerson, 2013).

It is true most individuals feel anxiety when beginning a new job (Cangelosi, 2014; Gresham-Anderson, 2015; Murray et al., 2014; Schoening, 2013). New employees must gain knowledge of how the new organization works (Weiner, 2015). There is a need to clarify expectations of the new position and new faculty must develop new relationships within the new organization (Weiner, 2015). One area which causes stress to new employees is the need to be prepared for the position (Cangelosi, 2014; Loftus et al., 2013; Schoening, 2013). While there is limited research on the impact new faculty orientation, findings of Schoening (2013) indicated a structured orientation program could be used as a way to ease the transition from clinical practice to education.

Mentoring. Numerous parallels are observed with the exploration of aiding novice educators in their new role (Cangelosi, 2014; Loftus et al., 2013; Schoening, 2013). Mentoring is an area identified as beneficial to a novice educator (Loftus et al., 2013). Study findings from Cangelosi (2014) indicated while there is a need for

implementation of a formalized mentoring program, granting time for faculty to devote to mentoring is problematic due to budgetary constraints and faculty shortages. Creating a role model for a new faculty member can play an important part in the development of professional behavior (Yamani, Shakour, & Yousefi, 2016). Mentors can support novice educators in the adaption process in a reliable and constructive way (Takkac Tulgar, 2015).

Studies indicated mentors assist novice educators in alleviating feelings of inadequacy and self-doubt (Takkac Tulgar, 2015; Yamani et al., 2016). A mentor may differ in role and function depending on the academic area, yet the premise is essentially the same (Law et al., 2014). A mentor is defined by Law et al. (2014) as "someone who is usually a colleague in the same work environment and who is more advanced in the workforce" (p. 1).

Mentoring can be traced back to Greek Mythology (Gotian, 2016). A mentor can be referred to as an advisor, coach, a teacher and an advocate (Gotian, 2016). Mentoring has since evolved to a variety of areas and is now considered a professional activity as well as career development strategy where newer professionals learn by shadowing experienced professionals (Harris, 2015).

The use of a mentor helps nurture new staff, raise morale, and reduce turnover rates (Chen, Watson, & Hilton, 2016). There are varying reports on the role of a mentor (Chen et al., 2016; Harris, 2015). Law et al. (2014) stated a mentor is not a coach or friend but is considered more of a cheerleader; an advocate of the novice educator helping in adversarial situations. This definition of mentoring is conflicting to the

findings of Harris (2015) who stated mentors develop strong relationships and can become long lasting friends with their mentee.

A mentor can serve as a guide and resource throughout a novice educators' career (Law et al., 2014). In an article by Johnston, Keller, and Linnhoff, (2014), they purported "Mentoring can contribute to improved teaching as well as being an important tool for professional development of mentors and mentees" (p. 15). Mentors can help guide novice educators through the process of reflecting on the practice as educators (Takkac Tulgar, 2015). Gardner (2014) noted an effective mentor can influence teaching styles.

According to Callahan (2016), a mentoring program is only as good as its mentors and has recognized characteristics which are included in an effective mentoring program. Callahan (2016) identified having highly qualified teachers as mentors, strong professional development opportunities available to mentees, as well as training for the mentor as key components of successful mentoring programs. Having a well-developed mentoring program with clear goals and objectives for mentors to provide information and feedback to the mentee also supports new educators in their role (Callahan, 2016; Klinge, 2015).

While a novice educator may have been assigned a mentor it does not mean the mentor is effective (Gotian, 2016). Mentoring is considered a learned talent, a skill most individuals have not been given the opportunity to learn (Gotian, 2016). Having solid knowledge and expertise in a given field does not necessarily mean the person who possesses the skills will be a good mentor (Gotian, 2016; Takkac Tulgar, 2015). Mentors need to be willing to support mentees and have the appropriate time needed to provide the assistance needed (Loftus et al., 2013).

For effective mentoring to occur, pairing up the right mentor with the mentee is necessary (Klinge, 2015). If a mentee does not feel a mentor is effective, dissatisfaction with the job and the mentor/mentee relationship often occurs (Lozinak, 2016). The institution as a whole must support a mentoring process and appropriate pairing (Klinge, 2015; Lozinak, 2016). Literature identified problems with institutional support, as budgeting does not allow for funding of a mentor to permit them to take the time needed to be an effective mentor (Lozinak, 2016; Schoening, 2013).

In addition, a mentee needs to feel comfortable around a mentor (Klinge, 2015; Welsh & Dixon, 2016). A mentee should be able to practice a skill and feel safe and secure discussing it with the mentor (Klinge, 2015; Welsh & Dixon, 2016). In turn, a mentor is available to give constructive feedback to a mentee (Welsh & Dixon, 2016). Hearing feedback has been found to be an effective tool for a novice educator (Welsh & Dixon, 2016). This practice allowed novice educators to have a safe place to collaborate and discuss problems and solutions (Bradley-Levine, Mosier, & Lee, 2016). Giving mentees the opportunity to problem solve and figure out solutions to problems also lets a novice educator develop feelings of confidence as an educator, thus increasing self-efficacy (Bradley-Levine et al., 2016).

Another effective practice for novice educators occurs when there is time to self-reflect on their practice and evaluate their performance (Takkac Tulgar, 2015). However in the United States, only about a quarter of the universities have a formal mentorship program even though literature shows it is vital to a novice educator (Law et al., 2014; Loftus et al., 2013; Takkac Tulgar, 2015). If no formal mentoring is available, Gardner (2014) stated informal mentoring and support was beneficial for a novice educator.

Support from program directors was also identified as a way to aid novice educators in their new roles (Gresham-Anderson, 2015; McAllister, Oprescu, & Jones, 2014). It is imperative for program directors and department chairs to understand challenges novice educators face when transitioning from a professional field to education (Gresham-Anderson, 2015; Hemmings, 2015; Meanwell & Kleiner, 2014). Allowing novice educators dedicated time to read course material to become familiar with the material, is a strategy to help alleviate feelings of being unprepared and ultimately increase confidence and self-efficacy in new instructors (Cangelosi, 2014; Goodrich, 2014).

Faculty development was also commonly mentioned as a way to help professionals transition from clinical profession to a new role in education (Gresham-Anderson, 2015; Hemmings, 2015; Loftus et al., 2013). For some individuals, teaching is a gift, yet for most instructors it is an art which has to be learned, developed, and mastered (Spencer, 2013). A good faculty development program can aid in improving teaching skills and effectiveness (Behar-Horenstein, Garvan, Catalanotto, Su, & Feng, 2016; Lancaster, Stein, MacLean, Amburgh, & Persky, 2014; Loftus et al., 2013).

Faculty Development

Many would assume health care professionals who have successfully practiced in a clinical setting would also be considered experts in the content of their field (Cangelosi, 2014; Loftus et al., 2013). Because these individuals are health care professionals, they should be adequate educators (Cangelosi, 2014; Loftus et al., 2013). However, it is not always the case (Loftus et al., 2013). Society demands individuals to be competent in both clinical practice and teaching (Anwar & Humayun, 2015). Yet as stated earlier,

many health care educators lack formal education training and qualifications (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). Thus, the need arises for opportunities for health care professionals to develop skills and acquire the knowledge needed to be a successful educator (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013).

According to Behar-Horenstein et al. (2016), a faculty development program helps educators develop a sense of belonging. Evans (2014) stated educational leaders should support and facilitate professional learning and development. Loftus et al. (2013) indicated faculty development programs are aimed to aid educators in teaching abilities. A shared perspective of research conducted by Hemmings (2015) and Singh et al. (2013) is professional development increases self-efficacy in educators as well as a sense of belonging. For faculty development programs to be successful in promoting teacher self-efficacy, positive appraisals, and structured activities must be given in order to encourage success (Rowbotham, 2015).

Faculty development programs vary in degrees from institution to institution (Myer & Murrell, 2014). While there is no structural guideline to what is included in a program, studies have indicated faculty report the need for professional development programs, and specifically request these types of programs in an effort to increase knowledge and enhance teaching skills (Behar-Horenstein et al., 2016; Lancaster et al., 2014; Loftus et al., 2013). Hallmark (2015) theorized developing standards for faculty training creates a more consistent faculty development program.

Evaluations. Authors Malouff, Reid, Wilkes, and Emmerton (2015) completed a study on faculty evaluations. The purpose of the study was to create a systematic

evaluation process that would take feedback found in an evaluation and use it to improve teaching (Malouff et al., 2015). After searching extensively, Malouff et al. (2015) indicated a comprehensive set of steps could be used for evaluation to improve teaching, yet none could not be found. Therefore the team had to develop their own steps using concepts from experts in the field, Albert Bandura and John Dewey (Malouff et al., 2015). According to Malouff et al. (2015), a 14-step process created was used to evaluate several aspects including the course, instructor, and overall rating of the course and instructor. Findings provided initial evidence where the use of a systematic evaluation can have value (Malouff et al., 2015).

In one study a tool was created in an effort to improve teaching effectiveness, the Practical On-Site Cooperation Model (POCom) tool (Park, Kim, Park, Park, & Jeong 2015). The POCom model used a "top-down" method, in which the authors observed classes and tried to improve them without having any pre-determined or pre-developed methods or materials instead of a "bottom- up" approach which included teaching educators a theory and asking them to implement it in a classroom (Park et al., 2015). The study consisted of observation of a specific course for a total of four times (Park et al., 2015). After the first observation, experts in teaching met with the instructors (Park et al., 2015). The experts provided instructors discussion points and gave suggestions on ways to improve instructional effectiveness (Park et al., 2015).

The class was observed three more times, each time experts evaluated changes the teacher made in the course (Park et al., 2015). Park et al. (2015) indicated at the end of the study results indicated some improvement in teaching styles which increased some

test scores. Getting constructive feedback and ideas from other instructors can aid in teaching methods and effectiveness (Blair & Noel, 2014; Fraile & Bosch-Morell, 2015).

Carbone et al. (2015) used a different type of model to assist teachers, a peer-assisted teaching scheme (PATS). This model utilized teachers who supported each other in an effort to improve courses (Carbone et al., 2015). Participants reflected on their courses, worked with another teacher completing a structured exercise at specified times during the semester (Carbone et al., 2015). The approach was very similar to the model used by Park et al. (2015) to increase teaching methods and effectiveness. Both studies indicated an increase in effectiveness was reflected through student evaluations (Carbone et al., 2015; Park et al., 2015).

Feedback from colleagues as well as peer evaluations of a course can provide an educator with an unbiased opinion of their teaching which could result in an improvement to the way a course is taught (Carbone et al., 2014; Park et al., 2015). Stewart (2014) indicated instructors must be comfortable with the evaluator or peers. If instructors are not at ease, receiving feedback in a constructive manner may not occur (Daniels, Pirayoff, & Bessant, 2013; Stewart, 2014).

A study conducted by Tarun and Krueger (2016) assessed the types of test given by an instructor, critical thinking skills related to the test, and impact student evaluations had on faculty's promotion and tenure. The study designed and piloted an alternative student evaluation instrument (Tarun & Krueger, 2016). The tool used five factual questions in the evaluation in an effort to prevent a disengaged student from affecting the results of the evaluation (Tarun & Krueger, 2016). The existing evaluation was also used in an effort to statistically evaluate the two different assessments (Tarun & Krueger,

2016). Findings showed no statistical difference between the two evaluations (Tarun & Krueger, 2016). However, it did reveal the types of test administered, grades, as well as course difficulty influenced the way students evaluated courses (Tarun & Krueger, 2016).

One study by Daniels et al. (2013) created a professional development experience focused on peer observation and organized discussion around an essential question. The focus of the study was to understand if collaboration and peer observation influenced teachers' practice and attitude in a positive way (Daniels et al., 2013). Daniels et al. (2013) postulated teachers are required to differentiate instruction to meet the needs of each student; therefore professional development must also be differentiated to meet the needs of the teachers.

The essential question guiding the study was "How do we know that students are cognitively engaged and learning what we are teaching?" (Daniels et al., 2013, p. 269). The study consisted of three phases (Daniels et al., 2013). In the first phase, educators participating in the study met and talked about essential questions (Daniels et al., 2013). The second phase was the peer observation phase, and the third phase consisted of a formal meeting to discuss essential questions through an organized conversation which used specifics from the observation phase (Daniels et al., 2013).

Findings of the study indicated when an environment encourages collaboration and communication exists; participants can celebrate success, vent frustration, and brainstorm to find solutions to challenges (Daniels et al., 2013). Many participants were reminded of effective practices which had been removed from daily use (Daniels et al., 2013). By creating an environment that allowed for thoughtful analysis of practice, teachers were able to identify areas of which could be improved upon and make

necessary changes (Daniels et al., 2013). Findings of the Daniels et al. (2013) study coincide with Stewart (2014), where observation and collaboration can bring about successful changes to an educator's practice. An additional factor to note of the study was support of administration (Daniels et al., 2013). Support of leadership is an important component to a novice educator (Gresham-Anderson, 2015; McAllister et al., 2014).

Feedback. Student feedback or student evaluations are another method for educators to receive feedback from their courses (Carbone et al., 2015; Fraile & Bosch-Morell, 2014). Student evaluations date back to the first quarter of the century (Fraile & Bosch-Morell, 2014). There are conflicting reports on the effectiveness of student evaluations and the impact on teachers and teaching methods (Carbone et al., 2015; Fraile & Bosch-Morell, 2014).

It should be noted when there is a positive learning environment for students, student satisfaction as well as evaluation scores increase (Carbone et al., 2015). Higher education institutions utilize student evaluations as a way to highlight strengths of courses and lectures as well as identify areas for improvement (Blair & Noel, 2014). However, students do not always fill out evaluations accurately (Carbone et al., 2015; Tarun & Krueger, 2016).

While some educators may take student evaluations and use them to better teaching styles and improve courses, not all educators observe this practice (Malouff et al., 2015). A study conducted by Blair and Noel (2014) looked at student evaluations to determine if the students' voices were being heard. The research focused on the question "How do you think this course could be improved?" (Blair & Noel, 2014, p. 879).

Evaluations were gathered from a specified number of purposefully selected courses based on four criteria developed through literature review and rationality (Blair & Noel, 2014). Overall data analysis suggested educators may listen to some students' recommendations, especially if it pertains to an educator's behaviors or attitudes; however, change in the course is limited (Blair & Noel, 2014). Yet according to Blair and Noel (2014) when feedback relates to teaching strategies and instructional approaches, feedback seems to go unheard. The authors went on to state, findings indicated educators who received overall poor ratings failed to make appropriate changes based on feedback from student evaluations (Blair & Noel, 2014).

The results of the Blair and Noel (2014) study are consistent with findings of Fraile and Bosch-Morell (2014) which also indicated student evaluations can be used for feedback to improve courses and not just for promotion and tenure decisions. Faculty is missing an opportunity to become more effective teachers by not utilizing feedback from student evaluations and making appropriate changes to a course (Blair & Noel, 2014; Fraile & Bosch-Morell, 2014).

Faculty development plans and programs. The purpose of faculty development is "improving faculty perceptions on the value of teaching, increasing motivation and enthusiasm for teaching, increasing knowledge and behaviors, and disseminating skills" (Lancaster et al., 2014, p. 1). There is a lack of exploration on faculty development plans even though faculty development was cited as a need to improve faculty instruction (Lancaster et al., 2014; Loftus et al., 2013). It is important to determine what an effective faculty development program looks like (Lancaster et al., 2014). Programs can range from a one-time workshop, to regularly scheduled seminars, to multi-monthly scholar

programs (Lancaster et al., 2014). Varying structure and function of programs requires the university to look at best options, as they are dependent on key factors such as finances, staff support and faculty time, resources available from the campus, and expertise of faculty and staff members (Lancaster et al., 2014; Saroyan & Trigwell, 2015).

Faculty development is necessary for overall growth and development yet it may not be possible depending on the organization (Jiandani, Bogam, Shah, Prabhu, & Taksande, 2016). New teachers need opportunities to learn how to develop effective teaching skills as well as how to create student-teacher relationships (Lancaster et al., 2014; Loftus et al., 2013). Development of skills and creating relationships can be accomplished through effective faculty development (Behar-Horenstein et al., 2016; Lancaster et al., 2014). Having a strong faculty development program with an encouraging environment, as well as evidence-based practices which meet the distinctive needs of its faculty, will support faculty developing competence in teaching, as well as improve teacher self-efficacy (Loftus et al., 2013; Rowbotham, 2015).

Evans (2014) indicated professional development is not nearly about changing a person's behavior about one's own practice, but " how much they do or produce, or what generative effect their changed practice has – it is also about changes in attitudes, intellectual capacity and mindset" (p. 193). Professional or faculty development is not just being exposed to information by attending a seminar, or working in a formalized mentoring meeting (Evans, 2014; Hemmings, 2015; Jiandani et al., 2016). Evans (2014) and Jiandani et al. (2016) all supported the concept learning can be informal or unstructured and may occur at any time. Hemmings (2015) furthermore concluded less

structured workshops were also used to develop skills for the classroom and increase self-efficacy.

In a study conducted by Jiandani et al. (2016) self-motivation was an important factor for faculty development, requiring an educator to take ownership of their own development. Faculty development is an imperative piece in medical education (Singh et al., 2013). Participants in a recent study by Behar-Horenstein et al. (2016) reported the need for additional faculty development in the areas of

> …classroom management training, training on large and small group interactions, course development, learning better student-teacher dialogue, teaching methodology and skills, and updating technology skills, outcomes assessment and assessment methods, teaching organization and design, peer presentations, educational theory, evaluating critical thinking, interdisciplinary teaching, current trends in education, cooperative learning, publishing, and enhancing student retention of information. (p. 56)

With the aid of faculty development in the above areas, instruction can improve (Behar-Horenstein et al., 2016; Evans, 2014; Hemmings, 2015; Jiandani et al., 2016).

Merillat and Scheibmeir (2016) utilized a faculty enrichment program at a nursing facility in a Midwestern university to assess baseline skills in several aspects of instruction to include learning best practices, teaching, and technology with regards to learning management systems. Goals of a program included measuring the impact the program had on faculty development as it pertained to technology and to look at any

relationships between faculty development and student assessment (Merillat & Scheibmeir, 2016). Findings of the study support the need for faculty development to ensure faculty members are properly educated and trained on a learning management systems and are consistent with the results of other studies conducted (Behar-Horenstein et al., 2016; Loftus et al., 2013; Merillat & Scheibmeir, 2016).

Jetha, Boschma, and Clauson (2016) examined faculty development needs in novice nursing clinical teachers. In this study, the authors were able to identify characteristics of an effective clinical teacher through a review of literature; however, it was unclear how to obtain and support those effective characteristics (Jetha et al., 2015). Findings of the study suggested three evidence-based needs for supporting teaching practices of novice educators; socialization, professional development, and need for self-reflection and confidence (Jetha et al., 2015). Discoveries of the study parallel findings of Behar-Horenstein et al. (2016), Lancaster et al. (2014) and Loftus et al. (2013) where professional development needs include orientation, support, and guidance of institutional policies and practices.

Self-efficacy can be applied to specific situations (Bandura, 1977a). A study conducted by Rowbotham (2015), looked at the impact of faculty development on self-efficacy. The purpose of the study was to identify if teacher self-efficacy, teaching style, and teacher competence were influenced by a faculty development program (Rowbotham, 2015). The study involved two groups, a pre- and post-test quasi-experiment (Rowbotham, 2015). The first group was known as the intervention group and were given three specified tests to measure participants' self-efficacy, teaching competency, and instructional perspectives (Rowbotham, 2015). Various checkpoints

during the year allowed participants of the study to give their perceptive of how effective the program was and if it changed their competence and satisfaction with teaching (Rowbotham, 2015).

The second group in Rowbotham's (2015) study was the control group. The control group was given the same testing at the same point, but participants did not complete the program evaluation (Rowbotham, 2015). A faculty development program was created where an intervention group spent approximately 25 hours attending meetings and participants in learning actives (Rowbotham, 2015).

Findings of the study showed an increase of self-efficacy of the intervention group and a decrease in the control group (Rowbotham, 2015). Results suggest faculty development can increase self-efficacy of the educator and overall satisfaction of teaching (Rowbotham, 2015). Results of the Rowbotham (2015) study support findings faculty development increases self-efficacy (Behar-Horenstein et al., 2016; Jiandani et al., 2016; Lancaster et al., 2014).

Andragogy

Teaching children and adults require different methods and have dissimilar theories associated with them (Knowles, 1970). The term pedagogy is used for the art of teaching children, while andragogy is the art of science of helping adults learn (Knowles, 1970). There is a great deal of literature regarding these two instructional practices (Caruth, 2014; Knowles, 1970; Samaroo, Cooper & Green, 2013). It is beneficial to know similarities and differences of the two learning principles (Knowles, 1970; Samaroo et al., 2013). Peterson and Ray (2013) stated adult learning was not a main focus of educators until recently. The historical view of learning focused on children and

was thought to last throughout a lifetime (Peterson & Ray, 2013). An article written by Samaroo et al. (2013) discussed pedagogy and andragogy by defining both terms using principles of Knowles (1970).

In the pedagogy model, children are placed in a submissive role, require total obedience from a teacher in a classroom, and dependence on the teacher is promoted (Samaroo et al., 2013). The assumption with this practice is a learner only "needs to know what the teacher teaches" (Van Genderen, 2013, p. 78). Caruth (2014) added to the belief by stating the transfer of information requires a student to memorize the information given to them by a teacher.

The pedagogy form of learning is not successful when used with adults (Barr, 2014; Caruth, 2014). Adult learners are identified as self-directed by Knowles (1970), Sogunro (2015), and Barr (2014). All authors stated andragogy plays a part with self-directedness and autonomy as to what motivates learners (Barr, 2014; Knowles, 1970; Sogunro, 2015).

The purpose of learning is to allow personal growth (Barr, 2014). Adult learners are able to take their experiences and use them to aid in the learning process (Caruth, 2014). For adult learning, knowledge should occur by problem-solving skills instead of memorization (Knowles, 1970). Barr (2014) and Van Genderen (2013) arrived at similar conclusions when noting adult students need to feel autonomy and self-worth in their learning. Adult learners need to use their experiences to learn (Caruth, 2014; Sogunro 2015; Van Genderen, 2013). Most adults have vast life experiences which are an important part of who they are and can be readily used to gain additional knowledge (Caruth, 2014; Van Genderen, 2013).

Blakey and Sheffield (2015) discussed the term andragogy and stated while many feel it is not an educational theory, literature notated adults learn differently than children (Caruth, 2014; Donavant, Daniel, & MacKewn, 2013; Leigh, Whitted, & Hamilton, 2015). Adults use their own life experiences to help with the learning process (Barr, 2014; Caruth, 2014; Foote, 2015; Peterson, & Ray, 2013). Learning occurs when an adult learner can take a particular experience and use it to relate to new information (Foote, 2015).

Knowles (1970) identified five characteristics of adult learners: self-concept, experience, readiness to learn, orientation to learning, and motivation to learn. These characteristics are referenced by many when exploring anagogical practices (Knowles, 1970). Foote (2015) added to these features by identifying her own physiognomies when she returned to school as an adult. Her characteristics include the need to know, prior learning experiences, readiness to learn, and finally the motivation to learn (Foote, 2015). Adult learners do not like to be told how, when, and why; instead they want to make their own decisions and be recognized by their ability to do so (Giannoukos, Besas, Galiropoulos, & Hioctour, 2015; Samaroo et al., 2013; Van Genderen, 2013). Adults also want to know why information is needed (Conaway & Zorn-Arnold, 2015).

Education of adults has changed over the years (Loftus et al., 2013). As noted prior, adult learners learn differently from children and because of this difference, a change is required in the way educators teach (Foote, 2015). Looking at an adult learner's experience and using that knowledge is beneficial to both an adult learner and an educator (Conaway & Zorn-Arnold, 2015; Foote, 2015; Van Genderen, 2013). As an

educator, it is important to engage adult learners in ways they become self-directed learners (Leigh et al., 2015).

Donavant et al. (2013) reported faculty acknowledges adults are different than traditional college age students, as well as adding to a classroom environment, teachers often do not see a need to adapt instructional practices to accommodate this group of students. In the Donavant et al. (2013) study a survey was used on faculty from six institutions in Tennessee to determine the views on student interaction with professors, attitudes toward adult students, and attitudes toward mixed-aged classrooms.

Results from the Donavant et al. (2013) survey indicated adult students have a great intrinsic motivation in a classroom. Faculty reported adult learners worked harder on their studies, whereas many believed adults would seek help with material and nearly half of the faculty agreed adult learners had lower absenteeism than traditional students (Donavant et al., 2013). The majority of faculty did not feel having adults in the classroom prevented learning of traditional students and in fact, agreed having adult learners in class created a more informed and diverse perspective (Donavant et al., 2013).

The above study was in contrast to West (2013) who looked at her own teaching practices and transformations which occurred due to her study of adult learning theories. Upon reading a book titled, *Learning to Teach in Higher Ed*, by Ramsden, Ms. West (2013) reflected on the way she had been organizing her coursework. Instead of organizing courses in a manner where assignment deadlines dictated the course, concepts and understandings were used for end points (West, 2013). Course schedules were developed based on the institution's breaks and amount of assignments turned in a

particular week in an effort to ensure two courses did not submit large assignments to be graded in the same week (West, 2013).

Ms. West's view on teaching and learning is a "collaborative enterprises" (p. 13) and stated humans through interactions with other humans construct knowledge for themselves (West, 2013). Peterson & Ray (2013) concurred by affirming adult learners prosper when using collaborative learning. Social learning is done by observing, interacting, trial and error, and by trying to makes some sort of sense of the experience (Bandura, 1977a, 1986). Ms. West's goal as an educator was to help students with their understanding of teaching and learning, which is in direct opposition to a pedagogical way of teaching (Peterson & Ray, 2013; West, 2013).

The role of an educator is more than just providing students with a "toolbox box of instructional learning" (West, 2013, p. 13). A goal of an educator is to help students "develop a deep conceptual understanding of how children learn and a firm theoretical foundation on which to build their teaching practice" (West, 2013, p. 13). This view differs vastly from a study from Donavant et al. (2013), where results found a lack of understanding of good educational methodology with regards to adults entering higher education. Donavant et al. (2013) recommend educators should want to adapt research-based instructional methods in the undergraduate arena to help foster learning of adult learners however many do not feel the need to adapt.

According to Caruth (2014) over the past five decades, students 50 years of age or older are enrolling in higher education. While there is literature available supporting the need for institutions to acknowledge an adult learner, the focus tends to remain on traditional students (Caruth, 2014; Donavant et al., 2013). Institutions then find

themselves trying to figure out what to do when enrollment declines (Caruth, 2014). Several universities' programs that utilized andragogical theories in their curriculum created a better learning experience for students (Barr, 2014; Leigh et al., 2015; West, 2013). Therefore, faculty must incorporate andragogy into learning activities (Barr, 2014; Leigh et al., 2015; West, 2013). The andragogy method occurs when faculty act as guides in the learning process and encourage students to participate using a connection to their own experiences to the content (West, 2013). Increasing knowledge in any area allows for personal growth, in essence, the pupil is really just learning how to learn (Barr, 2014; Leigh et al., 2015; West, 2013).

An important aspect of the adult learning process is for faculty members to employ and engaging approach to all for self-directed learning on behalf of the students (Peterson & Ray, 2013; West, 2013). According to Leigh et al. (2015), learner-centered methods help to aid learning by adults. This approach should apply to program development, training strategies, and student evaluation (Leigh et al., 2015). Using teaching strategies to include reflections, self-awareness, self-direction, and self-evaluation can be used **(**Leigh et al., 2015; West 2013).

Motivation plays an important role in adult learning (Bandura, 1977a). Sogunro (2015) identified motivating factors for adult learners in higher education. Factors included overseeing the quality of instruction and curriculum (Sogunro, 2015). In addition, the relevance and pragmatisms of a course and assignments were also acknowledged (Sogunro, 2015).

Other motivating factors Sogunro (2015) identified included assessing how interactive classrooms lessons were, as well as the effective management practices.

Progressive assessments and timely feedback from an instructor were other areas measured (Sogunro, 2015). Finally, the two areas of motivation in adult learning identified by Sogunro (2015) were the self-directedness of a course along with a conducive learning environment and effective academic advising practices. Research is consistent with findings of these motivating factors of adult learners (Barr, 2014; Caruth, 2014; Leigh et al., 2015).

Murray et al. (2014) looked at conversational moves by professors to change the relationships they have with students to move students from a childlike pattern to a more andragogical pattern of learning. This type of transition can occur through conversations encouraging a student to take more personal responsibility, become more self-directed, and rely more on intrinsic motivation (Murray et al., 2014). The literature is supportive of a transition from a childlike pattern of learning to a more andragogical pattern (Barr, 2014; Caruth, 2014; Leigh et al., 2015). Van Genderen (2013) added to the above concept stating adults want to be self-directed and have a broad base of knowledge, which would allow for experiential learning. Empowering people to use self-directed learning can produce this type of transition (Van Genderen, 2013). The development of online learning allows for adult learners to pursue an education relying upon their self-direction (Van Genderen, 2013).

Online learning is becoming increasingly popular (Burton & Bessette, 2013). According to Conaway and Zorn-Arnold (2015), changes in learning platforms allow adults to learn expediently and apply knowledge to the workforce. While education may be done online, educational expectations do not change for this manner of learning (Blackley & Sheffield, 2015; Burton & Bessette, 2013). Proper preparation for online

coursework must be done in order to merge the understanding of online education with the changing society of today (Burton & Bessette, 2013). Many faculty members do not have experience teaching online (Caruth, 2014). It is important for faculty to identify an effective way to facilitate an online course and utilize the appropriate tools for teaching in this manner (Burton & Bessette 2013; Caruth 2014). By not adopting additional tools into practice, educators are limiting themselves as well as students (Burton & Bessette 2013; Caruth 2014). It is imperative for educators to ensure content is being delivered through andragogical means (Burton & Bessette, 2013).

Summary

The transition from professional to educator is a challenge many novice instructors face when entering the world of education (Gresham-Anderson, 2015; Loftus et al., 2013; Schoening, 2013). Expertise in one's professional field does not assist them in the field of education (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). Studies show this deficit often leads to feelings of inadequacy in the new role of an educator (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Murray et al., 2014; Schoening, 2013).

Utilizing the writings of Albert Bandura's (1977a, 1977b, 1986, 1997) social learning theory as the theoretical framework, it is clear how the theory applies to individuals who leave their health profession to become educators. Many times, teachers model methods they were taught or observed others use. In self-efficacy theory, also studied by Bandura, (1977a, 1977b, 1997) theorized a person has control to achieve a task or activity. Factors affecting self-efficacy are behaviors, environment, and personal/cognitive factors (Bandura, 1977a, 1977b, 1997).

Mentoring, orientation programs, and professional development are mentioned in the literature as ways to not only alleviate feelings of inadequacy but create a more positive environment for educators which has a direct impact on learning achieved by students (Evans, 2014; Jiandani et al., 2016). Mentors can serve as a guide and resource throughout a novice educators' career in teaching (Law et al., 2014). Yet mentoring programs are only as good as a mentor, and many institutions lack in supporting a mentoring program due to time and money (Callahan, 2016; Lozinak, 2016; Schoening, 2013). Student and faculty evaluations are other methods used to improve teaching methodology and courses (Carbone et al., 2015; Park et al., 2015).

Findings from literature indicated faculty evaluation can be very effective if properly constructed using observation and collaboration sessions (Daniels et al., 2013; Stewart, 2014). Student evaluations can provide great feedback to instructors, yet studies indicate many instructors do not use feedback to improve teaching; evaluations tend to be used more towards rank and promotion (Carbone et al., 2015; Fraile & Bosch-Morell, 2014; Malouff et al., 2015). The study of adult learning, based on the writings of Malcom Knowles (1970), aids in the development of teaching novice educators as adult learning differs from traditional pedagogy (Conaway & Zorn-Arnold, 2015; Foote, 2015; Van Genderen, 2013).

Utilizing andragogy theories in institutions' curriculum creates better learning experiences for students (Barr, 2014; Leigh et al., 2015; West, 2013). Therefore, faculty must incorporate andragogy into learning activities (Barr, 2014; Leigh et al., 2015; West, 2013). Motivation plays an important factor for adult learners (Barr, 2014; Caruth, 2014; Leigh et al., 2015).

In Chapter Three, the methodology of the study is provided. The research design is discussed as well as the ethical considerations of the study. Instrumentation of the study is addressed along with the protocols and steps to ensure the validity and reliability of the study. The population and sample of the study are identified. Finally, the plan and steps of data collection, as well as data analysis, are discussed.

Chapter Three: Methodology

Allied health professionals who transition into the academic world often find themselves treading in unchartered water (Gresham-Anderson, 2015; Loftus et al., 2013; Schoening, 2013). Lack of requirements regarding educational background and requirements for being a teacher of adults puts novice educators in positions where feelings of uncertainty and anxiousness may arise (Loftus et al., 2013; Steketee & Bate, 2013). Educators play an important role in a student's learning (Gresham-Anderson, 2015; Loftus et al., 2013).

While teaching is often the primary focus of an educator, it is not the only duty they face (Loftus et al., 2013). Novice educators find themselves struggling with advising students on educational planning, devoting time on college committees, and collaborating with other educators in research, all while trying to learn how to identify with their new role as educators (Loftus et al., 2013; Schoening, 2013). Students are not "one size fits all" when it comes to learning (Foote, 2015; Knowles, 1970). Educators must be able to adapt to different learning styles of students (Foote, 2015). Nursing and allied health care programs tend to recruit students of all age ranges (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016).

It is important educators know and understand pedagogy and andragogy to implement teaching techniques needed to accommodate various age groups of students (Donavant et al, 2013; Loftus et al., 2013). Without formal training in teaching, individuals in the nursing and allied health care field who have transitioned from clinical

practice to education often struggle with many of the above scenarios (Loftus et al., 2013; Schoening, 2013).

The transition from professional clinical practitioner to educator can be very difficult and challenging for a novice educator (Loftus et al., 2013; Steketee & Bate, 2013). Concentration of this research study was on gauging the self-efficacy of individuals who were professionals in a health care clinical setting but have since transitioned to a role of an educator in a nursing or allied health program. Different aspects of teaching and areas such as training and faculty development are addressed in regards to self-efficacy. Knowledge and implementation of andragogy are also assessed. Identification of any barriers these educators faced were evaluated. Understanding the steps novice educators took to enhance instruction in an effort to provide a quality education for students in the respected nursing and allied health programs was an essential component of this study.

In order to collect data required for this particular study, survey research was utilized. Surveys are conducted to "describe characteristics of a population" (Fraenkel et al., 2016, p. 391). Survey research is accomplished by asking questions and the responses become the information of the study (Fink, 2017; Fraenkel et al., 2016). Utilization of a sample population instead of selecting every member from the population is done for this type of study (Fraenkel et al., 2016).

In this chapter an overview of the problem and purpose of the study along with the research questions of the study are given. The research design best suited for this study is outlined along with any ethical considerations of the study. The population and

sample of the study is identified in addition to the instrumentation used for the study. Finally, data, collection and analysis procedures are reviewed.

Problem and Purpose Overview

Individuals entering the nursing and allied health care profession participate in extensive education and training in a specialty area (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016). After years of experience, individuals become experts in a health care profession role (Loftus et al., 2013). Health care professionals have extensive experience in their chosen profession and feel confident in their clinical abilities (Loftus et al., 2013). When educational positions become available, experienced health care professionals become novice educators (Loftus et al., 2013; Schoening, 2013).

Regardless of the level of their previous training, often times health care professionals are thrust into the academic world with little to no education or knowledge on the role of an educator (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Schoening, 2013). Novice educators can lack the knowledge needed for teaching specialty health care areas, as well as lack understanding of andragogy and how it pertains to the role of an educator (Donavant et al., 2013; Loftus et al., 2013). The review of literature in this study supports the need to evaluate the self-efficacy of novice educators and to view steps educators take to improve overall teaching (Evans, 2014).

The purpose of this study was to assess levels of self-efficacy of novice educators as it pertains to their overall desire to enhance knowledge of educational instruction and subsequently augment development in the field of teaching. Participants of the study rated their self-efficacy in clinical practice and then after entering the field of education.

How the change from clinical practice to education affected their self-efficacy was also evaluated (Evans, 2014). Steps educators took to improve knowledge in andragogy and the execution of this knowledge was also assessed (Conaway & Zorn-Arnold, 2015; Foote, 2015). Opportunities provided by institutions to educators which included mentoring and professional development were also considered. Identification of barriers preventing health care educators to become successful teachers was explored as well as what opportunities educators took to improve self-efficacy (Frantz & Smith, 2013; Loftus et al., 2013). Finally, perceived self-efficacy with regards to areas of instruction at the beginning of the teaching career and current self-efficacy was evaluated.

Research questions.

This study was designed to answer the following research questions:

1. How has the self-efficacy level of health care professionals changed from the time they entered the higher education teaching field to the present?

2. What types of opportunities do novice health care educators report improved their knowledge and execution of andragogy?

3. What barriers do health care educators report having to overcome in an effort towards becoming a teacher in higher education?

4. What personal actions, or opportunities, do health care educators with no prior experience or training in educational practices seek in an effort to improve their implementation of andragogy?

Research Design

Many different methods can be used to conduct research, depending on the type of study (Creswell, 2014; Fraenkel et al., 2016). Research design is known as the plan and procedures needed to take a study from broad assumptions to detailed methods of

data collection and analysis (Creswell, 2014). Essentially, there are three common types of research designs; quantitative, qualitative, and mixed methods (Creswell, 2014; Fraenkel et al., 2016). Qualitative methods tend to use words whereas quantitative focuses more on numbers and mixed methods use words and numbers (Creswell, 2014; Fraenkel et al., 2016). Quantitative and qualitative methods differ in the thought process on the purpose of a study, what type of methods are used by a researcher, the types of studies done, the actual role a researcher plays in a study, and the degree to which generalization is possible (Fraenkel et al., 2016). Mixed methods can be advantageous as it utilizes both methods and allows a researcher to gather data and analyze more and different types of data than when utilizing only one method (Fraenkel et al., 2016).

When using quantitative research, a researcher is looking to establish relationships between variables, discover, and on occasion explain the causes of the relationship (Fraenkel et al., 2016). Whereas according to Fraenkel et al. (2016) qualitative researchers desire to understand participants view on a situation or event. Mixed methods allow a researcher to establish a relationship and understand a situation (Fraenkel et al., 2016).

In this study, a quantitative methodology was chosen as the most appropriate approach to answer the research questions**.** Kazdin (2003) indicated a quantitative study is used to identify causal relations and find group differences or any patterns. Fraenkel et al. (2016) suggested quantitative research is examination through data collection and analysis for clarification of occurrences. According to Creswell (2014), in quantitative research "variables can be measured, typically on instruments, so the numbered data can be analyzed using statistical procedures" (p. 247). The purpose of the study was to look

at the perceived self-efficacy of nursing and allied health professionals at the beginning of their teaching career, where it is currently, as well as identify the effects faculty development had on the self-efficacy of these educators.

There are many different scientific methods of research, which include: experimental research, causal-comparative research, survey research, ethnographic research, historical research action research, and evaluation research (Fraenkel et al., 2016). Looking at each of these methods as well as the research questions, survey research was identified as the best method for this study. Reasoning for this type of research includes the study needed to cover a large geographical area in an inexpensive way (Fink, 2017). This can be accomplished by accessing email addresses on public websites; the online survey tool is easily accessible and will produce real time results as each person completes the survey (Fink, 2017).

The main purposes of a survey is to collect information from individuals to "describe, compare, or explain their knowledge, feelings, values, and behaviors." (Fink, 2017, p. 1). Fraenkel et al. (2016) stated surveys help find characters of a population and get opinions about a particular topic or issue. Surveys are usually self-administered questionnaires, which can be sent out electronically to a large population with little to no cost (Fink, 2017). In an effort to gain information needed, considering the population size, the use of survey research was utilized in this study to gain data of how faculty development affects self-efficacy of educators in nursing and allied health programs (Fink, 2017).

Qualitative methodology was considered and rejected as an option for methodology for this study as it was not considered the most effective way to quantify a

researcher's point (Fraenkel et al., 2016). Qualitative research looks at discovering and understanding what individuals in a group feel about a social or human problem (Creswell, 2014). Fraenkel et al. (2016) stated qualitative research is where the intricacy of occurrences is considered. Qualitative methodology involves a researcher collecting data via means such as; interviews, observation, documents, and audio-visual material. (Fraenkel et al., 2016). In many cases with qualitative research, a researcher is the critical instrument in this type of study (Fraenkel et al., 2016). Once data was collected, the researcher then analyzed and interpreted the information and reported the findings.

The overall objective of this study was to identify motivating factors novice educators have concerning improving teaching methods by the use of an electronic survey. Based on the objective of the study and the definitions of quantitative and qualitative; quantitative was preferred methodology over qualitative. The completed survey supplied data needed to help identify if there were any trends that improved the self-efficacy of novice educators with regards to professional development. Any barriers educators faced would be recognized as well as how educators rated their self-efficacy in regards to teaching. The educators' knowledge and execution of andragogy was also explored.

Ethical Considerations

Ethical considerations are very important components to take into deliberation when conducting research (Creswell, 2014). It is the responsibility of the researcher to do everything to protect the participants from any danger, discomfort, harm, or psychological damages (Fraenkel et al., 2016). A researcher must be aware of any potential ethical concerns during the investigation process (Fraenkel et al., 2016). It is

vital participants in this study be protected and subsequently assured confidentiality and anonymity will be ensured (Fraenkel et al., 2016). The participants were provided with an Informed Consent Form (see Appendix A) which contained detailed information regarding the purpose of the study, any risk, and benefits if any, of participating in the study, measures taken to ensure confidentiality of the study, along with approximate time required to participate in the study. Consent was obtained before the start of the survey.

To ensure security of data, safety measures such as safeguarding all electronic data by the use of a password on personal computer and the use of a secured site to protect confidentiality of the participants of the study was used (Fink, 2017). Participants were advised a possibility that comments made during the study may be recognized with approximation and modification in place. Data from this study will be kept for three years and then shredded (Creswell, 2014).

Population and Sample

This type of study could have been conducted at any geographical location using universities offering nursing and allied health programs (Fraenkel et al., 2016). Missouri has 52 higher educational institutions that include, 13 public four-year universities, 12 public two-year colleges, 1 public two-year technical college, 25 independent colleges, and more than 150 proprietary and private career schools (Missouri Department of Higher Education, 2016). Participants for this particular study were selected using nonrandom purposive sampling (Fraenkel et al., 2016). Fraenkel et al. (2016) indicated nonrandom purposive sampling allows for selecting specific individuals with certain qualifications. The participants of this study were educators in nursing and allied health care programs located at six colleges or university which included 1 public two-year

college, 1 pubic four-year university, and 4 private four-year universities. Programs included in the allied health care field were radiography, nursing, dental hygiene, paramedic, and respiratory therapy. By selecting specified locations, the population size was reduced to allow for a manageable study (Fraenkel et al., 2016). Ultimately, after distributing 202 surveys to participants, the sample size of the study was 63.

Instrumentation

To obtain data needed for this study, a survey instrument was developed specifically for this study (see Appendix B). The use of a survey was identified as the most effective means to gather information for the research questions (Fink, 2017). There are two types of surveys, cross-sectional surveys and longitudinal surveys (Fraenkel et al., 2016). Cross-sectional surveys are used when predetermined populations are surveyed at one point in time (Fraenkel et al., 2016). Longitudinal surveys collect information at varying points in time to look at changes which occur over a period of time (Fraenkel et al., 2016). Since the study only necessitated data be collected on nursing and allied health care educators in a specified geographic location and only one time, it was determined a cross-sectional survey would be used (Fink, 2017; Fraenkel et al., 2016).

In an effort to reach large numbers of participants in a relativity inexpensive way, an online survey was utilized (Fink, 2017; Fraenkel et al., 2016). No survey was in existence to answer the research questions tied to this study; therefore a unique electronic survey was developed for the study (Fraenkel, 2016). The survey was composed of specified closed-end questions divided into three parts. The first part was the demographics section. The second part of the survey asked questions regarding

participants' self-efficacy and the final part addressed the transition participants made from clinical practitioner to educator. Questions were designed to identify the self-efficacy of novice educators prior to their role change to education as well as where their self-efficacy is currently. The types of opportunities used to improve knowledge and execution of andragogy, identification of barriers, as well as personal action taken to improve overall instructional practices were also questions asked.

The survey tool, Qualtrics, was utilized for the study. Qualtrics is a web-based service, which easily allows researchers to create surveys (Qualtrics, 2017). Reporting features of Qualtrics allows data to be exported for further analysis by the researcher (Qualtrics, 2017).

The survey included the use of a Likert scale. A Likert scale defined by Davis et al. (2013) is a "questionnaire that requires individuals to indicate their degree of agreement or disagreement with a set of statements" (p. 607). An advantage to this type of survey is it is easily quantified which allowed the researcher to make comparisons (Fink, 2017; Frankel et al., 2017). Another advantage is several items can be combined to form an attitude scale (Davis et al., 2013). Participants were asked to rate the questions using either a five-scale rating ranging from strongly disagree to strongly agree or a five-scale rating ranging from low to high.

To check for validity, the survey was pilot tested to ensure appropriate formatting, questions, and scales of the test (Creswell, 2014). Fink (2017) stated the purpose of pilot testing ensures the survey provides the information needed for the study. Pilot testing also helps to determine if questions are clearly written and allows for verification participant understands the directions needed to provide an appropriate answer to the

survey questions (Fink, 2017). According to Fink (2017) and Fraenkel et al. (2016), pilot testing helps eliminate any problems and can be remedied prior to the administration of the survey to guarantee the survey runs efficiently.

The pilot test survey was given to faculty of nursing and allied health programs who did not participate in the actual study. Validity according to Fraenkel et al. (2016) "… refers to the appropriateness, correctness, meaningfulness, and usefulness of the specific inferences researchers make based on the data they collect" (p. 163). It is important to produce a valid survey in order to obtain accurate information for the study (Fraenkel et al., 2016).

The survey must also be reliable (Fink, 2017; Fraenkel et al., 2016). Fraenkel et al. (2016) explained reliability as it "refers to the consistency of the scores obtained- how consistent they are for each individual from one administration of an instrument to another and from one set of items to another" (p. 155). A reliable survey will have consistent results (Fink, 2017). Checking for internal consistency can be done to ensure reliability (Frankel et al., 2016). Several methods can be used to estimate reliability (Fraenkel et al., 2016).

The Cronbach Alpha test, used to calculate the alpha coefficient, was administered upon completion of the survey (Fraenkel et al., 2016). Internal consistency is expressed as a number between 0 and 1 and is used to describe the degree to which items in a test measure the same concept ensuring consistent scores (Tavakol & Dennick, 2011). Internal consistency reliability defines consistency of results delivered in a test (Fraenkel et al., 2016). If a test has more than one concept or idea, it would not be valuable to report alpha for the entire test as it will inflate the value of the alpha (Fraenkel

et al., 2016; Tavakol & Dennick, 2011). Instead, each section or group of questions should be calculated separately (Fraenkel et al., 2016; Tavakol & Dennick, 2011). Cronbach Alpha calculates the alpha coefficient when scoring items without a right or wrong answer (Fraenkel et al., 2016)

Data Collection

Research began once Lindenwood University's Institutional Review Board granted approval (see Appendix C). Because the researcher is an employee of one of the colleges being surveyed, approval was granted through the college's internal review board. In acquiring data needed for this study, college and university websites were utilized to search for faculty identified in nursing and allied health care programs needed. The public websites provide published email addresses of specified educators needed for the study. An email was sent out to potential participants identified as needed for the survey (see Appendix D). The email included an explanation of the purpose of the voluntary research along with a survey link.

Before anyone began the survey, a digital consent form was obtained. The form was located at the beginning of the survey. Once consent was given, the survey was made available to the participants. The survey was open for four weeks to allow for receipt, review, and completion (Fraenkel et al., 2016). A reminder email was sent out asking for participation two weeks prior to the end of the survey (see Appendix E). A final email was sent out the day prior to the closing of the survey (see Appendix F). Once the survey was closed, data was downloaded from the Qualtrics website and collected for analysis.

Data Analysis

The use of descriptive statistics provided a summary about the sample and responses to the survey questions (Fink, 2017). The study looked at the frequency and mode of each question to gather pertinent information needed to answer the research questions (Fraenkel et al, 2016). Fraenkel et al. (2016) stated to make sense of the data collected, it needs to be put in order. This was accomplished by creating a frequency distribution (Fraenkel et al., 2016).

To analyze results of the survey descriptive statistics were used. Descriptive statistics allows for summarization of data (Creswell, 2014). According to Fraenkel et al. (2016), the major benefit of descriptive statistics is "they permit researchers to describe the information contained in many, many scores with just a few indices…" (p. 187). Descriptive statistics allows for analysis of data techniques to let the researcher describe data with numerical indices or in a graphic form (Fraenkel et al., 2016). The use of an instrument can be used for statistical analysis of numbered data (Creswell, 2014). From the results, generalizations and claims were made by the researcher regarding self-efficacy in novice educators.

Summary

The concentration of the quantitative study was to identify the self-efficacy of novice educators in nursing and allied health programs. Data were gathered by means of an electronic survey in order to gain information on the self-efficacy of the participants when practicing as a health care professional. Self-efficacy was also addressed as participants reported changes as they transitioned to being an educator. The participants were asked about their knowledge and execution of andragogy, as well as opportunities

taken to improve knowledge and execution of andragogy. Participants were also questioned about taking any initiative to seek out ways to improve their self-efficacy in teaching, what professional development opportunities their institution provided, and if they were provided a mentor.

In Chapter Three the research problem and purpose were presented, along with the research questions and instrumentation used for the study was discussed in detail. The ethical concerns, population, and sample were identified. Survey research was used for the quantitative study in a form of an electronic survey. Qualtrics online survey program was utilized to send out the survey to a specified population. Data collected over a four-week time span of the survey was used and analyzed using descriptive statistics.

In Chapter Four, data obtained in the survey needed to answer the research questions of the study are provided. Summaries of participants' responses to each question are given using descriptive analysis. Comparisons of educators' perceived self-efficacy at the beginning of their career and current self-efficacy in teaching are made. The educator's knowledge of andragogy is evaluated and results reported. Any barriers identified in teaching and opportunities for faculty development are identified and reported.

Chapter Four: Analysis of Data

The study was designed to gather data on the perceived self-efficacy of educators in nursing and allied health care programs. Other information to be gleaned from the study included the educator's knowledge of andragogy and barriers or obstacles they faced when leaving clinical practice and transitioning into education. The types of opportunities educators took to improve teaching skills was also evaluated. Results of the study are presented in this chapter.

A survey was created to obtain required data needed for the study. The population of the study was identified and email addresses were obtained. The survey was then sent out to the participants. A reminder email was sent out two weeks later with a final email sent out the day prior to the end of the survey.

In this chapter, analysis of data collected is discussed in detail. Participants of the study are described in the demographics section. Results of the survey answers are given in descriptive and table format to show the findings. The results of the Cronbach Alpha test for reliability are reviewed. Finally, a summary of Chapter Four is given as well as an introduction of Chapter Five.

Analysis of Data

The survey used to collect data for the study was presented in three major components; demographics, self-efficacy, and transition from clinical practitioner to educator. Questions 1-7 pertain to the demographics of the participants. Questions 9-13 were related to self-efficacy. Educators participating in the study were asked to rate themselves in the area of self-efficacy. In the last component of the survey, questions

14-26, presented content centered on the transition from clinical practitioner to educator as well as asking specific questions regarding andragogy.

Demographics. In order to understand more clearly the participants in the study, the first questions presented in the survey were demographic in nature. These questions helped to identify the exact population of the participants by inquiring about education and work information. Facts regarding the type of institution as well as the type of program educators were employed with were also identified in the demographics section.

Two hundred and two surveys were sent out by email to a variety of different health care educators. Participants were identified to be either nursing, paramedic, respiratory therapy, dental hygiene or radiologic technology faculty members in a specified region in Southwest Missouri. The sample taken for the study was nonrandom purposive, meaning, participants were chosen because of specific knowledge they could share (Fink, 2017). Of 220 possible survey candidates, 68 assented to complete the survey. In all, 63 surveys were returned indicating a 30% response rate. A response rate of 70-80% has been noted as indicative of a good response rate for a survey, however, a definitive number to quantify survey responses as good or bad varies depending on the resource cited (Fink, 2017; Fraenkel et al., 2016). It should be noted not all survey questions were answered completely by all respondents.

The first question in the demographics section of the survey was designed to obtain responses about the type of institution where participants worked. Seventy-four percent reported working at four-year universities, 14% worked at community colleges, 3% were employed by a certificate or diploma program, and 9% of individuals selected the *other* category. The level of education held by the participants was widespread.

Most contributors to the study reported having graduate degrees while only a few reported only having a bachelor's degree. No participants in the study reported having an associate's degree.

It was important to determine the types of academic programs where participants served as instructors. Nursing had the most representation with 70% reporting teaching in a nursing program. Dental hygiene and radiologic technology had the next highest level of responders with 12% each and EMT/paramedic and respiratory therapy both reporting 1%. Three participants selected *othe*r in which an advanced specialty of a radiography program was specified.

Participants were also asked to report number of years of experience practicing in their clinical profession prior to entering into the teaching world. Clinical experiences of the respondents were varied. In Table 1, participants' years of experience are presented.

Table 1

Number of Years Practicing in Clinical Profession Prior to Role of an Educator

Number of years	Less than 5	6-10	11-20	21-30	30+
Number of Educators	12	13	19	15	4

Note. N = 63.

The next questions in the demographic section presented asked participants to identify the number of years taught in higher education. The responses were varied for this question. In Table 2, the years of teaching experience is presented.

Table 2

Number of Years Teaching Experience

Number of years	Less than 5	6-10	11-20	21-30	30+
Number of Educators	19	24	16	3	1

Note. $N = 63$.

Degrees offered at each of the institutions was also a question presented to participants. For this study, choices of certificates through master's degrees were presented as an option and participants were instructed to select all choices that applied to their institution. Twenty-four percent of educators reported their institution offered certificate/diploma degrees, whereas 71% of respondents reported offering associate's degrees. Eighty-four percent of educators stated their institution offered bachelor degrees and 82% of educators stated their institution offered master's degrees.

The participants were also asked to identify the type of program they taught in. The responses to this question varied. Thirteen percent of respondents reported teaching in a dental hygiene program and 2% of educators reported being part of an EMT/paramedic program. Nursing had the highest number of participants with 71% reported teaching in a nursing program, whereas 13% of educators reported instructing in a radiologic technology program and only 2% of educators reported teaching in a respiratory therapy program.

Self-efficacy. Questions 8-13 on the survey pertained to perceived levels of self-efficacy. The term *self-efficacy* was defined for participants. A five-point Likert Scale was used to help participants rate their level of self-efficacy using a rating of *Low,*

Somewhat low, Neither low or high, Somewhat high, and High. Results of each survey question will be discussed individually in the following section.

Survey question 8. The question, *I would rate my current self-efficacy with regards to teaching as*…, was asked of all participants. Sixty-two participants responded which equated to a response rate of 98%. Of this percentage, no instructors reported self-efficacy as being low. Five percent of responders reported current self-efficacy as somewhat low, 14% reported self-efficacy as being neither low or high and self-efficacy was reported as somewhat high by 50% of instructors. Finally, 31% reported a self-efficacy of being high.

Survey question 9. The question, *When I first started teaching I would rate my self-efficacy as*…, was asked of all participants. Sixty-two participants responded to this question. Fifteen percent of responders reported self-efficacy when they first started teaching was low, 32% reported self-efficacy as somewhat low. Twenty-seven percent of educators reported self-efficacy as neither low or high and 21% of instructors reported having a somewhat high self-efficacy. Lastly, 5% reported having a high self-efficacy.

Survey question 10. The question, *I would rate my self-efficacy when I was in clinical practice as*…, was asked of all participants. Sixty-one participants responded to this question. No participants reported a low self-efficacy. Three percent of responders reported self-efficacy in clinical practice as somewhat low, whereas 7% reported self-efficacy in clinical practice as neither low or high, and self-efficacy was reported as somewhat high by 34 % of instructors. Finally, 56% reported self-efficacy in clinical practice as high.

Survey question 11. The question, *The change from clinical practice to teaching in academia change my self-efficacy*…, was presented as a five-point Likert Scale to help participants rate self-efficacy using a rating of S*trongly disagree, Disagree, Neutral, Agree and Strongly agree.* Sixty-one participants of the survey responded to this question. Three percent of respondents reported strongly disagreeing self-efficacy changed, 8% disagreed with the question, and 25% answered neutral to a change in self-efficacy. Fifty-one percent agreed self-efficacy changed when entering academia and 13% strongly agreed self-efficacy changed.

***Survey question 12*.** The question, *Prior to this survey, I have been exposed to the concept of self-efficacy*…, was asked of participants. For this question, sixty-two participants responded to the survey. Of this percentage, none of the participants reported strongly disagreeing with having been exposed to self-efficacy prior to the survey, whereas 16% disagreed with the statement and 11% reported a neutral response. Forty-seven percent agreed they had been exposed to self-efficacy and 26% reported strongly agreed to having been exposed to self-efficacy prior to the survey.

***Survey question 13*.** The question, *I am successful in teaching my healthcare occupation to student*…, was asked of participants. For this question, sixty-one participants replied. In response to this question, none of the participants answered strongly disagree or disagree in relationship to being successful in teaching their healthcare occupation. Six percent reported a neutral response, while 38% of participants agreed they were successful teaching their occupation. Finally, 56% of participants strongly agreed with successfully teaching their area of healthcare to students.

Transition from clinical practitioner to educator. The third and final component of the survey included questions surrounding the transition from clinical practitioner to becoming an educator. This section was comprised of questions 14-26. Prior to question 14, the term *andragogy* was defined to the participants. The explanation was followed with questions regarding participant responses in regards to transitioning from clinical practice to the role of an educator.

Survey question 14. The question, *When transitioning to the role of educator, I was given instruction in andragogy*…, was presented to all participants of the study. Sixty-one participants answered this question about training in regards to adult learning and the answers given were varied. Over half of participants in the study responded strongly disagreeing or disagreeing they were given instruction in andragogy. More specifically, 13% of those who took the survey responded strongly disagreed, while 39% of participants disagreed in regards to being given instruction. Only 4% of educators replied with neutral response. Thirty-four percent of survey responders noted being given instructions on andragogy while 7% of responders reported strongly agreeing to the statement about instruction in andragogy.

Survey question 15. The question, *I have had formalized instruction in teaching*…, was asked of participants. Sixty-one participants answered this question. Five percent of educators strongly disagreed they were given formalized instruction in teaching, while 26% of educators disagreed. None of the educators gave a neutral response. Over half of participants in the study responded strongly agreed or agreed in their response about formalized instruction in teaching. Thirty-six percent of educators

agreed having formalized instruction in teaching and 33% of respondents strongly agreed about being given instruction in teaching.

Survey question 16. The question, I *was provided a mentor when I transitioned from clinical practice to academia*…, was asked of participants. Sixty-one participants answered Question 16. Once again, the responses to this question varied. Over half of participants in the study responded strongly disagree or disagree in response to being provided a mentor. Twenty-eight percent of the educators strongly disagreed they were provided a mentor and 28% disagreed with being provided a mentor. Eleven percent of participants responded neutrally to this question. Thirty-eight percent of educators responded in agreement of being provided a mentor and 13% strongly agreed they were provided a mentor when transitioning from clinical practice to academia.

Survey question 17. The question, I *was provided a mentor who supported my transition from clinical to academia* was asked of participants. Sixty-one percent of educators replied to this question. Ten percent of educators in the study responded they strongly disagreed a mentor supported them, and 34% responded disagree to the question a mentor supported them in the transition. Sixteen percent of responders in this study gave a neutral response to this question. Forty percent of respondents, or less than half, agreed or strongly agreed a mentor was assigned to support the transition to teaching, 28% and 12% respectfully.

Survey question 18. The question, *I was given training in teaching and other resources when transitioning from clinical to academia*…, was asked of participants. Sixty participants answered question 18. Twenty-seven percent of educators strongly disagreed being given training and other resources when transitioning from clinical to

academia. Thirty-five percent of respondents reported disagreeing they were given training and other resources. Twenty-two percent of educators who responded to this question did so as neutral. Thirty-three educators agreed with being given training and other resources, while 3% of respondents strongly agreed they were given training and other resources.

Survey question 19. The question, *My institution provided me with opportunities for professional development in teaching*…, was asked of participants. Sixty-one of the educators in the study answered this question. Two percent of educators strongly disagreed their institution provide them professional development opportunities in teaching, while 21% of respondents merely disagreed in response to being given opportunities for professional development in teaching. Ten percent of participants responded with a neutral response. Fifty-five percent of educators agreed their institution provided them with professional development opportunities in teaching and 11% of educators strongly agreed they were given professional development in teaching.

Survey question 20. The question, *I personally sought out resources to improve my teaching*…, was asked of participants. Sixty-one of the educators responded to this question. None of the educators strongly disagreed they personally sought out resources to improve teaching, while 2% merely disagreed seeking out resources to improve instruction. None of the educators responded with a neutral response. Thirty-three of the educators agreed to personally seeking out resources to improve instruction and the majority of educators, 65%, strongly agreed they sought our resources to improve teaching.

Survey question 21. The question, *What opportunities improved your knowledge and execution of andragogy*…, was the next question presented to participants. There were sixty-one participants who responded to this question. The participants were given several options to choose from and could select more than one option. In Table 3, the opportunities chosen are presented.

Table 3

Opportunities to Improve Knowledge and Execution of Andragogy

Type of Professional Development	Number of Responses
Completion of a college course	43
Attending seminar(s)	42
Directive reading(s)	24
Professional learning opportunities provided by institution	25
Professional journals	34
Articles	37
Books	34
None	1
Other	7

Note. Other = Webinars, mentoring, personal experience, interactions with faculty.

Survey question 22. The question, *What experiences have you participated in that have improved your self-efficacy as an instructor*…, was the next query presented. Sixty-one of participants responded to this question. The educators were given multiple options to choose from and were instructed to select all that applied with regards to experiences they participated in to improve self-efficacy. In Table 4, the experiences are presented.

Table 4

Experiences That Have Improved Self-Efficacy as an Instructor

Type of Professional Development	Number of Responses
Completion of college courses	43
Attending seminars/conferences	51
Directive learning opportunities provided by institution	19
Professional learning opportunities provided by institution	29
Professional journals	40
Books	27
None	0
Other	6

Note. Other = Webinars, review of evaluations, time in position, modeling, personal interaction with senior faculty.

Survey question 23. The question, *What obstacles were present when transitioning from the role of clinical practice to educator*…, was another query asked of participants. Sixty-one percentage of educators responded to this question. The educators were given several options of obstacles to choose from. Participants were instructed to select all that applied to their situation. In Table 5, the obstacles educators faced are presented.

Table 5

Obstacle Presented When Transitioning from Clinical Practice to Educator

Obstacles	Number of Responses
Little to no formal orientation	36
Mentoring not available	25
No preparatory time	25
No formalized training in education	26
Not familiar with subject matter	7
None	6
Other	6

Note. Other = New to accreditation process, lack of leadership support, lack of collegial support, extra duties, lack of staffing.

Survey question 24. The question, *I am aware that my self-efficacy has changed based upon…*, was answered by sixty-one of the participants. The educators were given five options to select from which helped to show self-efficacy had changed and instructions were given to choose all that applied. In Table 6, the options are presented.

Table 6

Options That Show Self-efficacy Has Changed

Options	Number of Responses
Faculty evaluations	26
An increase in student test scores	14
Less anxiety when teaching	52
None	4
Other	5

Note. Other = Formula training as an educator, formative and summative evaluations, student surveys and feedback, student responses, personal pursuit of how to teach effectively.

Survey question 25. The question, *Thinking back to the beginning of your teaching career, rate your self-efficacy in the following instructional areas*…, was asked of participants. Sixty participants answered all of the questions and fifty-nine participants answered the question regarding online teaching. Educators were given multiple instructional areas and asked to rate using a five-point Likert Scale of *none or very low, low, medium, high, or very high*. In Table 7, self-efficacy of educators in the area of instruction when they began teaching are presented.

Table 7

Self-efficacy in Area of Instruction in the Beginning of Teaching Career

Area of Instruction	None or Very Low	Low	Medium	High	Very High
Lecture	9	21	18	9	3
Lab/Simulation	8	10	18	17	7
Group Projects	9	15	26	9	1
Test/Test Questions	9	26	22	3	0
Online	13	13	20	11	2
Discussion	6	7	32	13	2
Flipped Classroom	25	19	12	4	0
Interactive Activities	10	17	26	6	1

Note. Statement was presented to 63 participants, yet not everyone responded.

Survey question 26. *Rate your current self-efficacy in the following instruction areas* was asked of participants. Full responses were not given to all survey questions as evidenced by the number of responses to each subject. The educators were asked to respond using a five-point Likert Scale of *none or very low, low, medium, high, or very high* to rate their perceived current self-efficacy regarding specified areas of instruction. In Table 8, the current self-efficacy of the educators in instruction are presented.

Table 8

Current Self-efficacy in Area of Instruction

Area of Instruction	None or Very Low	Low	Medium	High	Very High
Lecture	1	3	12	29	15
Lab/Simulation	1	3	10	24	22
Group Projects	2	2	13	35	8
Test/Test Questions	1	4	15	27	13
Online	2	1	15	22	19
Discussion	0	1	12	31	16
Flipped Classroom	7	7	19	17	8
Interactive Activities	0	4	11	31	13

Note: Statement was presented to 63 participants, yet not everyone responded.

Comparisons. Based on results of the survey, the perceived self-efficacy changed in areas of instruction of educators. A comparison of the beginning self-efficacy and current self-efficacy in each area of instruction was completed. In Table 9, the perceived self-efficacy at the beginning of the teaching career and the current self-efficacy in the area of instruction combined is presented.

Table 9

Comparison of Beginning and Current Self-efficacy in Area of Instruction

Area of Instruction	None or Very Low	Low	Medium	High	Very High
Lecture					
Beginning	9	21	18	9	3
Current	1	3	12	29	15
Lab/Simulation					
Beginning	8	10	18	17	7
Current	1	3	10	24	22
Group projects					
Beginning	9	15	26	9	1
Current	2	2	13	35	8
Test/test questions					
Beginning	9	26	22	3	0
Current	1	4	15	27	13
Online					
Beginning	13	13	20	11	2
Current	2	1	15	22	19
Discussion					
Beginning	6	7	32	13	2
Current	0	1	12	31	16
Interactive activities					
Beginning	10	17	26	6	1
Current	0	4	11	31	13
Flipped classroom					
Beginning	25	19	12	4	0
Current	7	7	19	17	8

Note. Statement was presented to 63 participants, yet not everyone responded.

In question 8 participants were asked to rate their current perceived self-efficacy with regards to teaching. Question 9 inquired about the perceived self-efficacy of

educators when first becoming an instructor. In Table 10, a comparison of the educators beginning and current self-efficacy is presented.

Table 10

Comparison of Beginning and Current Self-efficacy in Teaching

Area of Instruction	Low	Somewhat low	Neither high or low	Somewhat high	High
Beginning	9	20	17	13	3
Current	0	3	9	31	19

Note: N = 62.

The participants of the study were also asked if a mentor was provided to them when transitioning to teaching. The follow-up question in the survey asked if the mentor supported the participant's transition from clinical practice to academia. In Table 11 a comparison is presented of educators who were supplied a mentor and the support received.

Table 11

Comparison of Mentor and Support of Mentor

Mentoring	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Provided a mentor	5	18	7	23	8
Mentor supported transition	6	21	10	17	7

Note: N = 61.

In question 10, the participants were asked to rate their perceived self-efficacy in clinical practice. The participants also rated their self-efficacy at the beginning of their

teaching career. In Table 12, a comparison of the educators' self-efficacy in clinical practice and the launch of their teaching career is presented.

Table 12

Comparison of Self-efficacy in Clinical Practice and Beginning of Teaching

Profession	Self-efficacy Level				
	Low	Somewhat low	Neither high or low	Somewhat high	High
Clinical Practice	0	2	4	21	34
Beginning Educator	9	20	17	13	3

Note: Statement was presented to 63 participants, yet not everyone responded.

Reliability of data. Testing reliability of a survey according to Fraenkel et al. (2016) is "consistency of the scores obtained" (p. 255). To determine the reliability of the survey taken by the participants, the Cronbach's Alpha test was administered to check for internal consistency. The procedure of determining uniformity within a survey shows the extent questions measure the same notion or idea (Tavakol & Dennick, 2011). There must be an interrelatedness of questions or the instrument cannot be considered reliable (Fraenkel et al., 2016). Acceptable values of alpha, range from 0.70 to 0.95 (Nunnally & Bernstein, 1994).

Two different Likert scales were used: questions 8-13 contained a scale of low, somewhat low, neither low or high, somewhat high, high. Questions 14-20 contained a five-point scale of strongly disagree, disagree, neutral, agree, strongly agree. After inspecting the data, the decision was made to run separate Cronbach Alpha tests on the questions related to self-efficacy and questions associated with transition from clinical

practice to education. For the self-efficacy questions, Cronbach Alpha was equal to .8093, which is considered an acceptable value (Nunnally & Bernstein, 1994). The remaining questions associated with transition from clinical practice were scored. Cronbach Alpha was equal to .7471, which is a score in the acceptable range (Nunnally & Bernstein, 1994).

Summary

A survey was conducted to gather data from educators in nursing and allied health care programs in a specified geographical location in Southwest Missouri. Email addresses of participants were identified through each of the institution's public website. An email was sent to 202 educators who were identified in nursing, radiologic technology, paramedic, respiratory therapy, and dental hygiene programs, included in the email was an electronic consent form and a link to the survey. The survey was open for four weeks and reminder emails were sent out at the two-week mark and the day prior to the end of the survey. Sixty-three participants consented to the survey, yet not all sixty-three educators responded to each question.

The survey was broken up into three sections: demographics, self-efficacy, and transition from clinical practitioner to educator. The demographic section helped identify the type of institution participants were employed at, with all most three-quarters of them working at a four-year institute. The participants' professional health care occupation and program they taught in were identified, with most being in the nursing field. All of the participants held a minimum of a bachelor's degree, and number of years working in their clinical profession was evenly distributed throughout the indicated years range. The number of years as an educator varied with 6-10 years reported to have the most

educators in the study, followed closely by novice educators with less than five years of teaching experience.

The perceived self-efficacy of participants as current educators and their perceived self-efficacy at the beginning of their teaching career, as well as the knowledge of andragogy were the topic of questions 8-13. The majority of participants rated their current self-efficacy as an educator as either high or somewhat high, as compared to when they first started teaching. Most respondents reported self-efficacy in clinical practices as somewhat high or high.

Educators in the survey were also asked about mentoring when transitioning from clinical practice to educator, and if the mentor supported the transition. Almost half of educators agreed a mentor was provided when beginning their teaching career. Of those responses, results varied on the amount of support participants received from their mentor.

For the study, it was important to identify if educators were given training or some type of resources or professional development in teaching. The results of this question were mixed, with almost equal responses of some participants received training while others did not. Almost two-thirds of participants reported their institution provided them with professional opportunities in teaching. The majority of educators personally sought out resources to improve teaching. Educators were asked to report methods used to help them identify self-efficacy had changed.

Questions 21-26 were used to query educators on the transition from clinical practice to educator to include the knowledge of andragogy. All but one participant identified taking opportunities to improve knowledge as well as the execution of

andragogy. Responses were varied on the experiences which helped participants to improve self-efficacy. Many of the educators in the study reported barriers when transitioning to the role of an educator.

Participants of the study were asked to acknowledge how they knew their self-efficacy had changed with the clear majority reporting less anxiety when teaching. Finally, educators were asked to rate their self-efficacy in specific areas of instruction when first beginning their teaching career and how they perceived their current self-efficacy in those same areas of instruction. The findings of these questions showed educators' self-efficacy improved in all areas of instruction when comparing themselves a beginning teacher to the present.

A survey tool must show validity and reliability (Fink, 2017; Fraenkel et al., 2016). The survey was pilot tested prior to the start of the study to check for validity (Fraenkel et al., 2016). To ensure reliability of the test, the Cronbach Alpha test was used to check for internal consistency of the survey. Questions were separated into two separate categories self-efficacy and transition from clinical to educator with findings from both areas falling within the acceptable range (Nunnally & Bernstein, 1994).

In Chapter Five, the focus on findings from the research study is discussed. The conclusions drawn from the findings are reviewed. Implications of the study are addressed to include best practices to increase self-efficacy of novice educators when transitioning from clinical practice to a role of an educator based on the findings of the study and literature review. Recommendations for further research on this topic are discussed as well as a final summary containing the major components of the research study.

Chapter Five: Summary and Conclusions

This study was designed to provide insight into the self-efficacy of nursing and allied health care educators who have transitioned from clinical practice to teaching. Specifically, how faculty development affected self-efficacy of these educators. Many nursing and allied health care educators transition into teaching with little to no formal training in education (Cangelosi, 2014; Gresham-Anderson, 2015). While considered experts in their field of study they are novices in the area of education (Loftus et al., 2013; Schoening, 2013). The transition from clinical practice to educator has an impact on student learning, for the higher the teacher's self-efficacy, the better the learning experience is for the student (Casanova & Azzi, 2015; Goroshit & Hen, 2014).

Data collected for the quantitative study was collected via an electronic survey in an effort to look at the self-efficacy at the beginning of their teaching career and their current perceived self-efficacy as well as knowledge and implantation of andragogy. Obstacles educators faced along with opportunities educators took to improve self-efficacy were questioned. The study took place at colleges and universities in a specified geographic location in Southwest Missouri. A total of 202 surveys were sent out to nursing and allied health care professional educators. Sixty-three educators responded to the survey.

Findings

Of the 202 surveys mailed out by electronic email, 63 educators participated in the study. The survey was broken into three sections; demographic, self-efficacy, and transition from clinical practice to educator. The first several questions in the demographics section of the survey were designed to describe participants who

completed the study in more detail. The majority of participants were educators employed by four-year universities and community colleges, with certificate programs making up the rest of the participants. Most of the participants reported having master's degrees or doctorate degrees, and less than a hand full reported having only a bachelor's degree.

Participants of the survey reported holding certification or licensure in dental hygiene, EMT/paramedics, radiologic technology, nursing, and respiratory therapy. Almost 70% of participants reported nursing as their health care profession, the remaining fields made up the rest of the participants. The number of years practicing in their profession was fairly evenly distributed between the following choices of years; less than 5 years, 6-10 years, 11-20 years, and 21-30 years. A few educators reported practicing longer than 30 years.

Participants of the study were asked to report the number of years involved in teaching. Over half of the participants reported being a teacher for less than 10 years. A few participants reported teaching more than 21 years with the rest of educators reporting teaching in the range of 11-20 years.

In the survey, participants were asked to identify the program they taught in. Not surprisingly, 70% of educators taught in a nursing program. Radiologic technology and dental hygiene educators made up 12% each, with only one paramedic and one respiratory therapist reporting.

Self-efficacy. Eight questions on the survey were designed to obtain information in regards to the self-efficacy of educators. Most participants ranked their current self-efficacy in teaching as high or somewhat high. A small percentage of responders rated

self-efficacy to be low or somewhat low. Another small percentage rated self-efficacy as neither high or low.

The responses differed greatly on the next question of the survey where participants were asked to rate their self-efficacy at the beginning of their teaching career. In this question, almost half of educators rated self-efficacy as low, or somewhat low. Nearly one-quarter of the survey participants rated self-efficacy as neither low or high and the remaining educators rated self-efficacy as a new instructor as somewhat high or high.

When asked to rank self-efficacy in clinical practice, none of the educators reported low self-efficacy, a very small percentage reported somewhat low and four reported neither low or high self-efficacy. The majority of educators reported having a somewhat high or high self-efficacy when in clinical practice. Educators were also asked their level of agreement or disagreement in regards to if their self-efficacy changed from clinical practice to teaching in higher education. Over half of participants agreed or strongly agreed self-efficacy changed when switching roles. Only a small percentage of educators reported neither a high or low self-efficacy shift when moving to the role of an educator. Another small percentage of participants reported disagreeing or strongly disagreeing there was a change in self-efficacy when transitioning from clinical practice to teaching.

Participants were also asked about exposure to the concept of self-efficacy prior to the survey. While none of the participants strongly disagreed with the statement, a small percentage disagreed and another small percentage reported a neutral response.

The majority of educators agreed or strongly agreed they had experience with the concept of self-efficacy.

The final question in the self-efficacy section asked if the participants were successful teaching their healthcare occupation to students. None of the participants disagreed or strongly disagreed with the statement. A small percentage responded with a neutral response. The majority of educators agreed or strongly agreed with being successful in teaching their healthcare occupation to students.

Transition from clinical practice to education. Questions 14-26 of the survey addressed the transition from clinical practice to education. The first question in this section asked if the educator was given instruction on andragogy. The results were somewhat divided with half of participants responding they had not been given instruction in andragogy. Nearly half of the educators agreed or strongly agreed to being given instruction on andragogy. Only a small portion of the participants responded neutrally to this question.

In the next question presented on the survey, educators were asked about being given formalized instruction in teaching. The majority of participants agreed or strongly agreed formalized instruction in education had been presented to them. A small percentage of educators disagreed or strongly disagreed to receiving any formalized instruction in education. On this question, no one gave a neutral response.

Participants were also asked about being provided a mentor when they transitioned from clinical practice to education. The results of this questioned were varied. Over half of educators agreed or strongly agreed they were given a mentor. Nearly half of the educators disagreed or strongly with being given a mentor during the

transition from clinical to education. A few of the participants responded neutrally to this question.

As a follow-up to the previous question about mentoring, participants were asked if the mentor provided support in the transition from clinical to education. Once again, results were polarized. Nearly half of the educators agreed or strongly agreed the mentor assigned supported the transition to education. While a small percentage of participants gave a neutral response in regards to the effectiveness of having a mentor, almost half of the educators disagreed or strongly disagreed the mentor provided supported the transition from clinical to education.

Participants were asked about training in instruction and other resources received when transitioning to teaching. Nearly half of the educators reported disagreeing or strongly disagreeing in regards to being given training in teaching and other resources. A small percentage of participants gave a neutral response whereas over a quarter of educators agreed or strongly agreed with training in teaching and other resources being received when they transitioned.

The next questions presented on the survey surrounded the topic of professional development. A question was presented to determine if the institution participants were affiliated with provided opportunities for professional development in teaching. The results of this question showed only a small percentage educators disagreed or strongly disagreed with the statement. Another small percentage participants gave a neutral response. The majority of educators reported agreeing or strongly agreeing with being provided professional development opportunities.

In survey question 20, participants were asked if they personally sought out resources to improve teaching. All but one educator reported agreeing or strongly agreeing with this statement. These responses indicate most of the educators wanted to improve instruction in the classroom.

The participants were asked what opportunities improved their knowledge and execution of andragogy and given a list of options educators could choose from along with a place to fill in a choice not presented. Only one participant responded not taking any opportunities. The rest of the educators who completed the survey reported completing college courses, attending seminars, reading articles, books, professional journals, and directive reading. The participants also reported the use of webinars, mentoring, use of faculty, and personal experience as opportunities to improve knowledge and execution of andragogy.

The participants of the study were asked about the types of experiences they had participated in to improve their self-efficacy as an instructor. Responders to the survey were given many of the same options as the previous questions and asked to select all that applied. Not one of the educators selected none. The participants reported attending a seminar or conference and completion of a college course improved self-efficacy. Other opportunities included reading professional journals, directive learning opportunities, and books as well as professional learning opportunities provided by institutions. Experiences such as webinars, review of evaluations, time in the position, modeling, personal interaction with senior faculty, and self-assessment were identified as other ways to improve self-efficacy as an instructor.

The next survey question asked participants to identify obstacles presented when transitioning from the role of clinical practice to educator. Six options were presented to choose from along with the opportunity to specify any not listed and instructions to check all that applied. A small percentage of educators who completed the survey reported no obstacles when transitioning from clinical practice to an educator. Participants reported having little to no formal orientation, no formalized training in education, no mentoring or preparatory time, and not familiar with subject matter.

Participants were also asked to identify how they knew their self-efficacy changed. Survey responders were asked to check all of the options which applied and were allowed to add any not listed. The majority of educators reported less anxiety in teaching as an indicator their self-efficacy had changed. A very small percentage of participants of the study selected none. Educators reported faculty evaluations and an increase in student test scores was evidence of a change in self-efficacy.

The participants were asked to think back to the beginning of their teaching career and were asked to rate their self-efficacy using a scale of none or very low to very high in eight areas of instruction. Participants were given specified areas of teaching. The areas of instruction included: lecture, lab/simulation, group projects, test/test questions, online, discussion, flipped classroom, and interactive activities.

The final question on the survey asked the participants to rank their current self-efficacy using a scale of none or very low to very high in eight areas of instruction. Participants were given specified areas of teaching. The areas of instruction included: lecture, lab/simulation, group projects, test/test questions, online, discussion, flipped classroom, and interactive activities.

Conclusions

The initial purpose of the study was to assess levels of self-efficacy of novice educators as it pertains to their overall desire to enhance knowledge of educational instruction and subsequently augment development in the field of education. Obstacles and barriers educators faced when entering academia were also identified along with opportunities to improve self-efficacy. The findings of the study are summarized by the research questions and tied to the literature found in Chapter Two.

Research question one. The first research questions guiding the study was: *How has the self-efficacy level of health care professionals changed from the time they entered the higher education teaching field to the present*? In the survey, participants were asked to rate their self-efficacy at the beginning of their teaching career as well as their current self-efficacy. Twenty-nine of participants ranked self-efficacy as low or somewhat low when beginning teaching as compared to only three ranking current self-efficacy somewhat low. These findings are consistent with research presented in the literature review. According to multiple sources, individuals who transition into teaching from clinical practice have a lower self-efficacy at the time of their career change (Anderson, 2009; Hand, 2014; Izadinia, 2014; Loftus et al., 2013). The results of the survey also showed only 16 participants ranked self-efficacy as somewhat high or high when starting their teaching career as compared to 50 educators, who ranked their current self-efficacy as somewhat high to high. Results of the survey indicated an increase in self-efficacy from the time the participants entered into higher education to present time. The data reported is consistent with findings in the literature review, which suggest more time and

experience increases self-efficacy in teaching (Gardner, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Whitfield & Hickerson, 2013).

Research question two. The second research question guiding this study was: *What types of opportunities do novice health care educators report improved their knowledge and execution of andragogy?* The survey was used to ask participants what opportunities improved their knowledge and execution of andragogy. Over 70% of participants reported completion of college courses, while 70% of educators attended a seminar to improve knowledge and execution of andragogy. Over half the respondents reported reading articles, professional journals, and books. A little less than half of educators took part in professional learning opportunities and the use of directive readings. One person indicated no opportunities were taken to improve knowledge and execution of andragogy. Others reported webinars, mentoring, or using mentors. The literature supports faculty development opportunities increasing knowledge and execution of andragogy (Lancaster et al., 2014; Loftus et al., 2013; Merillat & Scheibmeir, 2016).

Research question three. The third research question guiding the study was: *What barriers do health care educators report having to overcome in an effort towards becoming a teacher in higher education*? The survey contained several questions regarding the transitioning from clinical practice to education. One question, in particular, asked educators to identify obstacles present when transitioning from clinical practice to education. Of the options provided in the survey, 36 of the participants reported little to no formal orientation to education. Twenty-six of the respondents cited no formalized training in education, and 25 educators stated no mentoring and no

preparatory time. The findings of this question identified educators had to overcome many obstacles in the transition from clinical practice to education. Research indicated educators who transitions from clinical practice to education face many struggles (Cangelosi, 2014; Gresham-Anderson, 2015; Murray et al., 2014; Schoening, 2013). Lack of mentors, understanding of curriculum and objectives as well as how to teach are just a few of the obstacles novice educators faced (Gresham-Anderson, 2015; Loftus et al., 2013).

Research question four. The fourth research question guiding the study was: *What personal actions, or opportunities, do health care educators with no prior experience or training in educational practices seek in an effort to improve their implementation of andragogy?* In the survey, participants were asked if their institutions provided opportunities for professional development. Sixty-seven percent of educators agreed their institution provide them with professional development. When asked about pursuing resources on their own, 98% of educators responded positively to seeking out resources to improve their teaching. Based on results of the survey, educators used various resources to help improve their implementation of andragogy. These resources include completion of college courses, attending seminars, and reading of journals, articles, directive readings, and books. Individuals who participate in faculty development programs find an increase in self-efficacy as well as a sense of belonging (Hemmings, 2015; Singh et al., 2013).

Most of the educators reported self-efficacy changed from the beginning of their teaching career to present day. Many participants reported a low self-efficacy when first transitioning from clinical practice which was consistent with the findings of Schoening,

(2013). This is in contrast to their self-efficacy when in clinical practice, where survey results showed 89% of educators reported a high self-efficacy when in clinical practice, which falls in line with the findings of Loftus et al. (2013).

While novice educators were confident in their abilities in their respective health care profession, the transition to teaching lowered self-efficacy (Anderson, 2009; Izadinia, 2014). A decrease in self-efficacy is supported by research findings where individuals who transition from clinical practice to education feel overwhelmed and unprepared for their role as an educator (Cangelosi, 2014; Gresham-Anderson, 2015; Murray et al., 2014; Schoening, 2013). Sixty-four percent of participants in the study reported having formalized instruction in teaching while almost half of respondents reported a low self-efficacy at the beginning of their teaching career.

Without formal training in academia, novice educators face challenges and feelings of low confidence in their teaching abilities (Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015; Izadinia, 2014; Loftus et al., 2013). Educators feel overwhelmed and unprepared for the new duties as a teacher (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013). Of those with little to no experience teaching, novice educators often model their teaching practice based on their own experiences with teachers (Loftus et al., 2013).

The theoretical theory used for this study was Bandura's social learning theory (Bandura, 1977a, 1977b; Bandura et al., 1977). Social learning occurs when individuals learn behaviors, attitudes, as well as the outcomes of those behaviors by observation of others otherwise known as modeling (Bandura, 1977a, 1997). This type of behavior is often seen in educators who have no experience in teaching and teach in the manner

which they were taught (Loftus et al., 2013). Results of the survey showed half of the participants indicated a low self-efficacy in lecture and in interactive activities when becoming an educator.

Findings from the review of literature indicate mentoring and professional development opportunities can improve the self-efficacy of novice educators and their skill set as an educator (Anderson, 2009; Cangelosi, 2014; Loftus et al., 2013). Participants of the survey reported 50% of educators were provided a mentor when transitioning to education. In another question participants were asked if the mentor supported the transition from clinical to academia, 48% of educators responded their mentor did not support the transition into the field of education. The findings of the survey are consistent with the literature review in which mentors can be provided but it does not necessarily mean they are always effective (Gotian, 2016; Takkac Tulgar, 2015). According to Callahan (2016), a mentoring program is only as good as its mentors. Examination of the literature showed problems with mentoring programs as institutions do not allow for budgeting and support of the mentor to take the time needed to be an effective mentor (Lozinak, 2016; Schoening, 2013).

Professional development is an important component in improving the self-efficacy of educators (Hemmings, 2015; Singh et al. 2013). All participants but one indicated seeking out resources to improve teaching. Findings from the literature review indicated professional development increases self-efficacy in educators as well as a sense of belonging (Hemmings, 2015; Singh et al. 2013).

Implications

When conceptualizing data outcomes from this particular study, it was clear nursing and allied health care professionals who transition from clinical practice to education had a lower self-efficacy when first starting their teaching career (Loftus et al, 2013). While considered experts in their field of clinical study, educators find themselves feeling overwhelmed and unprepared for the role as educators (Schoening, 2013).

As reported in this study, 63% of educators responded their self-efficacy changed when upon transitioning from clinical practice to education. Even though many in the study had formalized instruction in teaching, self-efficacy levels were reported as low in the beginning stages of being an educator. Studies indicate the self-efficacy of teachers affects the learning experience of students (Mintzes et al., 2012; Phillippo & Stone, 2013; Sezgin & Erdogan, 2015). Ways to impact and improve the self-efficacy of nursing and allied health professionals who transition from clinical practice to the education would include formalized instruction in education and educational theories (Mintzes et al., 2012; Phillippo & Stone, 2013; Sezgin & Erdogan, 2015).

Other areas used to improve the teaching experience for novice educators include a formalized orientation process (Loftus et al., 2013; Whitfield & Hickerson, 2013). The results of the survey indicated 59% of participants received little to no formalized orientation. Loftus et al. (2013) indicated proper orientation to the role of an educator could alleviate feelings of doubt and being overwhelmed in the health professional's new role as an educator.

While teaching is a main component of the role of an educator, individuals often find themselves faced with other duties associated with the position (Cangelosi, 2014; Gresham-Anderson, 2015; Loftus et al., 2013; Wiseman, 2016). As Whitfield and Hickerson (2013) acknowledged, developing objectives, making tests, creating curriculum, and as one of the participants stated trying to learn all of the other "extra-curricular" information were just a few examples of other responsibilities of an educator. Giving novice educators expectations of their new role as well as support through the transition process can alleviate anxiety and increase self-efficacy (Gresham-Anderson, 2015; McAllister et al., 2014).

Faculty development. It was equally evident from this study, educators took action to improve self-efficacy through professional development opportunities provided to them, or those personally sought out. The majority of educators completed college courses in an effort to improve self-efficacy. Almost half of educators participated in professional learning opportunities provided by their institution. Participants of the study indicated being aware their self-efficacy changed as feelings of anxiety decreased when teaching, when there was an increase in student test scores, and improvement was indicated on faculty evaluations. Measuring the self-efficacy of educators at the beginning of their teaching career would provide a baseline of their perceived self-efficacy and give a novice educator as well as department chairs the ability to measure the growth. Expectations and goals a novice educator would need to achieve at the end of the first year could be set. By evaluating self-efficacy in the beginning of a teaching career a measurable account of growth can be obtained.

While not all organizations have structured professional development, findings of the literature indicated implementation of this type of program would aid in increasing the self-efficacy of novice educators (Hemmings 2015; Loftus et al., 2013; Singh et al., 2013). There are subject areas to consider when creating faculty development program. Suggested areas could include, teaching strategies for educators, an understanding of the different learning styles of students, as well as curriculum models where various styles of learning are incorporated (Loftus et al., 2013). Giving instructors resources which allow them to understand their audience will also improve the educational experience (Cangelosi, 2014; Hemmings, 2015; Loftus et al., 2013).

Many students in nursing and allied health programs are known as adult learners (Accreditation Commission for Education in Nursing, 2016). The learning approach to adult learners differs from children (Knowles, 1970). Providing formalized education on andragogy would not only increase an educator's self-efficacy but also improve students' learning experience as well (Knowles, 1970; Loftus et al., 2013).

Most health care professionals need to keep up with professional certifications and licensures, completed through continuing education credits (Accreditation Commission for Education in Nursing, 2016; American Registry of Radiologic Technologists, 2016). In order to be an effective teacher, nursing and allied health care educators need to stay abreast of current practices in their profession in an effort to educate students on the latest technology and standard of care (American Registry of Radiologic Technologists, 2016). Providing educators faculty development to align professional content with certification would allow educators to keep with the instruction of health care practice (Loftus et al., 2013).

Mentoring. Studies presented in the literature review indicated the use of a mentor was an effective means of supporting a novice educator and indicated mentoring assisted novice educators in alleviating feelings of inadequacy and self-doubt (Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015; Meanwell & Kleiner, 2014; Whitfield & Hickerson, 2013). However, another question in the survey yielded educators were provided a mentor at the beginning of their teaching career; however, not all mentors supported the transition from clinical practice to education. Research findings from Cangelosi (2014) indicated while there is a need for implementation of a formalized mentoring program, it can be problematic for the institution for granting time for faculty to devote to mentoring due to budgetary constraints and faculty shortages. Only a quarter of universities have a formalized mentorship program (Law et al., 2014). These findings do not diminish the fact a mentoring program should be established to aid in the transition from clinical practice to education.

Mentors can serve as a guide and help a novice educator by offering resources to aid in the teaching role (Law et al., 2014). While mentoring can take on many different forms, having a formalized mentoring program can ensure proper support novice educators needs to be successful in their new career as an educator (Callahan, 2016; Klinge, 2015). Since mentoring is considered a learned skill, not all individuals are effective mentors (Callahan, 2016; Gotian, 2016). In an effort to increase the effectiveness of mentoring programs, institutions need to support the mentoring process (Lozinak, 2016).

Lack of support from the institution concerning allowing time for mentoring to occur can be a problem at some universities (Lozinak, 2016; Schoening, 2013). Pairing

the mentee and the mentor is very important in this process (Klinge, 2015). A good relationship between the mentor and mentee is a crucial piece of the process (Callahan, 2016; Klinge, 2015). If set up properly, a good mentor program could be very effective in alleviating feelings of anxiety and self-doubt in a novice educator (Callahan, 2016; Klinge, 2015).

Future Research

While the study contributes to the knowledge on how faculty development aids in the self-efficacy of novice educators in nursing and allied health programs, it is by no means exhaustive. Several changes in the construction of this study should be considered for future studies. Changes would help gain a more comprehensive understanding of barriers novice educators experience when transitioning from clinical practice as well as the steps taken to improve their self-efficacy.

Because this study was conducted in a specified geographic region in Southwest Missouri, there were limitations to the generalization of its findings (Fraenkel et al., 2016). Further research done should include more nursing and allied health care programs in the country. By expanding the sample size, the study would have more opportunity to be generalized due to different demographic populations (Fraenkel et al., 2016). The increase of population would allow for a larger sample size, which could give a more accurate estimation of the population of nursing and allied health care educators. Furthermore, the geographic and cultural differences could have an impact on the type of formalized instruction educators have received in education (Fink, 2017). Gathering data from larger universities could glean different approaches for faculty development opportunities (Fraenkel et al., 2016).

The use of descriptive statistics in this study and future research could benefit from using inferential statistics. Hypothesis testing could be utilized to determine if faculty development increased self-efficacy. A study could be conducted on two groups of educators; one group could be given faculty development opportunities, and another group who have to initiate their own faculty development. A comparison could be completed to answer the question if any organized faculty development actually improves self-efficacy.

A qualitative study could also garner insight into implications of the study. Talking with novice educators who have transitioned from clinical practice to education could result in gaining additional information into a variety of ways to improve self-efficacy in regards to teaching and the knowledge and execution of andragogy. Identifying exact types of faculty development opportunities made available to educators by their institution which helped improve self-efficacy may be obtained through questions in a qualitative study. Questions regarding barriers novice educators faced could gather additional information to remove these barriers from for future educators.

The use of mixed methods would allow for both quantitative and qualitative methodology (Creswell, 2014; Fraenkel et al., 2016). This type of study would obtain comprehensive information on both methods (Fraenkel et al., 2016). A survey could be conducted on self-efficacy with the addition of interviews where more information could be obtained, thus adding significant information to the field of study.

Summary

This quantitative study was intended to discover if faculty development improved self-efficacy of nursing and allied health care educators. Using Bandura's (!977a; 1977b)

theory of social learning as well as self-efficacy as the theoretical framework, the study was guided by research questions intended to determine if faculty development improved self-efficacy. In addition, opportunities for faculty development and obstacles presented to nursing and allied health care educators were identified. The educators' self-efficacy at the beginning of their teaching career, as well as the current self-efficacy, was evaluated.

In Chapter Two, the literature review detailed Bandura's theory of social learning citing learning occurred through three modes for motivating the observation and modeling process: live modeling, verbal instruction, and symbolic model (Bandura, 1986). Nursing and allied health educators who lack formalized training often learn to teach modeling the methods of how they were taught (Loftus et al., 2013). Bandura (1986) postulated by using live modeling a demonstration of teaching would occur, whereas verbal instruction an educator can describe how teaching is done and symbolic modeling would allow a novice educator to observe teaching through of avenues such as TV, books, or internet (Mintzes et al., 2013).

Many findings of the study echoed the literature found in Chapter Two. The participants had difficulty and struggles while transitioning from clinical practice to education. Self-efficacy lowered when transitioning from clinical practice to education as heath care professionals are in essence establishing a new identity as an educator (Izadinia, 2014; Loftus et al., 2013; Woolfolk & Hoy, 1990). Literature supports the need for all educators to be provided with formal training on becoming an educator (Loftus et al., 2013; Whitfield & Hickerson, 2013). While almost half of the participants of the survey reported being offered mentors, it was also stated mentorship was not as supportive as it could have been. Mentoring programs alleviate feelings of self-doubt

(Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015; Meanwell & Kleiner, 2014; Whitfield & Hickerson, 2013).

Barriers identified by participants were consistent with the literature review. Little to no formal orientation to the new role of an educator creates anxiety (Loftus et al., 2013). A lack of time to prepare for the role as an educator, as well as a deficiency of knowledge on specific areas of academia such as curriculum, objectives, and outcomes were also noted as barriers (Cangelosi, 2014; Goodrich, 2014; Gresham-Anderson, 2015). Teaching methodology and other job duties of educators creates anxiety and can lower self-efficacy (DaRosa et al., 2011; Loftus et al., 2013).

Faculty development programs help increase self-efficacy of educators (Hemmings, 2105; Singh et al, 2013). Results of the survey showed all but one educator participated in some sort of faculty development. Faculty development is necessary for overall growth and development of an educator (Jiandani et al., 2016).

The findings of the study showed a definite change in self-efficacy in all areas of instruction from the beginning of the teaching career to present. Faculty development opportunities were utilized by the majority of educators. Institutions have the opportunity to make the transition from clinical practice to education less taxing on a novice educator. Implementing a formalized orientation process and mentoring program, as well as faculty development, can alleviate the anxiety of novice educators and create a better learning environment for the students (Loftus et al., 2013).

Appendix A

Informed Consent

LINDENWOOD

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Programs as it Pertains to Faculty Development

Principal Investigator: Amanda Doneski
Telephone: [redacted] E-mail: [redacted]

Participant_____Contact info _____

1. You are invited to participate in a research study conducted by Amanda Doneski under the guidance of Dr. Rhonda Bishop. The purpose of this research is evaluate the self-efficacy of nursing and allied health professionals as it faculty development.

2. a) Your participation will involve:
   - An introductory email explaining the nature of this study. It will be followed by an online survey of questions asking you to evaluate your self-efficacy as an educator in nursing or allied health professions.
   - The online survey, which should take approximately 15 minutes, will be sent directly to the email address of the instructors in allied health programs. This survey is not linked to the Primary Investigator's email address.

   b) Approximately 200 participants will be involved in this research.

3. There are no anticipated risks associated with this research.
4. There are no direct benefits for you participating in this study. However, your participation will contribute to the knowledge of self-efficacy in novice educators in nursing and allied health programs and could provide institutions with information to support novice educators.
5. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw.
6. We will do everything we can to protect your privacy. As part of this effort, your identity will not be revealed in any publication or presentation that may result from

this study and the information collected will remain in the possession of the investigator in a safe location.

7. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Investigator, Amanda Doneski at [redacted] or the Supervising Faculty, Dr. Rhonda Bishop at [redacted] You may also ask questions of or state concerns regarding your participation to the Lindenwood Institutional Review Board (IRB) through contacting Dr. Marilyn Abbott, Provost, at mabbott@lindenwood.edu or 636-949-4912.

I have read this consent form and have been given the opportunity to ask questions. I may retain a copy of this consent form for my records. I consent to my participation in the research described above by completing the survey.

Appendix B

Survey Instrument

Evaluating the Self-efficacy of Educators in Nursing and Allied Health Programs

1. I consent to participate in this study.

   Yes
   No

Demographics

Evaluating the self-efficacy of educators in nursing and allied health programs

2. Please choose the type of institution where you are employed.
   Community College
   Four-year University
   Certificate/Diploma Program
   Other (please specify)

3. Please choose the highest degree you have received.
   Associate
   Bachelor
   Master
   Doctorate
   Please state what your degree is in.

4. Please list what your health care profession license/certification is in.
   Dental Hygienist
   EMT/Paramedic
   Radiologic Technologist
   Registered Nurse
   Respiratory Therapist
   Other (please specify)

5. Please choose the number of years practicing in your profession prior to your role as an educator.
   Less than 5 years
   6-10 years
   11-20 years
   21-30 years
   30+ years

6. Please list the number of years teaching.
   Less than 5 years
   6-10 years
   11-20 years
   21-30 years
   30+ years

7. Please list the degrees offered by your institution.
   Certificate/Diploma
   Associate
   Bachelors
   Master

8. Please select program you are teaching in:
   Dental Hygiene
   EMT/Paramedic
   Nursing
   Radiologic Technology
   Respiratory Therapy

Self-Efficacy

Self-Efficacy is the belief in one's capabilities to organize and execute the courses of action required to produce given attainment (Bandura, 1977b).

9. I would rate my current self-efficacy with regards to teaching as:
   Low
   Somewhat low
   Neither low or high
   Somewhat high
   High

10. When I first started teaching I would rate my self-efficacy as:
    Low
    Somewhat low
    Neither low or high
    Somewhat high
    High

11. I would rate my self-efficacy when I was in clinical practice as:
    Low
    Somewhat low
    Neither low or high
    Somewhat high
    High

12. The change from clinical practice to teaching in academia changed my self-efficacy.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

13. Prior to this survey, I have been exposed to the concept of self-efficacy.
    Strongly Disagree
    Disagree
    Neutral
    Agee
    Strong agree

14. I am successful in teaching my healthcare occupation to students.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

Transition from Clinical Practitioner to Educator

Andragogy is the art of science of helping adults learn (Knowles, 1970).

15. When transitioning to the role of educator I was given instruction on andragogy.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

16. I have formalized instruction in the field of education.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

17. I was provided a mentor when I transitioned from clinical practice to academia.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

18. I was provided a mentor who supported my transition from clinical to academia.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly Agree

19. I was given training in teaching and other resources when transitioning from clinical to academia.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

20. My institution provided me with opportunities for professional development in teaching.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly Agree

21. I personally sought out resources to improve my teaching.
    Strongly disagree
    Disagree
    Neutral
    Agree
    Strongly agree

22. What opportunities improved your knowledge and execution of andragogy? *(check all that apply)*

Completion of college courses
Attending seminar(s)
Directive reading(s)
Professional learning opportunities proved by institution
Professional journals
Articles
Books
None
Other (please specify)

23. What experiences have you participated in that have improved your self-efficacy as an instructor? *(check all that apply)*

Completion college courses
Attending seminars/conferences
Directive Readings
Professional learning opportunities provided by institution
Articles
Books
None
Other (please specify)

24. What obstacles were present when transitioning from the role of clinical practice to educator? (*check all that apply)*

Little to no formal orientation
Mentoring not available
No preparatory time
No formalized training in education
Not familiar with subject matter
None
Other (please specify)

25. I am aware that my self-efficacy has changed based upon: *(check all that apply)*

Faculty evaluations
An increase in students test scores
Less anxiety when teaching
None
Other (please specify)

26. Rate the area of instruction where your self-efficacy was at the beginning of your teaching career using the scale: None or Very Low Low Medium High Very High

	None or Very Low	Low	Medium	High Very	High
Lecture					
Lab/Simulation					
Group Projects					
Test/Test Questions					
Online					
Discussion					
Flipped Classroom					
Interactive Activities					

27. Rate the area of instruction where your self-efficacy is presently using the scale: None or Very Low Low Medium High Very High

	None or Very Low	Low	Medium	High Very	High
Lecture					
Lab/Simulation					
Group Projects					
Test/Test Questions					
Online					
Discussion					
Flipped Classroom					
Interactive Activities					

Appendix C

Approval Letter
Institutional Review Board

LINDENWOOD

LINDENWOOD UNIVERSITY ST. CHARLES, MISSOURI

DATE:	December 2, 2016
TO:	Amanda Doneski
FROM:	Lindenwood University Institutional Review Board
STUDY TITLE:	[930739-1] Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Care Programs as it Pertains to Faculty Development
IRB REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS DECISION
DATE:	December 2, 2016
REVIEW CATEGORY:	Exemption category # *2*

Thank you for your submission of New Project materials for this research study. Lindenwood University Institutional Review Board has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will put a copy of this correspondence on file in our office.

If you have any questions, please send them to IRB@lindenwood.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Lindenwood University Institutional Review Board's records.

Appendix D

Email Recruitment Letter

My name is Amanda Doneski, and I am a Doctoral Candidate in the School of Education at Lindenwood University. I am working on my dissertation entitled, *Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Programs as it Pertains to Faculty Development*. In this study, I will be utilizing an online survey which should take approximately 15 minutes to complete. The purpose of my research is to evaluate the self-efficacy of novice nursing and allied health educators as it pertains to their overall desire to enhance their knowledge of educational instruction and subsequently augment their development in the field of academia.

I would appreciate your participation in the online survey. All return surveys will be anonymous. There will not be any unique identifiers related to either the institution or faculty where you are employed or other faculty members. There is no compensation for responding nor is there any known risks. In order to ensure that all information will remain confidential; please *do not* include your name. Participation is strictly voluntary and you may leave the survey at any time.

The data collected will provide useful information regarding self-efficacy in teaching as well as faculty development opportunities that aid in increasing teacher self-efficacy in nursing and allied healthcare programs. No data will be shared beyond the purpose of the survey. If you have received this e-mail in error, or you are not the correct contact person within your school, please forward it to the appropriate person. If you have any questions or concerns before participating in this survey please feel free to contact me either by e-mail at [redacted] or by phone at [redacted].

Thank you for your time.

Amanda Doneski, MAHR, RT(R)

Appendix E

Email Recruitment Letter First Reminder

Hello,

I am re-sending this as a reminder asking for your help in participating in a survey for my doctoral dissertation. Please see below for the link. If you have already competed the survey thank you very much and please disregard this email.

My name is Amanda Doneski, and I am a Doctoral Candidate in the School of Education at Lindenwood University. I am working on my dissertation entitled, *Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Programs as it Pertains to Faculty Development*. In this study, I will be utilizing an online survey which should take approximately 15 minutes to complete. The purpose of my research is to evaluate the self-efficacy of novice nursing and allied health educators as it pertains to their overall desire to enhance their knowledge of educational instruction and subsequently augment their development in the field of academia.

I would appreciate your participation in the online survey. All return surveys will be anonymous. There will not be any unique identifiers related to either the institution or faculty where you are employed or other faculty members. There is no compensation for responding nor is there any known risks. In order to ensure that all information will remain confidential; please *do not* include your name. Participation is strictly voluntary and you may leave the survey at any time.

The data collected will provide useful information regarding self-efficacy in teaching as well as faculty development opportunities that aid in increasing teacher self-efficacy in nursing and allied healthcare programs. No data will be shared beyond the purpose of the survey. If you have received this e-mail in error, or you are not the correct contact person within your school, please forward it to the appropriate person. If you have any questions or concerns before participating in this survey please feel free to contact me either by e-mail at [redacted] or by phone at [redacted].

Thank you for your time.

Amanda Doneski, MAHR, RT(R)

Appendix F

Email Recruitment Letter Final Reminder

This is a final reminder asking for participation in my survey as it will close Tuesday night. If you have already completed it, thank you very much for your help!

My name is Amanda Doneski, and I am a Doctoral Candidate in the School of Education at Lindenwood University. I am working on my dissertation entitled, *Evaluating the Self-Efficacy of Novice Educators in Nursing and Allied Health Programs as it Pertains to Faculty Development*. In this study, I will be utilizing an online survey which should take approximately 15 minutes to complete. The purpose of my research is to evaluate the self-efficacy of novice nursing and allied health educators as it pertains to their overall desire to enhance their knowledge of educational instruction and subsequently augment their development in the field of academia.

I would appreciate your participation in the online survey. All return surveys will be anonymous. There will not be any unique identifiers related to either the institution or faculty where you are employed or other faculty members. There is no compensation for responding nor is there any known risks. In order to ensure that all information will remain confidential; please *do not* include your name. Participation is strictly voluntary and you may leave the survey at any time.

The data collected will provide useful information regarding self-efficacy in teaching as well as faculty development opportunities that aid in increasing teacher self-efficacy in nursing and allied healthcare programs. No data will be shared beyond the purpose of the survey. If you have received this e-mail in error, or you are not the correct contact person within your school, please forward it to the appropriate person. If you have any questions or concerns before participating in this survey please feel free to contact me either by e-mail at [redacted] or by phone at [redacted].

Thank you for your time.

Amanda Doneski, MAHR, RT(R)

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Vita

Amanda Doneski is an Assistant Professor for Southwest Baptist University at Mercy College of Nursing and Health Sciences. Doneski obtained a Bachelor of Art degree in Health Care Administration from Ottawa University and a Master of Art degree in Human Resources from Ottawa University.

Prior to her current role, Doneski was an instructor in a radiologic technology program in Missouri. Doneski also practiced as a radiologic technologist at a hospital in Greene County, Missouri. In an effort to stay active in her profession, Doneski serves on the board of directors for the Missouri Society of Radiologic Technologist.

Doneski has been married to Robert Doneski for 18 years. Robert and Amanda have two children, Christian age 14 and Claire age 6. Amanda and her family enjoy camping and going to the beach for fun and relaxation.